BMI The Sloane Hospital

Quality Report

BMI The Sloane 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	Good
Are services safe?	Good
Are services effective?	Good
Are services caring?	Good
Are services responsive?	Good
Are services well-led?	Good

Mental Health Act responsibilities and Mental Capacity Act and Deprivation of Liberty Safeguards

We include our assessment of the provider's compliance with the Mental Capacity Act and, where relevant, Mental Health Act in our overall inspection of the service.

We do not give a rating for Mental Capacity Act or Mental Health Act, however we do use our findings to determine the overall rating for the service.

Further information about findings in relation to the Mental Capacity Act and Mental Health Act can be found later in this report.

Summary of findings

Letter from the Chief Inspector of Hospitals

BMI The Sloane Hospital is an acute independent hospital that provides outpatient, day care and inpatient services. The hospital is owned and managed by BMI Healthcare Limited. The hospital offers a range of surgical services and physiotherapy. It also provides a diagnostic imaging service which is outsourced.

Services are available to people with private or corporate health insurance or to those paying for one off treatment. The hospital also offers services to NHS patients on behalf of the NHS through local contractual arrangements.

BMI The Sloane Hospital was selected for a comprehensive inspection as part of our routine inspection programme. The inspection was conducted using the Care Quality Commission's new inspection methodology. We carried out a comprehensive inspection of BMI The Sloane Hospital on 17 - 18 August 2016. We reviewed how the hospital provided outpatient and surgical services.

Our key findings were as follows:

Are services safe at this hospital
We rated safe as good because;

Staff knew how to report incidents and learning from incidents was shared with staff

The hospital had a safeguarding lead and staff were aware of how to recognise and escalate any concerns about potential or actual abuse.

There were sufficient staff to care for patients. A resident medical officer was available 24 hours a day, seven days a week with consultants responsible for overall care and management of patients.

The environment appeared clean and equipment checks were up to date.

Staff were up to date with their mandatory training.

However;

Floor coverings were not in line with infection prevention and control best practice guidance.

There were no hand hygiene sinks in patient's rooms and staff had to use sinks in the patient's bathroom or on the corridor.

There was no formal rota for consultant cover out of hours cover.

Pre- procedure checks were performed, but the doctor had not always countersigned they were correct.

Are services effective at this hospital
We rated effective as good because;

Care and treatment was informed by best practice guidance and staff had access to polices and procedures.

Audits were carried out and improvements made where necessary.

Staff knew their responsibilities in relation to consent and the Mental Capacity Act (2005).

Staff were up to date with training and competent to care for patients and many staff had an appraisal.

Patient's pain was assessed and treated effectively and there was good multidisciplinary working.

The hospital had systems to monitor revalidation for consultants and check they had appropriate indemnity or insurance cover.

Summary of findings

Are service caring at this hospital
We rated caring as good because;

Patients spoke positively about their experience of the hospital and described staff as friendly and caring.

Staff involved patients in discussions about their care and treatment and explained beforehand any procedure they carried out. Patients told they were informed about the different treatment options and their family or friend could attend a consultation with them.

Responses to recent Family and Friends tests indicated that patients were either likely or very likely to recommend the service.

Are services responsive at this hospital
We rated responsive as good because;

Patients did not experience long waiting times to be seen in outpatients or have treatment as inpatient or day case.

Pre-operative assessments were carried out to ensure the hospital identified and meet all the needs of patients including those who were living with dementia or had a learning disability.

Extended opening hours in the outpatients department meant patients could be seen after work or on a Saturday.

Patients were provided with information about their procedure.

Patients were encouraged to raise concerns and were given details about how to make a complaint. All complaints between April 2015 - March 2016 had been resolved and closed and staff were able to give examples of changes following a complaint.

Are services well led at this service
We rated well led as good because;

There was an overarching BMI Healthcare strategy with strategic priorities for the hospital. Staff told us the focus was to provide the best patient care and outcomes.

Systems to monitor the quality and safety of care were effective and risks were recorded and action taken to mitigate them.

Staff were positive about the leadership and told us there was a inclusive culture. They told us the senior team were visible and approachable and they were able to raise concerns.

Action the provider SHOULD take to improve

- Ensure fittings and furniture in all clinical areas are compliant with infection prevention and control best practice guidance.
- Ensure staff have access to hand washing sinks in line with infection prevention and control guidance.
- Continue to review systems to ensure compliance with national guidelines in relation to the continuity of power supply in theatres.
- Ensure there is a formal out of hours rota for consultant cover.
- Review systems in place to ensure pre-procedure checklists are completed accurately.

Professor Sir Mike Richards
Chief Inspector of Hospitals

Overall summary

Summary of findings

Overall, we rated the services at this hospital as good.

The hospital had taken action to mitigate risks to patients and surgical safety checklists were completed prior to surgery.

Patient records were up to date and contained all relevant information.

Medicines were managed safely and equipment was available and ready to use.

There were sufficient staff with appropriate qualifications to care for patients.

Staff were trained and aware of how to recognise the signs of abuse in adults and knew what action to take.

Care and treatment was informed by evidence based guidance.

Patients received effective pain relief.

Staff treated patients with dignity and respect and patients spoke positively about staff and the care they received. We observed staff speaking to patients in a calm reassuring tone.

Access for treatment was generally good with a low rate for procedures being cancelled and patients being readmitted.

The hospital followed the BMI national complaints procedure and complaints were discussed at the Medical Advisory Committee and trends identified. They were also discussed at staff team meetings.

Services were well led and senior staff had oversight of the risks, with plans to mitigate them, for each area. An example of this was the suspension of children's services because they were not meeting the standards for children's services.

The daily inter-department (10@10) meeting was attended by staff from each service and the hospital manager had an opportunity to share information on activities, equipment, staffing and incidents.

Staff from all departments were positive about the local and hospital leadership and commented how it had improved since the appointment of the new hospital manager. Staff felt they were supported by the local and hospital leadership team and their views were sought through the staff forum.

However:

Access to hand washing sinks and sinks did not comply with infection prevention and control guidelines. Floor coverings were not in line with infection prevention and control best practice guidance.

There was no formal rota for out of hours consultant cover.

Pre- procedure checks were performed, but the doctor had not always countersigned they were correct.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Surgery	Good	We rated surgery as good because: The hospital had systems to minimise risks to patients undergoing surgery. These included use of the World Health Organisation surgery checklist and reporting and learning from incidents. There were enough competent staff to care for patients with a resident medical officer on site 24/7 and consultants available via phone. Care and treatment was informed by evidence based guidance. There were effective working relationships across theatres and the wards and other teams in the hospital. Staff were caring towards patients and treated them with dignity and respect. Responses to the Family and Friends test indicated patients would recommend the hospital. Waiting times for treatment varied and all patients had a pre-operative assessment. Translation services were available for patients and patients were given meals according to their dietary preference/requirements. The hospital had an effective complaints system and we were given examples of changes following complaints. Staff were positive about their local manager and the hospital manager. They told us they felt supported and were able to raise concerns. There were a range of committees that monitored the quality and safety of care provided and dashboards in relation to quality and performance. However: There were no hand hygiene sinks in patient's rooms. There was no formal rota for out of hours consultant cover.
Outpatients and diagnostic imaging	Good	We rated outpatients as good because: Staff identified and took action in response to risks to ensure patients received safe care.

Summary of findings

The department was clean and all equipment had been checked. A laser protection officer from a local NHS foundation trust oversaw safety arrangements for the laser service.
There were sufficient staff who were up to date with their mandatory training.
Waiting times for an appointment were two to four weeks for NHS funded patients and one to two weeks for privately funded patients.
All patients were consented prior to any procedure and staff were aware of their responsibilities under the Mental Capacity Act 2005.
Patients told us they were involved in discussions about their care and treatment and described the staff as friendly and caring. They were pleased with how they were treated and feedback indicated they would recommend the service to their family and friends.
The risk register was up to date. Information about performance and quality of care was shared with staff.
Staff told us there was an open culture and staff felt able to voice concerns and felt they were listened to. They spoke positively about the management team.
However:
Pre- procedure checks were performed, but the doctor had not always countersigned they were correct.
Some areas in the physiotherapy department were carpeted.

Summary of findings

Contents

Good

BMI The Sloane Hospital

Services we looked at :
Surgery and Outpatients.

Summary of this inspection

Background to BMI The Sloane Hospital

BMI The Sloane Hospital in Beckenham Kent is part of BMI Healthcare Limited, the UKs largest provider of independent healthcare. The hospital has 32 inpatient beds, of which 30 are in use, across two wards. It provides services to people within the catchment of Greater London but takes patients from across the country. The imaging diagnostic service is outsourced and was not included in this inspection.

The hospital has been providing patient care for over 30 years. It has two theatres, one of which being laminar flow, through which they treat all elective surgical specialties. There are 32 registered beds, of which 30 are currently in use over two wards. The outpatient department has 12 consulting rooms, a treatment room, health screening and pre assessment areas. There is a separate physiotherapy department consisting of a gym and five further consulting rooms.

The registered manager titled as the hospital manager had been in post for three months at the time of the inspection.

Our inspection team

Our inspection team was led by:

Inspector: Temi Oke, Care Quality Commission

The team included CQC inspectors and a variety of specialists. There was a surgical consultant, an executive level nurse and senior nurses with backgrounds in surgery and outpatients.

Why we carried out this inspection

We carried out this inspection as part of our planned programme of regulatory visits.

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 peoples' needs?
- Is it well led?

Before visiting we reviewed a range of information we held about the hospital. Patients were invited to contact CQC with their feedback. We visited the hospital on 17 and 18 August 2016 to undertake an announced inspection. As part of the inspection visit process we spoke with members of the executive management team and individual staff of all grades. We also met with groups of staff in structured focus groups.

We spoke with people attending the outpatient clinics as well as those using inpatient services. We looked at comments made by patients who used the services of BMI The Sloane Hospital when completing the hospital satisfaction survey and reviewed complaints that had been raised with the hospital.

We inspected all areas of the hospital over a two day period, looking at outpatients and surgical care .

Our inspectors and specialist advisors spent time observing care across the hospital, including in the operating theatres. We reviewed patient's records where

Summary of this inspection

necessary to help us understand the care that they had received. We also reviewed maintenance, training, monitoring and other records held by the hospital. We spoke with staff, including managers, consultants, medical staff, registered nurses, health care assistants, operating department assistants, allied health professionals, and administrative staff. We spoke with patients and relatives, and observed care and treatment.

Information about BMI The Sloane Hospital

The hospital provides services to adults and young adults aged 16 years and over.

At the time of the inspection visit, there were 228 doctors working at the hospital under practicing privileges. The hospital had a Resident Medical Officer (RMO) who was provided through an agency under a contract.

An interim outpatient manager was in post whilst the hospital was in the process of recruiting a permanent member of staff. A theatre manager led the theatre staff and a ward manager led nursing staff on the ward.

There were 29.7 full time equivalent (FTE) registered nurses employed at the Hospital at the time of our inspection. Of these 15.3 FTE nurses were working on the inpatient department, 8 FTE nurses were working in theatres and 6.4 FTE nurses in the outpatients department.

There were 11.6 FTE operating department technicians and health care assistants; 2.8 FTE were working in the inpatient departments, 2.5 FTE in the outpatient department and 6.3 FTE in theatres.

During the period April 2015 - March 2016 the hospital had 3,388 inpatient and day case patients. Of these 9% were NHS funded. In outpatients there were 10,706 first attendances and 16,766 follow up attendances.

Pathology, emergency blood supplies, histopathology, diagnostic imaging and catering are outsourced to third party suppliers.

Accident and emergency, end of life care, maternity services and termination of pregnancy services are not provided at the hospital.

The hospital manager was the Controlled Drugs Accountable Officer.

What people who use the service say

Patients and relatives we spoke with were positive about the care and treatment they received. They told us they were involved in discussions about their treatment and staff treated them with dignity and respect.

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

Good

We rated safe as good because;

- The hospital had taken action to mitigate risks to patients. Risk assessments were carried out on patients whose condition might deteriorate using evidence based tools.
- Staff knew how to report incidents and received feedback about individual incidents and trends.
- Equipment was checked and cleaned and all areas we inspected appeared clean.
- Medicines were stored securely and in line with best practice.
- Attendance at mandatory training was monitored and the majority of staff were up to date with their training.
- There were sufficient competent staff to care for patients.
- Staff were aware of their responsibilities in relation to safeguarding and knew the action to take if they suspected abuse.

However;

- There were no hand hygiene sinks in patient's rooms and staff had to use sinks in the patient's bathroom or on the corridor.
- There was no formal rota for consultant cover out of hours cover.
- Pre- procedure checks were performed, but the doctor had not always countersigned they were correct.

Are services effective?

Good

We rated effectiveness as good because;

- Care and treatment was informed by evidence based practice.
- We saw evidence that audits were carried out and where possible the hospital submitted data to national audit data bases.
- The medical advisory committee (MAC) conducted an annual review of practising privileges for consultants working at the hospital and we saw evidence this was recorded.
- The majority of staff had had an appraisal and staff were supported to remain competent through training provided by a practice development nurse.
- Staff had completed training in consent and the Mental Capacity Act 2005 and consent forms we reviewed were fully completed.

Summary of this inspection

- Staff used evidence based tools to asses patient's pain and patients we spoke with said their pain had been managed effectively.

Are services caring?

Good

We rated caring as good because:

- Patients spoke positively about the care and treatment they received and how staff interacted with them.
- For 11 months between May 2015 - May 2016, 100% of patients who completed the Friends and Family test said they would recommend the hospital.
- We observed interactions between staff and patients were caring and staff introduced themselves to patients.

Are services responsive?

Good

We rated responsive as good because;

- Pre-operative assessments were carried out to identify potential risks to patients undergoing surgery.
- Patients did not experience long waiting times for an outpatient appointment or their surgery and the hospital had a low cancellation rate for surgical procedures.
- Extended opening hours in the outpatients department meant patients could be seen after work or on a Saturday.
- Translation services were available for patients and information leaflets were available.
- Staff were aware of the complaints process and information was available for patients. Complaints were discussed at governance and staff team meetings.

Are services well-led?

Good

We rated well-led as good because:

- Staff spoke positively about the new hospital manager and their local line managers. They felt the culture and support had recently improved and their managers were visible and approachable.
- Staff described an open culture and they felt comfortable raising concerns.
- There were monthly governance meetings where the quality and safety of care was discussed and actions taken.
- Risk registers were up to date with actions to mitigate risks.
- The hospital had systems to monitor and review practising privileges for consultants.
- There was evidence of staff and patient engagement with managers responding to feedback.

Detailed findings from this inspection

Overview of ratings

Our ratings for this location are:

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

Notes

Good

Surgery

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

Information about the service

Surgery is the primary inpatient activity of BMI The Sloane Hospital. The key services offered include general surgery, orthopaedics, gynaecology, ophthalmology, ear nose and throat (ENT), aesthetics, oral/dental, vascular and general medicine.

The hospital has two operating theatres, one with laminar flow (a system of circulating filtered air to reduce the risk of airborne contamination). In addition, there are two anaesthetic rooms and a three bay recovery. One theatre was closed during our inspection.

The hospital has 32 beds spread over two floors. Cator ward is on the ground floor and used as an inpatient ward while Langley ward is on the first floor and used as a day case ward. Langley ward was closed during the period of our inspection. The hospital has no critical care facilities. In an emergency, the hospital transfers patients to a nearby NHS trust.

Between April 2015 and March 2016, there were 3,388 inpatient treatments. Of these 9% were NHS funded. There were 800 inpatient discharges and 2,588 day-case discharges during the period. Five young adults aged 16 and 17 years were discharged from the inpatient ward and 14 young adults aged 16 and 17 years were discharged from the day-case ward. The hospital did not admit children under the age of 16. Patients aged 16 and 17 years have to meet the adult care pathway requirements to be admitted. There were 3,208 visits to theatre.

The inspection included a review of all the areas where patients received care and treatment. We visited the pre-assessment clinic, the inpatient ward, anaesthetic rooms, theatres and recovery area. We spoke to five patients and one relative and reviewed five patient records. We spoke to 20 members of staff including managers, medical staff, registered nurses, health care assistants, operating department practitioners and administrative staff.

Good

Surgery

Summary of findings

Overall, we rated surgery at The Sloane Hospital as good because:

- The World Health Organisation (WHO) 'five steps to safer surgery' checklist was fully implemented and the hospital carried out regular audits to monitor adherence. There were effective systems in place to protect patients from harm and a good incident reporting culture. Learning from incident investigations were disseminated to staff.
- Patient records were comprehensive, with appropriate risk assessments completed. Medicines were generally stored safely and securely.
- Staff routinely assessed and monitored risks to patients. They used the national early warning score to identify patients whose condition might deteriorate.
- There were clear policies and procedures in line with best practice guidelines. Patients were cared for by appropriately qualified nursing staff who had received an induction and achieved specific competencies before being able to care for patients independently. Resident medical officers (RMOs) received regular training as well as support from consultants who had practising privileges in place.
- Theatre and ward staff provided a caring, kind, and compassionate service, which involved patients in their care and we received positive comments from patients. Patients' feedback was sought and the latest Friend and Family Test results showed 100% of patients would recommend the hospital.
- Staff were aware of people's individual needs and considered these when providing care. The hospital dealt with complaints and concerns promptly, and there was evidence the hospital used learning from complaints to improve the quality of care.
- We saw good local leadership within the department and staff reflected this in their conversation with us. Staff were supported in their role and had opportunities for training and development. There was a positive culture in the theatres and ward and members of staff said they could raise concerns with the leadership team.

However,

- There were no hand washing facilities in patient rooms and staff had to wash their hands in patient's bathrooms or the nearest hand hygiene sinks in the utility rooms at the end of the ward.
- There was no backup uninterrupted power supply (UPS) system in the theatres. Although individual items of equipment had back up batteries and the hospital emergency power generator could come into effect within 20 seconds of a power outage.

Good

Surgery

Are surgery services safe?

Good

We rated safe as good because:

- The World Health Organisation (WHO) 'five steps to safer surgery' checklist was fully implemented and the hospital carried out regular audits to monitor adherence.
- There were effective systems to protect patients from harm and a good incident reporting culture. Learning from incident investigations was disseminated to staff.
- There were effective arrangements for safeguarding vulnerable adults and children.
- Staff had access to a wide range of equipment and most equipment were adequately maintained.
- Patient records were comprehensive, with appropriate risk assessments completed.
- Medicines were generally stored safely and securely.
- Staff routinely assessed and monitored risks to patients. They used the national early warning score to identify patients whose condition might deteriorate.
- The environment and equipment were clean and staff complied with infection prevention and control guidelines.

However:

- Carpet flooring in Langley ward and uneven flooring in one of the theatres presented an infection prevention and control risk.
- There were no dedicated hand hygiene sinks in patient's rooms. Staff had to wash their hands in patient's bathrooms or the nearest hand hygiene sink in the clean utility room at the end of the ward.
- There was no formal on-call rota for consultants.

Incidents

- There had been 298 clinical incidents reported in the hospital between April 2015 and March 2016. Of these, 259 clinical incidents occurred within surgery and inpatient department. These were not broken down by service or department. There were 33 incidents of moderate harm, 90 of low harm and 175 clinical incidents of no harm. The rate of clinical incidents was higher than the average of other independent acute hospitals in the same period. Senior staff told us they had a high incident-reporting rate because staff were encouraged to report incidents.
- There were 51 non-clinical incidents related to surgery or inpatients department. The rate of non-clinical incidents was higher than the average of other independent acute hospitals during the same reporting period.
- Staff reported incidents on a paper based form. This was then transferred onto the hospital's electronic system. Staff were clear on incident reporting and knew how to report incidents. They told us they received feedback on individual incidents they reported and on trends within the hospital. Senior staff shared information regarding incidents and learnings at handovers, through emails and on the staff notice board.
- We reviewed the root cause analysis (RCA) report of a patient who had an anaphylactic reaction following administration of drugs prior to surgery. The incident occurred in June 2016 and the severity of harm on the patient was identified as moderate. The RCA was sufficiently detailed, covering contributory factors, chronology, root cause, recommendations and lessons learnt. We saw details regarding the support provided for the patient, relatives and staff in line with the duty of candour regulations. A detailed action plan accompanied the RCA and lessons learnt were subsequently communicated to staff.
- The hospital reported an incident of unexpected death which occurred in May 2016. We reviewed the RCA report of an invasive group A streptococcal infection leading to necrotising fasciitis following surgery in May 2016. The RCA was detailed, covering contributory factors, chronology, root cause, recommendations and lessons learnt. The report concluded that it was a very rare complication of surgery with no fault involved. However, the report identified evidence of some inadequate documentation. A detailed action plan accompanied the RCA including review of medical and nursing documentation. Lessons learnt were shared with staff.

- The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support to that person. Staff were familiar with the duty of candour regulations and were able to explain what this meant in practice. They identified the need to be honest about any mistakes made, offer an apology and provide support to the affected patient. They provided examples where they adhered to this duty and we saw evidence of this being demonstrated in written letters to patients and their relatives.

Safety thermometer

- The NHS Safety Thermometer is a tool for measuring, monitoring, and analysing patient harm and 'harm free' care on one day each month. The hospital audited and monitored avoidable harm caused to patients, however, the results of these audits were not displayed for the public to see.
- Venous thromboembolism (VTE) screening rates were above 95% for two quarters of the reporting period (April 2015 to March 2016). They were 94% between April 2015 and June 2015 and 90% between July 2015 and September 2015. There were no incidents of hospital acquired VTE or Pulmonary Embolism (PE) in the reporting period.

Cleanliness, infection control and hygiene

- The theatres and patient wards were visibly clean and all the patients we spoke with were satisfied with the cleanliness. Domestic staff understood cleaning frequency and standards. They said they received appropriate training required for the role and were supported by management.
- Personal protective equipment (PPE), such as gloves and aprons were available in all clinical areas including the inpatient wards and theatres. In addition, theatre gowns, caps and shoes were available in the changing rooms within the theatre's department. All staff observed the 'bare below the elbow' policy and we observed them using PPE when required.
- Equipment used in the department, including commodes and bedpans were clean. Staff used 'I am clean stickers' to indicate an item of equipment was cleaned and decontaminated. Sharps bins in the wards and theatres department were properly assembled, labelled and they were not filled above the line indicated on the bin. However, we observed a sharps bin with spots of blood in anaesthetic room one. Patient privacy curtains in the recovery ward and inpatient wards were clean and labelled with the date they were last changed.
- We saw domestic staff used the correct colour of waste bags for clinical and domestic waste. Waste was disposed in a secure area and there was a separate area for clinical and domestic waste.
- All areas in the theatres department and in Cator ward had laminated flooring. However, the rooms and hallways in Langley ward had carpet flooring thereby posing a risk to infection prevention and control. The carpets were vacuumed daily and deep cleaned every six months, however, this was not sufficient to prevent the spread of infections such as norovirus. To mitigate this risk, Langley ward was only used for day case patients and patients presenting with possible cross-infection risk were cared for in Cator ward. We observed that Langley ward was closed during the period of our inspection. Senior staff confirmed they opened Langley ward when Cator ward is at full capacity. The hospital had plans to replace the carpets with laminate flooring. Senior staff informed us they aim to complete this by December 2016.
- The patient wards consisted of single occupancy rooms which meant patients presenting with possible cross-infection risk could be easily isolated. Staff told us rooms were cleaned at least once a day and after every occupant. If a patient was barrier nursed or had an infection then the room was steam cleaned.
- Results of the last patient-led assessment of the care environment (PLACE) audit for the period February 2015 to June 2015 showed that the hospital scored 100% for cleanliness. This was higher than the national average for independent hospitals.
- The hospital carried out a monthly environmental audit. Each department was rated from one (for poor) to four (for good) on a number of quality indicators for general housekeeping, machinery, tools and equipment, first aid, PPE, Control of Substances Hazardous to Health (COSHH), shelving and racking . The audit for July 2016

showed that the theatres scored four in most of the 30 areas assessed. It scored three (satisfactory) in six areas and two (adequate – barely operational) in the indicator requiring the list of qualified first aider or appointed persons to be displayed in relevant areas.

- Langley ward scored four in most of the 30 areas assessed and it scored three in two areas. It scored two for "further hazards found" namely carpets flooring on the ward. Cator scored four in most of the 29 areas assessed. It scored three for the indicator requiring the list of qualified first aiders to be displayed in relevant areas. It also scored three for the indicator requiring all hazardous substances are inventoried, risk assessments in date and accompanied by the material safety data sheet.
- The hospital had an infection prevention and control (IPC) lead. Staff undertook hand hygiene audits based on the standards of the World Health Organisation's (WHO) 'five moments to hand hygiene'. Between May 2016 and July 2016 hand hygiene compliance in the theatres and wards was 100%.
- There were hand-washing facilities in all areas of the theatres department, including the anaesthetic rooms, the theatres and the recovery unit. Antibacterial hand gel was also available in all these areas with printed instructions to encourage use.
- There were no dedicated hand hygiene sinks in patient's rooms. Staff had to wash their hands in patient's bathrooms or the nearest hand hygiene sink in the clean utility room at the end of the ward. There were antibacterial hand gels in each patient room.
- There were three surgical site infections (SSIs) reported between April 2015 and March 2016 all of which involved orthopaedic and trauma procedures. There were no reported cases of methicillin-resistant staphylococcus aureus (MRSA), meticillin sensitive staphylococcus aureus (MSSA), escherichia coli (E-coli) or clostridium difficile (C.diff) in the last one year.
- Compliance with IPC training varied based on the level of staff required. Eighty five per cent of staff had completed the IPC awareness training organised for staff who did not have direct contact with patients. Seventy one per cent of staff had completed the IPC in health care training for anyone who enters a patient's bedroom. Sixteen out of 23 non-compliant staff were booked to attend the training. Seventy eight per cent of staff had completed the IPC - high impact intervention and care bundles aseptic non touch technique (ANTT) training for clinical roles that extend to working with high impact intervention and care bundles. Six out of 11 non-compliant staff were booked to attend the training.

Environment and equipment

- The theatres' department consisted of two theatres, two anaesthetic rooms, a recovery room, a materials room, male and female changing rooms and a staff room with kitchen facilities. The inpatient wards consisted of two wards – Cator ward and Langley ward, both were single occupancy rooms all equipped with en-suite facilities.
- Equipment checks in the wards and theatres were mostly up to date. Staff maintained a reliable and documented programme of checks. Nursing staff on the units maintained resuscitation equipment with daily documented checks. However, we noted an expired blood bottle in the resuscitation trolley in Cator ward. We alerted staff to this and they removed it for immediate replacement.
- Most of the equipment we inspected had maintenance stickers showing they had been serviced in the last year. However, we found two patient controlled analgesia (PCA) pumps in recovery which were out of date for servicing. We flagged this to staff and it was immediately removed for servicing.
- We observed equipment for each operation on the theatre list was selected by staff and stacked on shelves with the name of the consultant undertaking the list. Staff told us this was always readily available and on time.
- We observed there was no uninterrupted power supply (UPS) system in the theatres during the period of our inspection. This was also highlighted on the risk register and we raised our concerns with senior staff. We were provided with a copy of the risk assessment for this issue. It showed existing protocols to mitigate the risk to patient safety. Individual items of equipment in the department possessed their own back-up systems or battery packs which lasted for approximately 20 minutes. In addition, the hospital had a backup emergency power generator which comes into effect within 20 seconds of the mains power failing. The

hospital carried out monthly generator tests. We were provided with the test certificates for three months prior to the inspection showing the generator was in good working order.

- The hospital did not have an endoscopy unit. Endoscopy was carried out in theatres with one scope per patient. This was recycled for decontamination in another location, which had an endoscopy unit accredited by the Joint Advisory Group on Gastrointestinal Endoscopy (JAG). Staff placed barcoded-tracking stickers on equipment going out for decontamination. The unit had separate entry and exit areas for clean and dirty equipment.
- Dirty and clean surgery were carried out in the same theatre. Staff informed us the orthopaedic list was carried out prior to endoscopy lists and endoscopy was mostly carried out in the evening. Staff relied on the hospital's infection control guidelines and endoscopy standards of practice.
- There was an uneven floor surface in theatre two during the period of our inspection. Staff told us the uneven surface was repaired with a patch but a bubble appeared and it was awaiting repair. This presented an infection control risk as staff found it difficult to clean the floor properly. Staff mitigated the risk of trips by positioning the equipment over this area. Senior staff told us the floor surface was scheduled for repairs within the next two to three weeks of our inspection.

Medicines

- Controlled drugs (CD) on the ward and in theatre were stored inside a controlled drugs cupboard and locked. The lead nurse on duty kept the keys to the controlled drug cupboard. We observed that the general medicine cupboard in theatre was opened for ease of access. Staff audited controlled drugs on daily basis and documented their audits in the CD register. A pharmacy assistant checked drug stock twice a week and the pharmacy team carried out quarterly medicine audits.
- We reviewed three medicine administration record (MAR) sheets (in inpatient wards) and saw the allergy statuses of patients were recorded.
- Staff monitored fridge temperatures on a daily basis and recorded minimum and maximum temperatures.
- Out-of-hours, the RMO and nurse in charge could gain access to stock items from the pharmacy. An out of hours medicine cupboard was also situated on Cator ward which covers nearly all the medication required to take home (TTO).

Records

- We looked at a random sample of five patient notes. All records documented the pre-operative assessments, diagnosis and management plan, VTE risk assessment, patient observations and national early warning scores (NEWS). All but one patient record documented the name and grade of staff reviewing the patient. In one patient record, the treatment notes were signed but no clear designation of the staff was documented.
- Risk assessments completed included pressure ulcer, manual handling, bed rail, pain, analgesia needs, phlebitis score and DVT prophylaxis.
- Eighty five per cent of staff had completed the documentation and legal aspects training. Ninety one per cent were compliant with information governance training.
- An audit of 10 medical records carried out in September 2015 showed all the patient notes were secured within the file for all records. All the records included details of the GP, reasons for admission and every page had a patient unique identification. Consultant entries in all the records were dated, timed and signed. All nursing entries were dated, timed and signed with printed names. However, one of the nursing entries did not have the designation of the person who signed it.

Safeguarding

- There were appropriate systems and processes for safeguarding patients from abuse. Staff were aware of their responsibilities to protect vulnerable adults and children. They understood safeguarding procedures and how to report concerns.
- The hospital had a dedicated safeguarding lead who could provide rapid support to staff on demand. Staff knew who the safeguarding lead was.
- The hospital had a safeguarding adult policy and a safeguarding children policy and staff were aware of how to access these.

- Eighty seven per cent of staff (93 out of 107) were compliant with the safeguarding children level one training. Ninety one per cent (10 out of 11) were compliant with the safeguarding children level two training.
- Ninety per cent of staff (96 out of 107) were compliant with the safeguarding adult level one training. Ninety one per cent (10 out of 11) were compliant with the safeguarding adult level two training.
- Only the safeguarding lead had completed level three safeguarding training for children and adults. The lead confirmed the hospital was putting measures in place to ensure all clinical staff who came into contact with children were trained to safeguarding level three. Children were not admitted to theatres or on the ward. The hospital admitted 16 and 17 year old patients only if they met strict criteria enabling them to be treated as adults.

Mandatory training

- A practice development nurse (PDN) managed mandatory training, including annual refreshers and induction for new staff. Most staff were up to date with their mandatory training with overall compliance at 86%.
- Mandatory training included resuscitation training, conflict resolution, consent, dementia awareness, infection prevention and control, safeguarding, blood transfusion, pain assessment and management, acute illness management, documentation and legal aspects, equality and diversity, fire safety, moving and handling and medical gases.
- Staff spoke highly of their opportunities for training and said it enabled them to keep up to date with best practice.

Assessing and responding to patient risk

- Theatre staff used the 'five steps to safer surgery' WHO checklist; this is a nationally recognised system of checks before, during and after surgery, designed to prevent avoidable harm and mistakes during surgical procedures. We observed the WHO checklist was completed appropriately during a surgical procedure. Staff regularly audited completion of the checklist and results for March 2016 showed 100% compliance.
- Staff used the National Early Warning Scores (NEWS) system to identify patients whose condition was deteriorating. Staff could escalate concerns to the Resident Medical Officer (RMO) and the patient's consultant. If a patient's consultant was not available, the RMO and senior nurse would seek a second opinion from another consultant from the same speciality.
- The critically ill transfer out procedure standard operating procedure (SOP) provided detailed guidance to staff in the event of patient deterioration. The RMO and consultant would consider whether the patient could be managed in the hospital. If not, they would consider transfer to a nearby BMI facility or to a local NHS Trust via the London Ambulance Service.
- There was a service level agreement (SLA) in place with another BMI hospital at the time of the inspection. At the time of the inspection, the hospital was negotiating a SLA with a local NHS Trust for urgent transfers. Following the inspection, we were provided with a signed copy of the SLA with the NHS Trust.
- Compliance with the acute illness management (AIMS) training for registered nurses was 100% while compliance with the AIMS training for health care assistants (HCAs) was 75%.

Nursing staffing

- The hospital used the nursing dependency and skill mix tool to ensure the right number of staff with the rights skills were on shift. The staffing tool was used to plan the skill mix five days in advance, with review and updates on a daily basis. Actual hours worked were also entered retrospectively to understand variances from the planned hours and the reasons for these. Theatres were planning rosters four weeks in advance.
- A theatre manager led the theatre staff and a ward manager led nursing staff on the ward. Senior staff informed us they had found it challenging to recruit permanent theatre staff. Eight full time equivalent (FTE) nurses worked in the theatres. They were supported by 6.3 FTE operating department practitioners (OPDs) and health care assistants (HCAs). BMI bank staff were used to cover staff shortages in the theatres. During the inspection, five theatre staff were rostered to cover the morning and afternoon shifts. Four staff were rostered to cover the evening shift. Two staff were rostered to cover each shift in recovery.

Good

Surgery

- The inpatient department was fully staffed with 15.3 FTE nurses and they were supported by 2.8 HCAs. During the inspection, there were four staff on each shift with a ratio of one staff to four patients.
- The information displayed in the theatres' department and on the ward showed the required number of staff and the actual staff on shift were the same.
- New staff went through a period of induction and competency training.

Surgical staffing

- The hospital had a RMO who was provided through an agency under a contract. RMOs were based on site for one to two weeks at a time, covering the service 24 hours a day, 7 days a week, with sleep – in facilities provided.
- The hospital had 228 consultants who worked for the hospital via practising privileges and attended the hospital depending on whether they had patients there.
- Consultants were required (as set out in their offer of practising privileges) to be available by phone or have a named alternative contact if they were unavailable. Anaesthetic consultants stayed on site until the patient had recovered from their surgery. There was no formal on-call rota for consultants.
- RMO we spoke to confirmed they had not had any issue contacting consultants. They told us consultants were around until 8pm to 9pm during the week and until 1pm on weekends. They confirmed that consultants provided a named alternative contact when they were on leave.

Major incident awareness and training

- The hospital had a business continuity plan, a hard copy of which was available in the hospital's main reception and an electronic copy was available on the hospital's shared drive. It included action cards, which explained roles in the event of a wide variety of incidents and scenarios, but was not specific to individual staff or departments.
- Staff knew what to do in the event of a fire or emergency evacuation. Each department had a fire warden. Fire training was included in mandatory training. The hospital tested the fire alarms weekly.

Are surgery services effective?

Good

We rated effective as good because:

- There were clear policies and procedures in line with best practice guidelines.
- Patients were cared for by appropriately qualified nursing staff who had received an induction to the unit and achieved specific competencies before being able to care for patients independently. Resident medical officers (RMOs) received regular training as well as support from consultants who had practising privileges in place.
- Staff knew their responsibilities in relation to consent and the Mental Capacity Act (2005).
- Staff managed pain relief effectively and patient nutrition and hydration needs were closely monitored
- There was good multidisciplinary team working in place.

Evidence-based care and treatment

- Policies were developed in conjunction with national guidance and best practice evidenced from professional bodies, such as the Royal College of Nursing and the National Institute for Health and Care Excellence (NICE) and Association of Anaesthetists of Great Britain and Ireland (AAGBI) guidelines.
- Adherence with guidelines was encouraged through the development of illness specific proformas to prompt use of best practice guidelines. For example, we saw evidence of the use of World Health Organisation (WHO) checklist for surgical procedures. We also observed that VTE assessments and NEWS were recorded in line with local guidelines. AAGBI safety guideline on the management of severe local anaesthetic toxicity were available in the anaesthetic rooms. Guidelines were easily accessible on the BMI intranet page.
- There was a programme of clinical and non-clinical audits. Staff completed weekly audits of the WHO checklist audit. Our review of five weekly audits completed in March 2016 showed that theatre staff adhered to all items on the checklist for all patients. An

audit of 20 patient records in March 2016 showed that staff completed venous thromboembolism (VTE) assessments for patients on admission and within 24 hours following admission.

- An audit of 10 medical records carried out in January 2016 showed staff completed assessments for most of the patients. The allergy statuses of patients were completed on all prescription charts, however, the weight of the patients were not recorded in two prescription charts. Clinical risk assessments were completed for all patients for pressure areas, moving and handling and falls. Nutritional risk assessments were also completed for all patients. All records had evidence of 48 hours discharge follow up telephone call. All records showed the BMI care pathway was used to plan and manage care. A copy of the discharge letter/ summary was included in all records. However, one of the records did not have a completed corporate consent form and completed operation notes. Two of the records did not have a consultant discharge summary. A subsequent audit of 10 medical records in March 2016 showed that all consent forms, operation notes and discharge summaries were completed.
- We reviewed a copy of the laser equipment and usage safety audit for operating theatres completed in March 2015. The report indicated that the two laser equipment inspected were partially compliant with a number of minor improvement necessary. The report recommended that a laser protection supervisor (LPS) should be appointed for theatres, a separate list of authorised operators should be maintained for each user and a combined risk assessments should be completed for all lasers used in the theatres.
- As at 26 June 2016, the hospital had appointed a new laser protection supervisor (LPS) for theatres, the risk assessments had been completed and we were provided with a list of authorised operators. The local rules for the use of laser in theatres was within date and were written in accordance with the medicines and healthcare products regulatory agency's guidance on the safe use of lasers, intense light source systems and LEDs in medical, surgical, dental and aesthetic practices, DB2008(03).

Pain relief

- Nurses discussed post-operative pain relief with patients at pre-assessment, and gave them information about pain control and anaesthesia.
- Staff used a standardised tool to assess patients' pain and recorded pain assessments in patients' notes. Patients also told us that they received pain relief when they required it and that it was reviewed regularly.
- Results of a day case and inpatient pain audit carried out in February 2016 showed that all indicated their post-operative pain was managed appropriately. The results showed that all patient notes had documented evidence that the patient was asked for pain and their pain was assessed every four hours. All patients had been prescribed regular analgesia and their pain levels were evaluated after analgesia was given. All patients indicated they were advised and prepared for their post-operative pain management. However, all inpatients indicated they were not shown or informed about the pain assessment tool used.
- The hospital patient satisfaction dashboard measured the hospital for a number of quality indicators in comparison with other BMI hospitals. It showed that patient satisfaction with help in controlling pain had increased by 5.1% from 91.3% in May 2015 to 96.4% in May 2016.

Nutrition and hydration

- Staff advised patients about fasting times prior to surgery at pre-assessment. Staff told us fluids fasting was two to three hours prior to an operation.
- Staff carried out a malnutrition screening tool (MUST) assessment on admission of a patient and whenever there was a change in condition. Intravenous fluids were given when required and a fluid balance chart was used to monitor changes.

Patient outcomes

- There were six unplanned transfers between April 2015 and March 2016. This was the same as similar independent health providers. There were 12 unplanned readmissions within 28 days within the same reporting period. This was also similar in comparison to similar acute independent hospitals. There were six cases of unplanned return to the operating theatre.

- NHS patients participated in the patient reported outcome measures (PROMS) data collection if they had undergone surgery for hip or knee replacement and inguinal hernia repair. PROMS measures the quality of care and health gain received from the patient's perspective. The latest PROMS data available was for the period April 2014 to March 2015. However, data collected were under the expected range for the audit.
- The hospital was only eligible to participate in National Joint Registry (NJR) audit in the same period. The NJR monitors the result of joint replacement surgery in England, Wales and Northern Ireland. The results of the audit showed that the consent rate for the hospital was 89% and data linkability was 76%. However, data collected for hip and knee surgery were under the expected range for the audit.

Competent staff

- The hospital had a practice development nurse (PDN) who provided training support to clinical staff. This included induction programmes for new staff, competency assessments and mandatory training for all staff. Staff also received monthly training on specific pieces of equipment as required.
- All theatre staff had received an appraisal in the last one year. All nursing staff and health care assistants on the ward had received an appraisal in the last one year. Seventy five per cent of other staff (including operating department practitioners) had received an appraisal in the last one year.
- Resident medical officers (RMOs) were supplied by a third party agreement with an agency. The hospital carried out checks with the agency to make sure RMOs had up to date training. RMOs undertook a hospital induction at the start of their contract.
- The medical advisory committee (MAC) conducted an annual review of practising privileges for consultants working at the hospital. Consultants were required to have had an annual appraisal and to provide evidence of mandatory training. Ninety per cent of consultants had received an appraisal in the last one year. In addition, 96% of consultants had an appropriate insurance or indemnity cover in place.
- New applicants for practising privileges were required to have current registration with the general medical council (GMC) or other appropriate professional body; and hold or have held within five years, a substantive post within the NHS or a defence medical service hospital. They were required to have a certificate of appropriate insurance or indemnity cover, an annual appraisal and evidence of mandatory training. Applicants with independent practice experience had to demonstrate experience over a sustained period and a support network to provide safe cover and care for patients to the satisfaction of the hospital manager and MAC chair.
- Consultants were only allowed to treat patients at the hospital within the scope of clinical practice specified in the signed offer of practising privileges.
- There was 100% completion rate of validation of registration for doctors working under practicing privileges. There was also 100% revalidation rate for nurses.

Multidisciplinary working

- The hospital held daily inter-department ('10@10') staff meetings where information from all departments was shared and cascaded to the remaining staff in their respective departments.
- Senior staff described an excellent working relationship with the external company that provided the diagnostic imaging services. Staff reported good access to imaging services.
- Staff reported good working relationships between the theatres' department and ward staff. We observed the handover of a patient from the theatres to ward staff. The handover was detailed and staff provided relevant information about the patient's needs.
- Physiotherapy staff supported effective recovery and rehabilitation for inpatients, including follow up at outpatient clinics if required.

Seven-day services

- A RMO was on duty 24 hours a day, 7 days a week. Consultants as part of the requirement of their practising privileges were available on phone and, if required in person when they had inpatients in the hospital.
- All nurses and health care assistants were rostered to provide cover for 24 hours a day, 7 days a week.

Good

Surgery

- Theatres were open from 7.30am to 9pm, Monday to Saturday. Theatre session times were 7.30am to 1pm, 1pm to 5pm and 5.30pm to 9pm.
- The pharmacy department was open 8am to 4pm, Monday to Friday. The pharmacy team consisted of one full time pharmacist, who was also the manager, and one full-time pharmacy technician. There was also a part-time pharmacy assistant. The Resident Medical Officer (RMO) and senior nurse on duty had access to the pharmacy out of hours.
- The diagnostic service was open from 7am to 8pm, Monday to Friday and 8am to 12pm on Saturday. However, they provided on call service to the hospital out of hours.
- Physiotherapy was open from 8am to 8pm Monday to Thursday, 8am to 5pm on Friday and from 08.30 to 1pm on Saturday. The department provided on call service to the hospital out of hours.

Access to information

- Staff had access to relevant guidelines and policies on the hospital's intranet.
- Diagnostic imaging used a picture archiving and communication system (PACS) which meant that staff could view images on any computer connected to the intranet in all BMI hospitals.
- Staff had access to patient's notes and could contact the patient's consultant if necessary. Discharge letters were sent to patients' GPs following discharge from the hospital.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff had access to best practice guidance and local mental capacity policies on the unit. Consent training was included in the mandatory training required in the hospital and 96% of staff had completed this training.
- Staff were clear about their responsibilities in relation to gaining consent from people, including those people who lacked capacity to consent to their care and treatment. Our review of medical records showed well documented consent forms were completed.
- Staff were aware of their responsibilities under the Mental Capacity Act (2005). They were able to talk about the deprivation of liberty safeguards and how this would impact a patient on the unit.

Are surgery services caring?

Good

We rated caring as good because:

- Theatre and ward staff provided a caring, kind, and compassionate service and we received positive comments from patients.
- Patient's privacy and dignity was maintained.
- Patients and their relatives reported they were involved in their care and were given explanations about their treatment.
- Patients' feedback was sought and the latest Friend and Family Test results showed 100% of patients would recommend hospital.
- Staff were aware of people's individual needs and considered these when providing care.

Compassionate care

- Patient, family and friends feedback was mostly positive. During all our observations, we saw staff treat patients and visitors with warmth and care. We observed staff interactions with patients. Staff were courteous, professional and demonstrated compassion to all patients.
- We also observed staff maintain patients' privacy and dignity. Staff cared for patients in individual patient rooms with the doors closed.
- Patients said they felt safe in the unit and they were happy with the care provided. They said staff explained procedures and obtained their consent before conducting them. One patient said he was happy with the care provided by the hospital and his whole family used the hospital.
- Staff told us the hospital was patient focussed and they were proud of the care they provided, they received regular thank you cards and letters from patients.

Good

Surgery

- The results of the Friends and Family Test (FFT) survey between May 2015 and May 2016 showed that 100% of patients (in 11 out of 13 months) would recommend the hospital to their friends and family. The exception to this was in August 2015 (92%) and February 2016 (67%). The FFT response rate varied between 25% to 32% during the period. FFT response rates at the hospital were lower than the England average except for May 2015 (65%), August 2015 (41%), November 2016 (65%) and January 2016 (41.6%) when they were higher.
- Patient satisfaction with theatre staff between May 2015 and May 2016 ranged between 97% and 98%.

Understanding and involvement of patients and those close to them

- Patients and their relatives reported they were involved in their care and were given explanations about their treatment. We observed staff introducing themselves to patients before attending to them. Staff explained the procedure they were about to carry out and the risks were discussed.
- We observed a staff member conduct a pre-operative assessment with a patient. The staff was reassuring and gave relevant information including the procedure on the day of surgery and post-operative instructions including travel back home.

Emotional support

- We observed staff speaking to patients in a reassuring manner and providing clarification where necessary.
- Patients received a follow-up telephone call following discharged.

Are surgery services responsive?

Good

We rated responsive as good because:

- Pre-operative assessments were carried out to assess patients' needs prior to surgery.
- Patients were given sufficient information about their procedure, and were able to discuss it with their consultant and nursing staff.
- The hospital dealt with complaints and concerns promptly, and there was evidence the hospital used learning from complaints to improve the quality of care.
- All patient rooms had a range of facilities including en-suite facilities, electrically operated beds, direct dial telephone and satellite television.
- Patients were provided meals based on their preference or dietary needs.

However:

- There was a recent decrease in patient satisfaction with the meals provided.

Service planning and delivery to meet the needs of local people

- Ninety one per cent of inpatient and day case episodes of care were privately funded whilst 9% were NHS funded.
- The hospital pre-planned all admissions to allow staff to assess patients' needs prior to surgery or medical care. They accepted patients for treatments with low risks of complication, and whose post-operative or medical care needs were met through ward-based nursing.
- Staff carried out pre-operative assessment at least two weeks prior to admission and no less than five days. However, under exceptional circumstances pre admission assessments could be undertaken no less than 72 hours with approval from the Director of Clinical Services.
- The hospital informed us that some patients did not require a full pre assessment. Notwithstanding, all patients had a swab taken no later than 48 hours before surgery.

Access and flow

- Admission to the hospital could only be made by a consultant who had been granted admission privileges by the medical advisory committee (MAC) of the hospital. Special requirements were outlined in the admission policy to meet the needs of patients living with dementia or who had a learning disability. It was preferred that these patients attended a face to face pre assessment appointment with their main carer present.
- NHS patients were usually referred to the hospital by their GP and through NHS spot contracts. All

orthopaedic, vascular, NHS patients and patients who have had a previous positive MRSA screening were treated using the MRSA eradication protocol prior to admission. Children aged 16 years must be pre assessed and meet the adult care pathway requirements.

- Unplanned admissions were coordinated by the nurse in charge and could be accepted only with medical referral. Admissions were dependent upon bed availability, skill mix, patient condition and theatre availability (if applicable).
- The hospital had a clear exclusion criteria for planned or unplanned admission. These included consultants admitting without admitting rights, children under the age of 16 years, some trauma cases, patients requiring critical care level two or level three, termination of pregnancy, acute cardiology, infectious diseases, mental health, pregnancy more than 24 weeks gestation amongst others.
- The referral to treatment (RTT) waiting times or targets for admitted patients beginning treatment within 18 weeks of referral was above 90% for five months between April 2015 and March 2016. The percentage of patients seen varied between 82% and 89% for seven months in the same period.
- There were 3208 surgical procedures carried out between April 2015 and March 2015. The hospital had cancelled 19 procedures for non-clinical reasons in the last 12 months; of these 13 patients were offered another appointment within 28 days of the cancelled appointment.
- Discharges were authorised by the admitting consultant. Senior staff told us patients were discharged with the correct medications and follow up appointments.

Meeting people's individual needs

- Staff told us they had access to telephone translation services if required. However, they said they hardly had patients who required translation services.
- Senior staff informed us patients with learning disabilities and dementia were identified during pre-operative assessment. Nursing staff obtained details of any special requirements they may have had.
- Any concerns about consent were flagged prior to attendance and patients would be accompanied by an advocate. Staff were required to complete the dementia awareness training as part of their mandatory training. Ninety one per cent of staff had completed this training.
- All patients we spoke to felt staff had given them sufficient information about their procedure, and were able to discuss it with their consultant and nursing staff. Staff gave patients information about their procedure at pre-assessment. This included procedure specific information leaflets and a patient information booklet about their stay. Staff discussed their care in detail and explained what to expect post-operatively including length of stay, and involved patients in their plans for discharge.
- Ward staff gave patients a discharge pack with specific post-operative instructions.
- All patient rooms had a range of facilities including en-suite facilities, electrically operated beds, direct dial telephone and satellite television.
- Patients were provided meals based on their preference or dietary needs. However, there was a recent decrease in hospital patient satisfaction survey scores with meal provision.
- The hospital patient satisfaction dashboard for May 2016 measures the hospital for a number of quality indicators in comparison with other BMI hospitals. It shows the hospital scores were the same or higher for the quality of care, nursing care, overall impression of consultant surgeon, overall impression of consultant anaesthetist and meeting or exceeding expectations. However, the hospital was rated lower than other BMI hospitals for their discharge procedure, catering, accommodation and the arrival process.
- Four of the five most deteriorated satisfaction scores in the same period were in relation to the food provided. The temperature of food had a 10.5% decrease from 93.9% in May 2015 to 83.3% in May 2016. The quality of food had a 9.5% decrease from 95.5% to 86%. The variety or choice of food had 9.3% decrease from 88.5% to 79.2%. Satisfaction with the correctness of patient's order had 7.6% decrease from 94.9% to 87.3%. Bathroom facilities had 9.35% decrease from 93.8% to 84.5%. Two out of the five patients we spoke with indicated they did not like the food.

Good

Surgery

Learning from complaints and concerns

- The hospital received 72 complaints between April 2015 and March 2016. Most of the complaints were about financial cost or charges, catering and treatment. All the complaints were fully resolved and closed. None were referred to the Ombudsman or Independent Healthcare Sector Complaints Adjudications Service (ISCAS).
- All complaints were logged onto a database where they could be monitored. We reviewed the complaint log from December 2015 to May 2016. It provided details of the complaint, the department involved, whether it was upheld or not and the stage at which it was resolved. All the complaints were resolved at stage one.
- Patients were provided with feedback leaflets and comment cards, which encouraged them to report concerns, and provided details of how to make a complaint.
- The quality and risk lead collated responses and supported the heads of department in investigating, writing responses and ensuring any learning is embedded. The hospital manager also contacted every patient by phone on receipt of the complaint and they tried to meet patients face to face wherever possible.
- The hospital followed the corporate BMI Healthcare guidelines for managing complaints. Patient complaints followed a three stage process, with each stage having set timeframes for responses. Stage one involved an investigation and response by the hospital within 20 days. Stage two resulted in regional or corporate investigation and response within 20 days and stage three provided an independent external adjudication.
- The medical advisory committee (MAC) and clinical governance committees reviewed complaints and compliments as appropriate for trends and themes. We reviewed minutes of MAC meetings which showed that complaints were discussed at the meetings to identify any trends.
- Complaints were also discussed at monthly heads of department (HOD) meetings, relevant sub-committee meetings and at staff meetings.
- The hospital recently purchased new products to assists patients who were hard of hearing following a complaint by a patient who felt the thermometer used on the ward was painful for his ear.

Are surgery services well-led?

Good

We rated well led as good because:

- We saw good local leadership within the department and staff reflected this in their conversation with us. Staff were supported in their role and had opportunities for training and development.
- There was a positive culture in the theatres and ward and members of staff said they could raise concerns with the leadership team.
- The management team had oversight of the risks within the services and mitigating plans were in place.
- There was evidence of staff engagement and changes being made as a result.
- Patients were engaged through surveys and feedback forms.

Vision and strategy for this core service

- The hospital's vision was driven by the wider vision of BMI Healthcare, which was to provide the best patient experience, best outcomes and be cost effective.
- The hospital had eight strategic priorities covering the governance framework, superior patient care, people, performance and culture, business growth, maximising efficiency and cost management, facilities and sustainability, internal and external communications and information management. The hospital had objectives and action plans in place to monitor the strategic priorities.
- Staff we spoke to were clear that the hospital's vision was to provide the best patient experience and outcomes.
- The executive team told us they planned to increase the number of NHS patients and would like to offer community services to the residents of Bromley.

Governance, risk management and quality measurement for this core service

- A theatre manager led the theatres' department while a ward manager led the day case and inpatient wards. Both managers reported to the director of clinical services and the hospital manager.
- The hospital had its own governance structure, which reported into the regional committee. Departments reported through their respective meetings to the heads of departments (HODs), and they in turn, along with the hospital clinical governance committee, and hospital health and safety committee reported to the local executive Team. The latter reported into the medical advisory committee (MAC).
- There were monthly clinical governance meetings, senior management meetings and department meetings for the theatres and wards. There were also regular MAC meetings attended by the MAC chair, hospital manager, director of clinical services and medical representatives from each speciality. We reviewed four MAC meeting minutes between June 2015 and April 2016 and noted that they discussed consultant practice, applications for practicing privileges, incidents and clinical services and techniques.
- We also reviewed the minutes of senior management and departmental meetings. They contained standard agenda items, such as, hospital activity, finance, legislation and corporate policies, significant events and complaints, and updates to the risk register. Actions had been identified with ownership, date for delivery, and the status.
- Data from quality reports and dashboards provided oversight in relation to safety, effectiveness and performance in general.
- The hospital manager, director of clinical services, all departmental managers as well as a consultant representative, attended monthly clinical governance meetings. We reviewed several sets of minutes from such meetings and noted there was a detailed agenda, which addressed a wide range of subjects, relevant to governance, safety and quality. However, we noted there had not been consultant attendance at the last two meetings.
- The unit maintained a risk register, including concerns and assessments of potential risks on the unit. Mitigating plans were put in place and risk assessments were conducted were necessary. Senior staff routinely discussed risks at clinical governance meetings and identified them on the hospital's business plan.

Leadership / culture of service related to this core service

- Staff at all levels spoke highly of their new hospital manager and said there was a positive culture of inclusiveness in the hospital. Staff said the leadership team including the local executive, theatre manager and ward manager were visible and approachable. Managers told us they felt supported by the regional management who attend the hospital frequently.
- A '10@10' meeting took place daily, where a staff representative from each department had the opportunity to update the hospital manager and colleagues with respect to their department. We attended one of these and each manager provided information about their department including admissions, number of patients in each department, payroll, staff training, clinical audits, incidents and complaints.
- Some staff members on the ward expressed there was low morale until the new leadership team came into post. They said they now feel valued as managers provided good level of support for staff. Theatre staff said they have flexible shifts in line with the theatre list. Black and minority ethnic (BME) staff we spoke with said they had equal opportunities for progress with other staff members.
- Staff spoke highly of the opportunities for progression. We spoke with staff who had progressed from a role as a domestic staff to a health care assistant (HCA).
- Staff expressed they were part of a team, engaged and well supported. One staff said, "everyone is patient, focussed and they all help each other".
- There was 3.4% staff turnover for theatre nurses and 0.3% staff turnover for operating department practitioners (ODPs) and health care assistants between April 2015 and March 2016. The rates of staff turnover were lower than average for other independent acute hospitals.

- There were 0.3% staff turnover for inpatient nurses and 5.6% for inpatient HCAs during the same period. These rates were also lower than the average of other independent acute hospitals.
- Staff said the department was open and transparent and they could raise any concerns with senior staff. Staff understood their responsibility under the duty of candour regulations and followed the correct process.

Public and staff engagement

- The hospital monitored patient satisfaction from patient surveys, comments and feedback forms. Outcome from patient surveys were used to improve the service. For example, the hospital carried out redecoration following patient feedback which indicated that the hospital could do with some decorating. They had also put some extra signage around the hospital to ease patient journey.
- Patients and their relatives told us they were involved in care and treatment decisions and the level of information given to them was clear and adequate.
- Staff had said morale had improved under the new leadership team. They gave examples of the hospital manager's quick response in dealing with an issue, for example in replacing the blood bank fridge as soon as it was clear a repair had not prevented a fault.
- The manager started a staff forum to gather views and share information, which were planned for every quarter. They were run on more than one occasion, at different times of the day, to encourage staff participation. Staff said they were kept informed about changes happening at the hospital. Each staff group had regular meetings.
- However, one staff member said there was no fridge or shower facilities for staff on the ward, although they acknowledged that there was a shower available in the outpatient department (OPD). Staff said there was a mixed sex changing room in OPD.
- We observed that staff in the theatres department had access to separate male and female changing rooms. They also had access to a staff room with kitchen facilities for staff to relax during their break. We also observed that there were relevant information on the staff board in other to communicate current issues within the department and the hospital as a whole.

Innovation, improvement and sustainability

- The hospital had upgraded treatment rooms on the ward with air-conditioned units, fully compliant sinks and storage racking. A hand hygiene sink had been installed by the entrance in Cator Ward. In addition, the hospital had purchased endoscopes, a theatre table and exercise treadmill in the last 12 months.
- Cator ward had laminate flooring whereas Langley ward had a carpet flooring. The hospital had plans to replace this with laminate wood flooring. In addition, there are plans to upgrade four rooms in Langley ward to create an ambulatory care service for patients.

Good

Outpatients and diagnostic imaging

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

Information about the service

The outpatient (OPD) is located on the first floor of the hospital. There are twelve consulting rooms and a minor procedures room. The OPD hold clinics every week including ophthalmology, gynaecology, cardiology, gastroenterology, dermatology, neurology, orthopaedics, physiotherapy, and health screening. Clinic times were planned to meet expected demand and consultant's availability.

Between April 2015-March 2016, the OPD had 28479 attendances, of which 1290 were children (under 18). Of these 4% were NHS funded and 96% were other funded.

An interim clinical manager is currently in post whilst the hospital is in the process of recruiting a permanent member of staff.

Diagnostic imaging services were provided by another health care organisation and this service was not included in our inspection.

At the time of our inspection, the hospital had temporarily suspended services for children under the age of 16. This meant we could not inspect the hospital's service for Children and Young Persons. It did continue to offer services to children aged 16 and 17 years that met the criteria to receive treatment as an adult.

We carried out the announced inspection of the hospital on the 17th and 18th August 2016.

Before the inspection, we reviewed information provided to us by the hospital. We reviewed external stakeholder information where provided. We observed processes, the environment, care, and the culture and looked at records during our inspection. We spoke to patients, relatives and staff.

Good

Outpatients and diagnostic imaging

Summary of findings

Overall, we rated the outpatients department as good.

- The outpatients departments provided a broad range of services for both privately funded and NHS funded patients. The patients we spoke with were positive about the care, treatment, and service they had received in both departments.
- Staff were competent and worked to national guidelines, ensuring patients received the best care and treatment.
- The culture within the department was patient focused, open, and honest. The staff we spoke to felt valued and worked well together. Many staff had worked at the hospital for a long time. Staff followed embedded policies and procedures to manage risks and to make sure they protected patients from the risk of harm.
- There were short waiting times for appointments. Privately funded patients were usually seen within one to two weeks, and NHS patients were usually seen within two to four weeks of referral. We found patients could get appointments with their chosen consultant and most clinics started on time.
- Patients we spoke with told us they were treated with dignity and respect. All patient feedback on the inspection was positive. They described the service as 'very caring' and 'friendly' and 'thorough'. The patients described the process of making an appointment as efficient.
- The outpatients department was visibly clean and well equipped.

However:

- We saw forms completed for patients having minor treatment showing that pre procedure checks were performed, but the doctor did not always countersign these as correct.
- Clinic start times and waiting times once patients arrived for their outpatient appointment were not being monitored.

Are outpatients and diagnostic imaging services safe?

Good

We rated the services as good for safety because:

- Staff reported incidents appropriately. Incidents were investigated, lessons were learned and then shared across the hospital.
- Staff knew the procedure for reporting safeguarding concerns. There were enough clinical and medical staff within the department to ensure patients received safe care and treatment.
- The department was fully staffed and all staff were compliant with mandatory safety training.
- Staff could identify and respond to patient risk.
- The department was clean and well equipped. Quality assurance checklists for infection prevention control and health and safety were used to monitor standards.
- Equipment was well maintained and there was enough equipment to ensure patients safely received the treatment they needed.

However:

- Pre-procedure checks were not always countersigned by a doctor.
- 'I am clean labels' were not being used consistently to indicate when an equipment was last cleaned.
- Carpet flooring in some areas of the physiotherapy department and venetian type blinds in consultation rooms presented an infection control risk.

Incidents

- Between April 2015 and March 2016, there were 31 clinical incidents and 31 non-clinical incidents in the OPD. They were rated as low or no harm incidents. The rate for reporting non-clinical incidents was higher than the average of other OPDs in similar hospitals. We saw evidence that the department had a good culture of incident reporting that accounts for the higher rate.

Good

Outpatients and diagnostic imaging

- Staff knew how to report incidents on a written form, and felt confident in doing so. The quality and risk lead entered these forms onto the hospital's electronic system.
- We examined incident records and found them to have been resolved appropriately.
- All of the staff we spoke to understood 'Duty of Candour' and were able to describe its principles. 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 received regular feedback on incidents. The manager gave daily feedback in response to current issues at the morning inter-department meeting and at monthly team meetings. Feedback included incidents from their department, from the wider hospital and from other hospitals in the group. Staff described the department as having a learning culture around incidents and felt informed.

Cleanliness, infection control and hygiene

- All clinical and public areas appeared clean and tidy.
- Domestic staff cleaned clinic rooms daily and we saw completed checklists indicating that areas had been cleaned.
- Staff told us nurses and healthcare assistants had responsibility for ensuring that each clinical room was clean. They completed a daily cleanliness checklist and ensured each clinical room was correctly stocked. We saw audits to ensure this had been completed.
- We checked all the consulting rooms and found all the curtains were visibly clean and had labels with the date when they were last changed.
- We found 'I am clean labels' were not being used consistently throughout the department. The 'I am clean labels' were used to indicate when equipment was last cleaned. This meant staff could not be sure if equipment was clean prior to use. However, all equipment looked visibly clean.
- We found there was no audit record to show that invasive ultra sound probes were cleaned between patients.
- There were handwashing facilities and hand gel dispensers in every consulting room. Although we did find two hand washing sinks in the physiotherapy department and one sink in the dirty utility room of this was not non-compliant with the hospital's infection prevention control guidelines. However, the hospital has risk assesse this and deemed it o be low risk.
- A hand hygiene observational audit conducted in July 2016 indicated 80% of the staff observed were bare below the elbows and 90% met hand hygiene decontamination standards. The staff we observed during our inspection were all bare below the elbows.
- Hand hygiene observational audit conducted by the hospital showed 90% of OPD staff were bare below the elbow in April 2016. The OPD achieved 100% compliance in May and June 2016, and 80% compliance in July 2016. Compliance against hand hygiene decontamination standards was 90% in April 2016, 100% in May 2016, 90% in June 2016 and 90% in July 2016. All staff we observed during our inspection were bare below the elbows.
- Staff complied with infection control and prevention policies, using supplied personal protective equipment (PPE), such as gloves and aprons.
- There were 'sharps' waste bins in all of the clinical rooms and all were less than half full and dated.
- Many of the consultation rooms had 'venetian' type blinds. These blinds could pose an infection risk due to difficulties in cleaning them. Senior staff informed us this formed part of the hospital's cleaning schedule.
- Some areas in the physiotherapy department were carpeted.
- All staff had completed their mandatory training on infection prevention and control.

Environment and equipment

- Resuscitation equipment in the department was checked and maintained daily. We saw records to confirm this.
- Staff in the OPD told us they had all necessary equipment to provide safe and effective treatment. Staff in physiotherapy told us they did not have access to a defibrillator in their department. The nearest one was kept in the main reception of the hospital. There was a

risk assessment in place with existing protocols to mitigate the risk to patient safety. A resuscitation grab bag was in the department and there was a cardiac team in place to respond to any emergency within the hospital. The management team informed us there were plans in place to purchase a new defibrillator by the end of the year.

- The minor treatment room had the necessary equipment to provide safe and effective treatment.
- Staff maintained a reliable and documented programme of equipment checks including portable appliance testing (PAT).
- A Laser Protection Officer from a local NHS Trust oversaw the safe working of the laser equipment in the department, with a dedicated nurse from OPD as liaison. The local rules for the use of laser in theatres was within date and were written in accordance with the medicines and healthcare products regulatory agency's guidance on the safe use of lasers, intense light source systems and LEDs in medical, surgical, dental and aesthetic practices, DB2008(03).

Medicines

- There was safe management and storage of medicines in cupboards in a locked room in the the OPD. The medicines refrigerator's temperature was checked daily and was within correct limits. Ambient temperatures of rooms where medicines were stored were checked and recorded. These measures ensured the medicine's potency. Nursing staff knew the actions to take if the fridge temperatures were not within an acceptable range. The OPD did not keep controlled drugs in the department.
- Flammable medicines were kept in a lockable fireproof cabinet.
- Emergency cardiac arrest and anaphylaxis drugs were kept on the resuscitation trolley and were checked daily. Anaphylaxis is a life threatening allergic reaction that requires immediate treatment.
- The nurse in charge kept the prescription pads for each clinic room in a locked room. These were given to doctors at the start of their clinics and audited at the end of every clinic. This ensured that no prescriptions went missing. Doctors wrote prescriptions at the time of the patient's consultation.
- The on-site pharmacist had a robust system in place to ensure medications were prescribed easily and correctly. The pharmacist directly dispensed medication for patients.
- The pharmacy staff and the nurse in charge jointly managed the medication stock levels.

Records

- Records for NHS patients were stored securely in the medical records department. The notes were available for clinics and then taken back to medical records. Individual consultants retained private patient's notes with copies held in medical records. Consultants were required to adhere to information governance policies.
- Staff told us that results for patient tests, including diagnostic imaging were readily available for all patients, but the hospital did not keep any data to confirm this.
- Diagnostic imaging used a picture archiving and communication system (PACS) which meant images could be viewed on any computer connected to the intranet in all BMI hospitals and via a remote access facility. This meant radiologists could report quickly in case of an emergency. PACS is a nationally recognised system used to report and store patient images securely.
- Outpatient records were held on site for one year and then taken off site for storage. The records were stored in indexed boxes so that they could recall them when required. Records taken off site were scanned within 10 days and this was accessible to staff on the electronic system.
- Staff told us records for patients were always available for clinics but the hospital did not keep any data to confirm this.
- We saw forms completed for patients having minor treatment showing that pre procedure checks were performed, but the doctor did not always countersign these as correct. In some instances a healthcare assistant signed these checks. This could lead to a procedural error.

Safeguarding

Good

Outpatients and diagnostic imaging

- Up to date policies on safeguarding for both adults and children were available to all staff on the hospital's shared drive. The hospital safeguarding lead was available should staff need advice or guidance.
- Staff knew who the safeguarding leads were for adults and children. They knew their responsibilities regarding safeguarding and knew how to escalate concerns.
- Clinical staff received level two adult and children safeguarding training as part of their mandatory training. There was only one trained children's nurse. Level three safeguarding trained staff were not always available in the hospital when children were in the department. This has led to the services for children and young persons being temporarily suspended. The hospital had an action plan to train staff to levels where safe treatment and care could be given.
- The department was still seeing 16 and 17 year old patients, but only if they met a strict criteria enabling them to be treated as adults.
- The department's manager told us there had been no safeguarding issues in the time they had been in post.
- Staff knew about what action to take if they suspected a patient may be at risk of abuse.
- The hospital had an up to date chaperoning policy. Staff were available for any patient requiring chaperoning. Records of chaperoning were kept in a log. Notices offering chaperoning to patients were widely on display in both the waiting area and clinic rooms. Senior staff informed us that all staff have completed e-learning and there are competencies in place for clinical staff.
- Staff told us they felt confident challenging any concerning practices or behaviours.

Mandatory training

- The staff we spoke to showed us their individual training records and information we received prior to the inspection showed that compliance with mandatory training was 100%. The hospital automatically monitored mandatory training online and each member of staff had a password protected training account. Staff received automated reminders when a module was due for completion and the manager reviewed the staffs' compliance with mandatory training each month.
- Mandatory training included basic life support, infection prevention and control, moving and handling, fire safety, safeguarding, information governance, and diversity and equality and the Mental Capacity Act 2005.
- Training could be delivered through e-learning and face-to-face sessions. Staff reported they were not always given sufficient time and support to complete their training whilst at work, and that it often needed to be completed in their own time.

Assessing and responding to patient risk

- When patients arrived in the reception area, reception staff greeted them.The department manager told us that if the staff on reception had concerns that a patient was at risk, they would immediately alert a nurse who would assess the patient.
- Staff on reception had not had any training on how to identify patients who were ill, frail, or at risk of falls. One member of reception staff had received first aid training. Senior staff informed us all non clinical staff were provided with annual basic life support training. They indicated non clinical staff were aware of the procedure to call clinical staff in an emergency.
- Nursing staff told us if a patient was identified as having any health related risks then they would move the patient from the main reception area and a trained staff member would remain with the patient.
- Staff told us they did not routinely take patient's base line observations during an OPD visit, but would do so if they assessed the patient as being unwell, and report this to the RMO or consultant immediately.
- The hospital had a trained emergency response team all of whom carried a bleep to respond to emergencies in the department. Alarm activation was via the telephone or from an emergency button in each clinic room. The hospital tested the system every day and a log kept of responses.
- All clinic rooms and toilets had emergency alarm button and pull cords.
- If a patient required urgent transfer to an appropriate NHS Emergency Department they would use the 999 system to call an ambulance and the attending doctor would alert the receiving hospital. At the time of the

inspection, the hospital was negotiating a service level agreement (SLA) with a local NHS Trust for urgent transfers. The SLA was signed shortly after the inspection.

Nursing staffing

- An interim OPD manager was in post whilst the hospital was in the process of recruiting a permanent member of staff. The department was fully staffed with both qualified nurses and healthcare assistants. There were always a minimum of two qualified nurses on duty. Healthcare assistants (HCAs) assisted in clinics. The manager told us they covered vacancies with their pool of permanent and bank staff and never have to use agency staff. We saw records to show that all shifts were appropriately filled. However, one staff told us they felt staffing levels were insufficient for the number of clinics running in the department.
- The manager completed staffing rotas four weeks in advance and there was a mix of early and late shifts, in response to planned clinics.
- The manager told us that in the event of an unplanned staff shortage, then the shift would either be covered by a permanent or bank staff or by the manager themselves.
- The department was aiming to have an equal mix of nurses and healthcare assistants on duty at any one time with its recruitment and staffing policy.

Medical staffing

- Every clinic was run by a consultant who saw each patient on his or her specific list.
- We reviewed records which showed the named consultant for each clinic had been available.
- Staff told us if a consultant had to cancel a clinic due to unforeseen circumstances then they would telephone patients to inform them and either re-arrange the appointment or offer an alternative appropriate consultant.
- The manager had started to keep an audit for a consultant who consistently started their clinics later than planned. No audit had been routinely undertaken to monitor other clinic start times, meaning that we could not see whether clinics started on time.
- We spoke to patients who all said they had been able to get an appointment with their chosen consultant.
- The hospital had 228 consultants who worked for the hospital via practising privileges and attended the hospital depending on whether they had patients there. The Hospital Manager and the Medical Advisory Committee (MAC) managed practising privileges for consultants.

Major incident awareness and training

- The hospital had a Business Continuity Plan, a hard copy of which was available in the hospital's main reception and an electronic copy was available on the hospital's shared drive. It included action cards, which explained roles in the event of a wide variety of incidents and scenarios, but was not specific to individual staff or departments.
- Staff knew what to do in the event of a fire or emergency evacuation. Each department had a fire warden. Fire training was included in mandatory training. The hospital tested the fire alarms weekly. We saw the hospital taking prompt action to repair the fire alarm system after one of these tests.

Are outpatients and diagnostic imaging services effective?

Not sufficient evidence to rate

At present we do not rate effectiveness for outpatient and diagnostic imaging services in acute independent hospitals but during our inspection we noted the following good practice:

- The outpatients and diagnostic imaging department were providing effective treatment for patients. Patients received diagnostic imaging results promptly.
- Treatment was always consultant led and used evidence based best practice from the World Health Organisation (WHO), the National Institute for Health and Care Excellence (NICE), and the Royal Colleges.
- All staff had an appraisal in the past year, and the hospital supported them through the Nursing and Midwifery Council's (NMC) revalidation process.

- Staff knew their responsibilities in relation to consent and the Mental Capacity Act (2005).

Evidence-based care and treatment

- Clinical staff knew of and used the relevant NICE guidelines for their department along with relevant Royal College guidelines. These guidelines could be accessed easily through the intranet.
- The departments undertook numerous clinical and non-clinical audits. These included infection prevention and control, cleaning, hand hygiene, medicines management and revenue. A medicines management audit highlighted that a folder containing information on Patient Group Directive (PGD) medication was outdated and difficult to locate. This meant that staff were not using the most up to date guidance. In response, this folder was updated, centrally located and staff received additional training.
- The minor treatment room used an adapted WHO surgical checklist, which met national guidelines.

Pain relief

- Staff told us that external requests to the outpatients department for pain relief were infrequent. They told us they would contact the patient's consultant or refer them to their GP if necessary.
- Appropriate pain relief was available to patients in the department.

Patient outcomes

- Staff told us that diagnostic test results, including diagnostic imaging, were available promptly. Most tests could be viewed electronically on terminals in each consultation room. Senior staff informed us there were strict contractual turnaround times for reporting; five days for NHS patients and 48 hours for privately insured patients.

Competent staff

- Nursing staff could work across all the speciality areas allowing them to cover any adult clinic. They could perform blood tests, electrocardiograms (ECG's) and assist in the minor treatment room.
- All staff had received an appraisal in the past 12 months. Appraisals were a reflection on the previous year's performance against set objectives, new objectives for the year ahead and any training requirements that staff felt would benefit their development.
- The hospital and OPD had an induction programme for new staff, to give an overview of the policies and procedures. We saw evidence showing these had been completed for staff.
- New members of staff were required to complete mandatory training as part of their induction.
- Competencies for the consultants, nurses and healthcare assistants were assessed and recorded and records kept by the OPD manager.
- The departments were aware of the importance of the Nursing and Midwifery Council's (NMC) revalidation of nursing staff and the staff reported that they felt supported in the process.
- Many staff had worked in the departments for a long time and described a good working relationship with the consultants. This meant that they felt confident in helping patients clarify points about their treatment with the consultants.
- The medical advisory committee (MAC) conducted an annual review of practising privileges for consultants working at the hospital. Consultants were required to have had an annual appraisal and to provide evidence of mandatory training. Ninety per cent of consultants had received an appraisal in the last one year. In addition, 96% of consultants had an appropriate insurance or indemnity cover in place.
- Minutes of MAC meetings confirmed removal of consultants' practising privileges where they had not provided the required information.

Multidisciplinary working

- Staff told us that they were able to call on the expertise from other departments in the hospital if required. They described a good working relationship with other departments, such as urology and surgery. The manager described an event where she was able to call on the assistance of an experience member of staff from the ward to perform a difficult procedure in the OPD.

Good

Outpatients and diagnostic imaging

- Both nursing and medical staff said they had a good working relationship with each other.
- The manager described an excellent working relationship with the external company that provided the diagnostic imaging services. No formal multidisciplinary meetings occurred with the diagnostic imaging provider.

Seven-day services

- The outpatients department was open from 8am to 8pm Monday to Friday and from 8am to 2pm on Saturdays.
- Physiotherapy was open from 8am to 8pm Monday to Thursday, 8am to 5pm on Friday and from 08.30 to 1pm on Saturday.
- The pharmacy was open from 8am to 4pm, Monday to Friday.

Access to information

- The results of diagnostic tests were available on the hospitals intranet system.
- Diagnostic imaging used a picture archiving and communication system (PACS) which meant that images could be viewed on any computer connected to the intranet in all BMI hospitals and via a remote access facility.
- There was no evidence of records being unavailable at consultations in the department.
- Staff had access to relevant guidelines, policies, and procedures through the hospital's intranet.
- Staff knew how to access patient's notes, and how to contact each consultant and the Resident Medical Officer. Staff sent discharge letters to patients' GPs following discharge.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff knew about consent procedures and discussed any issues with others involved in the patient's care and with the patient's family. The Mental Capacity Act 2005 (MCA) contains the law that applies to anyone who lacks the mental capacity needed to make their own decisions about their medical treatment.
- We looked at a number of records and saw evidence that procedures undertaken in the minor treatment room were consented appropriately.
- Patients told us they had been asked for their consent before a procedure.
- Mandatory training included the MCA. Staff knew the importance of gaining correct consent from patients with limited capacity.
- Nursing staff were aware of Deprivation of Liberty Safeguards, but could not recall an incident in the outpatient department when they had needed to be used.

Are outpatients and diagnostic imaging services caring?

Good

We rated the services as good for caring because:

- Staff treated patients with compassion, dignity, and respect.
- All patients were very positive about their experience of the department.
- Patient's privacy and dignity was maintained.
- Patients and their families felt involved in decision around their treatment.

Compassionate care

- Staff treated patients with care, dignity, and respect. We observed staff welcoming patients into the department and they explained the process for new patients. Staff offered patients complimentary refreshments and directed them to the waiting area.
- We observed staff introducing themselves by name and addressing the patients in a respectful and dignified manner.
- All of the patients we spoke to said they had a very positive experience. We saw feedback cards given to all patients, all of which were either likely or very likely to recommend the service to friends and families.

Good

Outpatients and diagnostic imaging

- Comments included “attentive friendly nurses and surgeons and very thorough” and “staff very caring, lovely environment, good service”.
- Consultants conducted appointments in private clinic rooms with the doors closed, with clear signs on the door indicating the name of the consultant, and whether the room was in use.
- The patient led assessment of the care environment (PLACE) scores for the hospital for privacy, dignity and wellbeing, were below the England average. This score could not be broken down to the hospital’s individual departments and we saw no evidence in the OPD that it was failing in this regard.

Understanding and involvement of patients and those close to them

- Patients we spoke to said they felt they were involved in their care. They told us the consultants had explained differing treatment options clearly, and what they could expect from their treatment. They told us when a consultant prescribed medication they explained how to take them and any possible side effects.
- Patients said their families or friends were welcomed at, and felt included in, consultations.

Emotional support

- Staff told us that upsetting or unexpected news would be delivered sensitively and in appropriate private surroundings. They said they would try to arrange a friend or family member to accompany the patient.
- The department did not have a dedicated service to refer patients, if they required additional emotional support. Staff told us they would try to give patients information on groups and charities that may be able to offer support or refer them back to their GP.
- Patients told us that consultants spoke to them in a sensitive manner but they ensured that the patient understood the information.

Are outpatients and diagnostic imaging services responsive?

Good

We rated responsive as good because:

- Patients did not experience long waiting times to see their chosen consultant.
- The OPD met the 18-week Referral to Treatment target for NHS patients of 92% for the year April 2015-March 2016.
- The department was accessible and responsive for people living with a disability.
- Patients were happy with their experience in outpatients.
- Information leaflets, on a wide range of topics, were available for patients in the reception area.
- Staff learnt from complaints.

Service planning and delivery to meet the needs of local people

- Staff told us that clinics ran on fixed days and patients were usually seen within one to two weeks of referral. Patients were given the next available appointment with their chosen consultant.
- Extended opening hours meant patients could be seen after work and on Saturday mornings.
- The OPD manager told us in the rare event of a clinic cancellation at short notice, staff would contact patients at the earliest opportunity. They would be offered of an alternative consultant to see, or the next available appointment with their chosen doctor.
- During our inspection, we observed a relaxed atmosphere in the outpatient area. The waiting areas were not overcrowded and clinics were running on time.

Access and flow

- Access to appointments for clinics was satisfactory. All the patients we spoke to told us they were happy with

the length of time they had waited to be seen following referral and had been offered times convenient to them. Patients could be referred by their GP or self-refer to a consultant.

- NHS 'choose and book' patients were seen within the 18-week referral to treatment time target for NHS patients. We saw evidence that the hospital was consistently above the 92% target for the year April 2015 – March 2016.
- We examined records from NHS patients that showed waiting times for an outpatient appointment was between two and four weeks. Private patients waited between one and two weeks. The OPD department did not routinely audit wait times for appointments.
- All staff reported clinics generally started on time and ran on schedule. The manager had started monitoring late starting clinics, with a view to referring any consultants who were consistently late to senior management.
- The patients we spoke to said they were seen either at, or very close to their appointment time.

Meeting people's individual needs

- Outpatient services were planned, delivered, and co-ordinated to accommodate patients with complex needs. This included patients living with dementia, learning difficulties or physical disabilities.
- The OPD was located on the first floor of the main building with both stair and lift access It was accessible to all patients, including wheelchair users. Patients had access to wheelchairs, which were available in the OPD reception area.
- The physiotherapy department was located in a small building separate from the main hospital. It did have a ramp access but the surface was uneven and is due to be replaced pending planning permission from the local authorities.
- There were sufficient chairs in the waiting area to suit individual needs.
- Staff told us that patient referral identified those patients who needed extra support at their appointment and this was flagged with clinic staff so they could organise this.
- Staff told us they often helped patients out of vehicles and into the department and would provide a wheelchair if required.
- The hospital did not provide in house interpreting services, but staff knew where to find information in order to obtain an interpreter. Staff told us they were normally made aware of whether English was not a patient's first language in the patient's referral letter, and would plan accordingly.
- Staff told us that if they identified a patient as having needs associated with dementia or learning difficulties, then they would ensure the patient remained comfortable. In consultation with the patient and their family or friends they could organise a suitable waiting area.
- We saw there was a range of information leaflets available to patients in the waiting area on wide variety of topics. BMI Healthcare had produced most of these and others produced by professional organisations.

Learning from complaints and concerns

- Staff knew the process should a patient want to complain.
- Staff told us they would try to resolve any informal complaints immediately. They told us that they could refer the patient to the department manager if required.
- The department manager told us if the complaint could not be resolved, they would launch a formal investigation. The department manager would be responsible for any subsequent investigation, under the direction of the hospital manager.
- The interim manager was unable to tell if there were specific themes to complaints in the OPD.
- Staff received feedback from complaints at the monthly team meeting. Staff unable to attend the monthly meeting would get a copy of the meeting's minutes.
- The hospital had published a leaflet entitled 'please tell us' which did contain correct information on the complaints procedure. This leaflet was available in a rack with other leaflets in the waiting area.

Are outpatients and diagnostic imaging services well-led?

Good

Outpatients and diagnostic imaging

Good

We rated well led as good because:

- Staff felt well supported by their line manager and senior managers. Staff told us senior managers were visible, engaging, and approachable.
- Staff all felt there was an open culture of learning and could express their opinions, which the hospital listened to.
- The outpatient services engaged with staff and patients. They gave them the opportunity to provide feedback about their experiences of the services.
- Staff told us they felt care and treatment was patient focused, and that they enjoyed working in the outpatient department. All felt part of a wider team.
- There was a robust governance structure aimed at improving patient services.
- The interim manager of the outpatients department was enthusiastic and proud of the departments despite being on a temporary contract.

Vision and strategy for this core service

- The hospital's vision was driven by the wider vision of BMI Healthcare, which was to provide the best patient experience, best outcomes and be cost effective.
- The hospital had eight strategic priorities covering the governance framework, superior patient care, people, performance and culture, business growth, maximising efficiency and cost management, facilities and sustainability, internal and external communications and information management. The hospital had objectives and action plans in place to monitor the strategic priorities.
- All staff we spoke to told us they thought their department was patient rather than profit focused. All were aware that the hospital was a business and that it needed to make a profit in order to keep operating.
- The hospital manager was new in post and was working towards developing a new vision and strategy for the hospital.

Governance, risk management and quality measurement for this core service

- The hospital had a risk register and managers updated this accordingly. The manager in the OPD was aware of their department's risks, and they were correctly recorded on the hospitals risk register.
- The hospital had identified that it was not meeting the required standards for safeguarding children and had suspended services for children at the time of our inspection. They had an action plan in place to ensure that they would be able to meet the necessary standards and would not be restarting services until those plans were completed. The plan required additional training for existing staff and the recruiting of suitably qualified and trained bank staff.
- The hospital had its own governance structure, which reported into the regional committee. We found there were 'Terms of Reference', which underpinned the purpose and functions of respective committees. Departments reported through their respective meetings into the Head of Departments, (HODs), and they in turn, along with the Hospital Clinical Governance Committee, and Hospital Health and Safety Committee reported to the Executive Team. The latter reported into the Medical Advisory Committee.
- A Laser Protection Officer from a local NHS foundation trust oversaw safety in the OPD. Staff told us they always were available for advice.
- The managers knew they were responsible for performance of their departments and received feedback from Clinical Governance and Heads of Department meetings.
- The department managers attended a daily inter-department ('10@10') meeting where a staff representative from each area had the opportunity to update the hospital manager and colleagues with respect to their department. We attended one of these, and witnessed the communication of information, such as activity, equipment matters, staffing, and incidents.
- There was a service level agreement (SLA) in place between the hospital and external provider for

diagnostic imaging services. The imaging manager attended daily '10@10' meetings as well as HOD meetings. The external provider also submitted monthly quality reports to the hospital.

Leadership / culture of service

- Staff we spoke with understood the departmental structure and knew who their line manager was.
- Staff in the departments were able to discuss issues with their line manager. They told us how they could contribute to the running of the department.
- Staff told us the new senior management team were extremely visible and approachable. They were confident in the ability of senior management, which had not been so with the previous management team. All reported that either the hospital manager or the director of clinical services would visit the department daily and engage with staff.
- Staff described the interim manager of the OPD department as enthusiastic, knowledgeable, and approachable.
- The staff told us they felt the hospital was patient focused and was able to provide a high level of care for patients.
- Staff told us there was an open culture where they felt confident to share ideas and to highlight any concerns, incidents, or errors and learn from the subsequent investigations.
- The requirements relating to duty of candour regulations were met through the processes for investigating incidents, and reviewing and responding to complaints. Staff were able to tell us how important it was to be open and honest with people when things went wrong.
- Staff sickness was not high when compared to the yearly average of other independent hospitals.
- The hospital was actively recruiting to fill the manager's position with a permanent member of staff as quickly as possible. The interim manager had committed to stay in post until such a time as a comprehensive handover was completed. There were no vacancies for nurses or health care assistants. The hospital fully supported one healthcare assistant to requalify as a nurse and was due to take up a post in the coming weeks. Many staff had been working in the department for a long time.
- Most staff were aware the hospital had a whistleblowing policy. The manager was aware that she could raise concerns directly to the Care Quality Commission.

Public and staff engagement

- Patients attending the outpatient department had the opportunity to provide feedback through cards given to patients during their visit to the OPD. We saw a number of completed cards. All were positive, indicating they were either likely or very likely to recommend friends or family to the OPD.
- To the question 'How likely are you to recommend our service to friends and family if they needed similar care and treatment' for NHS patients, 100% of patients responded they would recommend the service.
- Feedback cards were analysed and a report published by an independent company. The report was discussed with staff every month at their team meetings, which did included individualised feedback for positive comments. Negative feedback was given anonymously.
- We could find no evidence of the results of the patient survey on display in public areas in the department. This meant patients visiting the department were unaware of its performance. This information was available in other areas of the hospital
- All staff felt there was an open culture in the department, and felt engaged as a part of a close team.

Innovation, improvement and sustainability

- The minor treatment room and availability of laser equipment in the OPD had a positive impact on patients. Dermatology and ophthalmology patients especially could have minor procedures carried out without the need for a new appointment or admission to a bed.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider SHOULD take to improve

- Ensure fittings and furniture in all clinical areas are compliant with infection prevention and control best practice guidance.
- Ensure staff have access to hand washing sinks in line with infection prevention and control guidance.
- Continue toreview systems to ensure compliance with national guidelines in relation to the continuity of power supply in theatres.
- Ensure there is a formal out of hours rota for consultant cover.
- Review systems in place to ensure pre-procedure checklists are completed accurately.

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