BMI Gisburne Park Hospital

Quality Report

Gisburn Park Estate
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Clitheroe
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Date of inspection visit: 23, 24 August and 2 September 2016
Date of publication: 23/01/2017

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

Summary of findings

Letter from the Chief Inspector of Hospitals

BMI Gisburne Park Hospital in Clitheroe is part of BMI Healthcare, the UK's largest provider of independent healthcare. BMI Gisburne Park Hospital is registered to provide the following regulated activities:

Diagnostic and screening procedures.

Surgical procedures.

Treatment of disease, disorder or injury.

Family planning related to long term contraception.

Our inspection was part of our ongoing programme of comprehensive Independent Health Care inspections. We carried out an announced inspection visit of BMI Gisburne Park Hospital on 23 and 24 August 2016and an unannounced inspection on 2 September 2016.

We inspected the core services of surgery and outpatients and diagnostic imaging.

Are services safe at this hospital?

We rated safe as good.

- Incidents were reported by staff through effective systems. Lessons were learnt and investigation findings and improvements made were fed back to staff. There were systems in place to keep people safe and staff were aware of how to ensure patients were safeguarded from abuse.
- Medicines were stored safely and given to patients in a timely manner. The staffing levels and skills mix was sufficient to meet patients' needs.
- Equipment was maintained, appropriately checked and visibly clean. Medical equipment was checked and maintained by an independent company.
- Patient records were stored securely and access was limited to those who needed to use them.
- There were defects in the carpet on the ward corridor and we found floors in three patient bathrooms which were dirty in the corners and grouting on the tiles were not as clean as they should have been. We found that this had been addressed at our unannounced visit.
- Staff assessed and responded to patients' risks and used recognised assessments but these were not always fully completed.
- The majority of staff had completed their mandatory training.
- Senior staff were aware of their responsibilities relating to the duty of candour legislation and they were able to give us examples of when this had been implemented. The hospital had a duty of candour process in place to ensure that people had been appropriately informed of an incident and the actions that had been taken to prevent recurrence.
- Surgical procedures were carried out by a team of consultant surgeons and anaesthetists who were mainly employed by other organisations (such as in the NHS) in substantive posts and had practising privileges with the hospital.
- The consultants and anaesthetists were responsible for their individual patients during their hospital stay.
- Resident registered medical officers (RMOs) were employed to provide medical cover when the consultant was not available.

Are services effective at this hospital?

We rated effective as good.

Summary of findings

- Patients received care and treatment according to national guidelines such as National Institute for Health and Care Excellence (NICE) and the Royal Colleges of Nursing and Surgeons. Surgery services participated in national audits. Findings from performance reported outcomes measures (PROMs) and the National Joint Registry showed the majority of patients had a positive outcome following their care and treatment.
- The hospital monitored patient outcomes through surveys to ensure that patients were satisfied with the service they received.
- BMI corporate policies were based on National Institute for Health and Care Excellence (NICE), national and royal college guidelines were available to staff on the intranet.
- The rate of unplanned readmissions following surgery was within expected levels when compared to other independent hospitals.
- Care and treatment was provided by suitably trained, competent staff that worked well as part of a multidisciplinary team. The majority of staff had completed their appraisals.
- Procedures were in place to ensure that consultants holding practicing privileges were valid to practice. There were procedures in place to ensure all consultant requests to practice were reviewed by the Medical Advisory Committee (MAC).
- Staff sought consent from patients prior to delivering care and treatment and understood what actions to take if a patient lacked the capacity to make their own decisions.

Are services caring at this hospital?

We rated caring as good.

- Without exception, patients spoke positively about their care and treatment. Staff treated patients with dignity and respect and patients were kept involved in their care. Patient feedback from the NHS Friends and Family test and patient satisfaction surveys showed most patients were positive about recommending services to their friends and family.

Are services responsive at this hospital?

We rated responsive as good.

- There was daily planning by staff to ensure patients were admitted and discharged in a timely manner. There was sufficient capacity in the ward and theatres so patients could be seen promptly and receive the right level of care before and after surgery.
- There were systems in place to support vulnerable patients. Complaints about the services were resolved in a timely manner and information about complaints was shared with staff to aid learning.
- The department accessed translation services for those patients whose first language was not English, and information was available to patients in differing formats, if required. A hearing loop was available for those patients who were hard of hearing.
- The hospital had not implemented recognised schemes to help meet the individual needs of patients living with dementia.

Are services well led at this hospital?

We rated well-led as good.

- There were governance structures in place which included a risk register. The hospital's vision and values had been cascaded across the services and staff had a clear understanding of what these involved. There was clearly visible leadership within the services. Staff were positive about the culture within the services and the level of support they received. There was routine public and staff engagement. All staff were committed to delivering good, compassionate care and were motivated to work at the hospital.

Our key findings were as follows:

Summary of findings

- Incidents were reported by staff through effective systems. Lessons were learnt and investigation findings and improvements made were fed back to staff. All staff we spoke with described with confidence how they would recognise and report incidents. Lessons were learnt and investigation findings and improvements made. Feedback on the outcomes of the incident was shared across the organisation.
- There were systems in place to keep people safe and staff were aware of how to ensure patients were safeguarded from abuse.
- Medicines were stored safely and given to patients in a timely manner. The staffing levels and skill mix was sufficient to meet patients' needs and staff assessed and responded to patient risks. Care and treatment was provided by suitably trained, competent staff that worked well as part of a multidisciplinary team.
- Patients received care and treatment according to national guidelines such as National Institute for Health and Care Excellence (NICE) and the Royal Colleges of Surgeons and Nurses. Surgery services participated in national audits. Findings from performance reported outcomes measures (PROMs) and the National Joint Registry showed the majority of patients had a positive outcome following their care and treatment.
- Staff treated patients with dignity and respect and patients were kept involved in their care.
- There was daily planning by staff to ensure patients were admitted and discharged in a timely manner. There was sufficient capacity in the ward and theatres so patients could be seen promptly and receive the right level of care before and after surgery.
- There were systems in place to support vulnerable patients. Complaints about the services were resolved in a timely manner and information about complaints was shared with staff to aid learning.
- There were governance structures in place which included a risk register. Risks had been identified and actions taken to mitigate the risks in a number of areas that included infection control and patient safety.
- The hospital's vision and values had been cascaded across the services and staff had a clear understanding of what these involved. There was clearly visible leadership within the services. Staff were positive about the culture within the services and the level of support they received. There was routine public and staff engagement. All staff were committed to delivering good, compassionate care and were motivated to work at the hospital.
- From April 2015 to March 2016, there had been no reported cases of healthcare-associated infections that would place patients at risk of harm.
- Equipment was maintained, appropriately checked, and visibly clean. Medical equipment was checked and maintained by an independent company. We saw records to confirm that electrical equipment had been tested.
- Patient records were stored securely, and access was limited to those who needed to use them. This ensured that patient confidentiality was maintained at all times.
- The Radiology department had implemented the World Health Organisation (WHO) safety checklist for non-surgical interventional radiology. The safety checklist was audited every three months to ensure the checklist was being completed. The latest audit results for July 2016 showed 100 % compliance.
- Patient satisfaction was benchmarked against other BMI Healthcare hospitals. Information provided by the hospital showed that in July 2016 the hospital ranked 18th out of 55 BMI Healthcare hospitals.
- Staff treated patients with dignity and respect and patients were kept involved in their care. Patients and their relatives we spoke with told us they were supported by staff that were caring, compassionate and supportive to their needs.
- We observed that information was available to patients about who to contact if they had any concerns about their care. Additionally there was a wide variety of information leaflets available in all areas of the hospital.
- Patients had a choice of appointments available to them through the 'choose and book' service. This allowed patients to be able to attend appointments at a time best suited to their needs.
- The hospital accessed translation services for those patients whose first language was not English and information was available to patients in differing formats, if required. A hearing loop was available for those patients who were hard of hearing.

Summary of findings

- Procedures were in place to ensure that consultants holding practicing privileges were valid to practice. There were procedures in place to ensure all consultant requests to practice were reviewed by the Medical Advisory Committee (MAC).
- In the BMI healthcare staff survey 2015, 94% of staff would recommend the hospital as a place to work. This was above the national average of 70%.
- All staff told us that managers of the service were approachable and supportive. We observed managers to be present on the department providing advice and guidance to staff and interactions were positive and encouraging.
- Carpeting and seating did not assist in maintaining good standards of infection control. The seating and some flooring was not washable or wipe clean, if it became soiled, and could present an infection risk. This was being addressed by the service and a programme of refurbishment was in place.
- We observed that nasal endoscopes were being cleaned in the same room in which the treatment took place. Following discussion with senior managers, the service immediately ceased this practice and made arrangements to meet the risk assessment and policy for nasal endoscopy equipment to be cleaned in a separate area.
- At the time of inspection the outpatient department was experiencing a shortage of healthcare staff. We were told that staff from another department was able to help cover the unfilled shifts. We observed that this did not happen, and the outpatient manager provided the necessary cover required. This meant that the outpatient manager may not be able to provide effective management support of the outpatient area and ward.
- The hospital had not implemented recognised schemes to help meet the individual needs of patients living with dementia. For example signage was not clear, and there were no quiet spaces for patients who may be feeling anxious or confused.
- Staff compliance with mandatory training was variable across the department. Outpatients' compliance with training was 100%, physiotherapy compliance was 86% and Radiology was 77% compliant with training. The hospital target was 90% and a plan was in place for the service to meet the target.
- Although risk assessments on the radiology department had been reviewed by the radiation protection supervisor in 2016, we saw from records provided that there was no clear evidence that they had been reviewed by the radiation protection advisor on an annual basis.
- We found no documentary evidence that staff had the competence to administer eye drops in the outpatients department. Current practice relied upon consultants to ascertain if staff were competent in administration of eye drops.

There were some areas where the provider needs to make improvements.

Action the hospital SHOULD take to improve

- The hospital should ensure that all patient bedrooms and bathrooms are thoroughly cleaned and audited on a regular basis.
- The hospital should take action to replace carpeting and seating to assist in maintaining good standards of infection control.
- The hospital should ensure that portable appliance testing is carried out on all electrical equipment.
- The hospital should ensure that oxygen cylinders are stored in line with guidelines when not in use.
- The hospital should ensure that all observations are correctly recorded.
- The hospital should ensure that all staff have an up to date appraisal.
- The hospital should ensure that all patients are seen post operatively by the consultant
- The hospital should ensure that the daily meetings between ward and theatre staff take place
- The hospital should consider appropriate signage and environment for people living with dementia or a cognitive impairment.
- The hospital should take action to improve the reviewing of risk assessments in radiology.
- The hospital should develop a competency programme for staff in the administration of eye drops.

Summary of findings

- The hospital should take action to improve the compliance rates with mandatory training to ensure the staff have the up to date knowledge and skills to care and treat patients.
- The hospital should consider including medicines management as part of the mandatory training programme.

Professor Sir Mike Richards

Chief Inspector of Hospitals

Overall summary

Overall we found services good at BMI Gisburne.

We inspected the core services of surgery and outpatients and diagnostic imaging.

- Incidents were reported by staff through effective systems. Lessons were learnt and investigation findings and improvements made were fed back to staff. There were systems in place to keep people safe and staff were aware of how to ensure patients were safeguarded from abuse.
- Medicines were stored safely and given to patients in a timely manner. The staffing levels and skills mix was sufficient to meet patients' needs.
- Equipment was maintained, appropriately checked and visibly clean. Medical equipment was checked and maintained by an independent company.
- Patient records were stored securely and access was limited to those who needed to use them.
- There were defects in the carpet on the ward corridor and we found floors in three patient bathrooms which were dirty in the corners and grouting on the tiles were not as clean as they should have been. We found that this had been addressed at our unannounced visit.
- Staff assessed and responded to patients' risks and used recognised assessments but these were not always fully completed.
- The majority of staff had completed their mandatory training.
- Senior staff were aware of their responsibilities relating to the duty of candour legislation and they were able to give us examples of when this had been implemented. The hospital had a duty of candour process in place to ensure that people had been appropriately informed of an incident and the actions that had been taken to prevent recurrence.
- Surgical procedures were carried out by a team of consultant surgeons and anaesthetists who were mainly employed by other organisations (such as in the NHS) in substantive posts and had practising privileges with the hospital.
- The consultants and anaesthetists were responsible for their individual patients during their hospital stay.
- Resident registered medical officers (RMOs) were employed to provide medical cover when the consultant was not available.
- Patients received care and treatment according to national guidelines such as National Institute for Health and Care Excellence (NICE) and the Royal Colleges of Nursing and Surgeons. Surgery services participated in national audits. Findings from performance reported outcomes measures (PROMs) and the National Joint Registry showed the majority of patients had a positive outcome following their care and treatment.
- The hospital monitored patient outcomes through surveys to ensure that patients were satisfied with the service they received.
- BMI corporate policies were based on National Institute for Health and Care Excellence (NICE), national and royal college guidelines were available to staff on the intranet.
- The rate of unplanned readmissions following surgery was within expected levels when compared to other independent hospitals.
- Care and treatment was provided by suitably trained, competent staff that worked well as part of a multidisciplinary team. The majority of staff had completed their appraisals.
- Procedures were in place to ensure that consultants holding practicing privileges were valid to practice. There were procedures in place to ensure all consultant requests to practice were reviewed by the Medical Advisory Committee (MAC).

Summary of findings

- Staff sought consent from patients prior to delivering care and treatment and understood what actions to take if a patient lacked the capacity to make their own decisions.
- Without exception, patients spoke positively about their care and treatment. Staff treated patients with dignity and respect and patients were kept involved in their care. Patient feedback from the NHS Friends and Family test and patient satisfaction surveys showed most patients were positive about recommending services to their friends and family.
- There was daily planning by staff to ensure patients were admitted and discharged in a timely manner. There was sufficient capacity in the ward and theatres so patients could be seen promptly and receive the right level of care before and after surgery.
- There were systems in place to support vulnerable patients. Complaints about the services were resolved in a timely manner and information about complaints was shared with staff to aid learning.
- The department accessed translation services for those patients whose first language was not English, and information was available to patients in differing formats, if required. A hearing loop was available for those patients who were hard of hearing.
- The hospital had not implemented recognised schemes to help meet the individual needs of patients living with dementia.
- There were governance structures in place which included a risk register. The hospital's vision and values had been cascaded across the services and staff had a clear understanding of what these involved. There was clearly visible leadership within the services. Staff were positive about the culture within the services and the level of support they received. There was routine public and staff engagement. All staff were committed to delivering good, compassionate care and were motivated to work at the hospital.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Surgery	Good	We gave the surgical services at Gisburne Park Hospital an overall rating of 'good'. This was because: - Incidents were reported by staff through effective systems. Lessons were learnt and investigation findings and improvements made were fed back to staff. There were systems in place to keep people safe and staff were aware of how to ensure patients' were safeguarded from abuse. The staffing levels and skills mix was sufficient to meet patients' needs and staff assessed and responded to patient risks. Care and treatment was provided by suitably trained, competent staff that worked well as part of a multidisciplinary team. Patients received care and treatment according to national guidelines such as National Institute for Health and Care Excellence (NICE). Staff treated patients with dignity and respect and patients were kept involved in their care. Patient feedback from the NHS Friends and Family Test and patient satisfaction surveys showed most patients were positive about recommending surgical services to friends and family. There were systems in place to support vulnerable patients. Complaints about the services were resolved in a timely manner and information about complaints was shared with staff to aid learning. There were governance structures in place which included a risk register. There was a hospital vision which had been cascaded across the surgical services and staff had a clear understanding of the hospital values. There was clear visible leadership within the services. Staff were positive about the culture within the services and the level of support they received. However, There were defects in the carpet on the ward corridor and three patient rooms needed further cleaning.Staff assessed and responded to patient's risks and used recognised assessments but these were not always fully completed.The hospital had not implemented recognised schemes to help meet the individual needs of patients living with dementia.Some staff had not completed their mandatory training or had an up to date appraisal.

Summary of findings

Outpatients and diagnostic imaging

Good 

We rated outpatients and diagnostic imaging as 'good' overall because;
Incidents were reported by staff through effective systems. Feedback on the outcomes of the incident was shared across the organisation. From April 2015 to March 2016, there had been no reported cases of healthcare-associated infections.
Equipment was maintained, appropriately checked, and visibly clean. Patient records were stored securely, and access was limited to those who needed to use them.
Care and treatment within the outpatient and diagnostic imaging department was delivered in line with evidence-based practice. Policies and procedures followed recognisable and approved guidelines such as those from the National Institute for Health and Care Excellence (NICE).
The Radiology department had implemented the World Health Organisation (WHO) safety checklist for non-surgical interventional radiology. Regular audits were undertaken to ensure good practice was in place.
The hospital monitored patient outcomes through surveys to ensure that patients were satisfied with the service they received
Patients and their relatives we spoke to told us they were supported by staff that were caring, compassionate and supportive to their needs.
Patients had a choice of appointments available to them through the 'choose and book' service. This allowed patients to be able to attend appointments at a time best suited to their needs.
We saw that risks had been identified and actions taken to mitigate the risks in a number of areas that included infection control and patient safety.
Procedures were in place to ensure that consultants holding practicing privileges were valid to practice.
In the BMI Healthcare staff survey 2015, 94% of staff would recommend the hospital as a place to work. This was above the national average of 70%.
All staff told us that managers of the service were approachable and supportive. We observed managers to be present on the department providing advice and guidance to staff and interactions were positive and encouraging.
However,
Carpeting and seating did not assist in maintaining good standards of infection control. The seating and

Summary of findings

some flooring was not washable or wipe clean if it became soiled and could present an infection risk. This was being addressed by the service and a programme of refurbishment was planned.
We observed that nasal endoscopes were being cleaned in the same room in which the treatment took place this practice was immediately ceased
At the time of inspection the outpatient department was experiencing a shortage of healthcare staff. We were told that staff from another department were able to help cover the unfilled shifts. We observed that this did not happen, and the outpatient manager provided the necessary cover required. This meant that the outpatient manager may not be able to provide effective management support of the outpatient area and ward.
The hospital environment had not been suitably adapted to respond to the needs of patients living with dementia.
Although risk assessments on the radiology department had been reviewed by the radiation protection supervisor in 2016, we saw from records provided that there was no clear evidence that they had been reviewed by the radiation protection advisor on an annual basis.
We found no documentary evidence that staff had the competence to administer eye drops in the outpatients department. Current practice relied upon consultants to ascertain if staff were competent in administration of eye drops.

Summary of findings

Contents

Good

BMI Gisburne

Services we looked at
Surgery; Outpatients and diagnostic imaging;

Summary of this inspection

Background to BMI Gisburne Park Hospital

BMI Gisburne Park Hospital in Clitheroe is housed in a Grade one listed building set in parkland with 35 bedrooms, all of which provide an ensuite facility.

BMI Gisburne Park Hospital is part of BMI Healthcare, the UK's largest provider of independent healthcare and opened in October 1985. The hospital has two theatres, one with laminar flow, 35 single en-suite rooms used by inpatients and day cases, and six chairs spread over two rooms for minor procedures.

At the time of our inspection the registered manager and accountable officer for controlled drugs for BMI Gisburne park is the hospital's Executive Director, who has been in post since 2014.

Out of 74 consultants 67 were employed by local NHS trusts. The remaining seven undertook their validation through the provider where they saw the majority of their patients. Three of the consultants undertook validation through BMI Healthcare. The main surgical procedures undertaken at the hospital include cataracts, hip and knee replacements and gynaecological procedures. These are undertaken between Monday to Friday and Monday to Saturday one week a month. The outpatients and diagnostic imaging services at BMI Gisburne park hospital covered a wide range of specialties including orthopaedics, ear nose and throat (ENT), urology, dermatology, gynaecology, neurosurgery, ophthalmology, general surgery, and cosmetic surgery.

The outpatient facilities consist of six consulting rooms, two treatment rooms and a diagnostic service of plain x-ray and ultrasound. Computed Tomography (CT) and magnetic resonance imaging (MRI) scans are not undertaken at this site and instead take place at an alternative, local BMI hospital. The hospital has a designated pharmacy, physiotherapy suite and a radiology department. We inspected the hospital as part of our routine comprehensive inspection programme for independent healthcare services. We carried out an announced inspection visit on 23 and 24 August 2016 and an unannounced inspection on 2 September 2016.

BMI Gisburne Park Hospital has previously been inspected by the Care Quality Commission in June 2013. Six core standards assessed were found to be compliant except one, which was a requirement relating to workers. The provider was re-inspected on 1 October 2013 when the service was found to be compliant.

Our inspection team

Our inspection team was led by:

Inspection Lead: Elizabeth McMullin Inspector Care Quality Commission

The team included four CQC inspectors, an expert by experience and a variety of specialists: governance specialist, consultant surgeon, senior theatre nurse manager and outpatient services manager.

Why we carried out this inspection

We inspected the hospital as part of our routine comprehensive inspection programme for independent healthcare services.

Summary of this inspection

How we carried out this inspection

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

We carried out an announced inspection visit on 23 and 24 August 2016 and an unannounced inspection on 2 September 2016.

We spoke with a range of staff in the hospital both individually and as part of focus groups, including the registered manager, nurses, consultants, administrative, ancillary and clerical staff.

During our inspection we reviewed services provided by BMI Gisburne Park Hospital in the ward, operating theatre, outpatients and diagnostic imaging departments.

During our inspection we spoke with 29 patients, three family members/carers and 32 staff, including the Consultant Surgeon who was chair of the Medical Advisory Committee. from all areas of the hospital, including the wards, operating theatre and the outpatient department.

We observed how people were being cared for and talked with patients and reviewed personal care or treatment records of patients.

We also reviewed data provided by the hospital and local commissioners of the service.

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

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

Information about BMI Gisburne Park Hospital

The service did not provide care and treatment to children and young people under the age of 18.

The hospital has 35 bedrooms all of which provide an ensuite facility. The main surgical procedures undertaken at the hospital include cataracts, hip and knee replacements and gynaecological procedures. These are undertaken between Monday to Friday and Monday to Saturday one week a month.

The outpatients and diagnostic imaging services at BMI Gisburne park hospital covered a wide range of specialties including orthopaedics, Ear Nose and Throat (ENT), urology, dermatology, gynaecology, neurosurgery, ophthalmology, general surgery, and cosmetic surgery.

There were 3,774 inpatient attendances and day case attendances at the hospital between April 2015 and March 2016. The majority of surgical patients attending the hospital underwent day surgery. The majority of patients (87%) were NHS funded patients and the remaining 13% were privately funded. The hospital reported that 23% of all NHS patients and 27% of all other funded patients stayed overnight at the hospital between April 2015 and March 2016.

From April 2015 to March 2016, outpatients saw a total of 14,763 patients. Seventy nine percent of outpatients were NHS funded and 21% had another funding source.

All patients are admitted and treated under the direct care of a consultant and medical care is supported 24 hours per day, seven days per week by an onsite resident medical officer (RMO). Patients are cared for and supported by registered nurses, care assistants, allied health professionals such as physiotherapists and pharmacists who are employed by the hospital. Doctors have practicing privileges and their individual activity is monitored.

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

- Incidents were reported by staff through effective systems. Lessons were learnt and investigation findings and improvements made were fed back to staff. There were systems in place to keep people safe and staff were aware of how to ensure patients were safeguarded from abuse.
- Medicines were stored safely and given to patients in a timely manner. The staffing levels and skills mix was sufficient to meet patients' needs.
- Equipment was maintained, appropriately checked and visibly clean. Medical equipment was checked and maintained by an independent company.
- Patient records were stored securely and access was limited to those who needed to use them.
- There were defects in the carpet on the ward corridor and we found floors in three patient bathrooms which were dirty in the corners and grouting on the tiles were not as clean as they should have been. We found that this had been addressed at our unannounced visit.
- Staff assessed and responded to patients' risks and used recognised assessments but these were not always fully completed.
- The majority of staff had completed their mandatory training.
- Senior staff were aware of their responsibilities relating to the duty of candour legislation and they were able to give us examples of when this had been implemented. The hospital had a duty of candour process in place to ensure that people had been appropriately informed of an incident and the actions that had been taken to prevent recurrence.
- Surgical procedures were carried out by a team of consultant surgeons and anaesthetists who were mainly employed by other organisations (such as in the NHS) in substantive posts and had practising privileges with the hospital.
- The consultants and anaesthetists were responsible for their individual patients during their hospital stay.
- Resident registered medical officers (RMOs) were employed to provide medical cover when the consultant was not available.

Are services effective?

Good

- Patients received care and treatment according to national guidelines such as National Institute for Health and Care Excellence (NICE) and the Royal Colleges of Nursing and

Summary of this inspection

Surgeons. Surgery services participated in national audits. Findings from performance reported outcomes measures (PROMs) and the National Joint Registry showed the majority of patients had a positive outcome following their care and treatment.

- The hospital monitored patient outcomes through surveys to ensure that patients were satisfied with the service they received.
- BMI corporate policies were based on National Institute for Health and Care Excellence (NICE), national and royal college guidelines were available to staff on the intranet.
- The rate of unplanned readmissions following surgery was within expected levels when compared to other independent hospitals.
- Care and treatment was provided by suitably trained, competent staff that worked well as part of a multidisciplinary team. The majority of staff had completed their appraisals.
- Procedures were in place to ensure that consultants holding practicing privileges were valid to practice. There were procedures in place to ensure all consultant requests to practice were reviewed by the Medical Advisory Committee (MAC).
- Staff sought consent from patients prior to delivering care and treatment and understood what actions to take if a patient lacked the capacity to make their own decisions.

Are services caring?

Good

- Without exception, patients spoke positively about their care and treatment. Staff treated patients with dignity and respect and patients were kept involved in their care. Patient feedback from the NHS Friends and Family test and patient satisfaction surveys showed most patients were positive about recommending services to their friends and family.

Are services responsive?

Good

- There was daily planning by staff to ensure patients were admitted and discharged in a timely manner. There was sufficient capacity in the ward and theatres so patients could be seen promptly and receive the right level of care before and after surgery.
- There were systems in place to support vulnerable patients. Complaints about the services were resolved in a timely manner and information about complaints was shared with staff to aid learning.

Summary of this inspection

- The department accessed translation services for those patients whose first language was not English, and information was available to patients in differing formats, if required. A hearing loop was available for those patients who were hard of hearing.
- The hospital had not implemented recognised schemes to help meet the individual needs of patients living with dementia.

Are services well-led?

Good

- There were governance structures in place which included a risk register. The hospital's vision and values had been cascaded across the services and staff had a clear understanding of what these involved. There was clearly visible leadership within the services. Staff were positive about the culture within the services and the level of support they received. There was routine public and staff engagement. All staff were committed to delivering good, compassionate care and were motivated to work at the hospital.

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

Good

Surgery

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

Are surgery services safe?

Good

We rated the surgical services as 'Good' for Safe. This was because: -

- Patient safety was monitored and staff reported incidents using an incident reporting system. Staff were aware of lessons learnt and that improvements were made from investigations.
- Medicines were stored safely and given to patients in a timely manner. There were systems in place to manage the safe administration and prescribing of medication. Audits were undertaken and actions had been identified to help staff improve when standards had not been met.
- Staff followed good practice guidance in relation to the control and prevention of infection in line with trust policies and procedures and we observed good hand hygiene practice.
- There had been no cases of Methicillin-resistant Staphylococcus aureus (MRSA) bacteraemia, Methicillin-sensitive Staphylococcus aureus (MSSA) bacteraemia, Clostridium difficile (C.diff) or Escherichia coli (E. coli) at the hospital between April 2015 and March 2016.
- Staff had received safeguarding training and understood how to identify potential abuse and report safeguarding concerns.
- The staffing levels and skill mix was sufficient to meet patients' needs.

However,

- Patient bathrooms were not as clean as they could have been and there were defects in the carpet on the ward corridor.
- Staff assessed and responded to patients' risks and used an early warning score system but this could not be correctly calculated as not all observations were being recorded.

Incidents

- Staff were familiar with and encouraged to use the hospital's policy and procedures for reporting incidents. Incidents were reported through a paper reporting system which was uploaded centrally onto an electronic system. We spoke with a range of staff across the service who were all aware of how to report incidents.
- A root cause analysis (RCA) tool was used to investigate serious incidents, and we saw that, where required, an action plan was put in place to reduce the risk of the incident happening again. Action plans included evidence of feedback and actions for learning. Where necessary, action plans indicated where further training in processes for staff was required.
- In the last 12 months surgical services at the hospital reported no never events. Never events are serious, wholly preventable patient safety incidents that should not occur if the available preventative measures have been implemented.
- Between April 2015 and March 2016, surgical services at the hospital reported 275 incidents. Of these, none were reported as severe harm with the majority being reported as low or no harm to patients. The biggest risk was the cancellation of operations but the majority were for clinical reasons on the day of the operation. For

example, the patient was unwell or had an infection. For those cancelled due to non-clinical reasons, for example, the consultant being delayed, actions and learning had been identified.

- Between April 2015 and March 2016, there had been one serious incident reported in surgical services at the hospital. An RCA had been completed which identified actions and learning for theatre staff. During the inspection we observed correct procedures were followed as outlined in the action plan.
- Senior staff told us general feedback on patient safety information was discussed at staff meetings or in staff huddles. Senior staff facilitated time with staff to look at lessons learnt from incidents.
- Staff were able to describe an example of a change following an incident where additional checks have been put in place following an incident where a patient came down to theatre with the wrong identification band on their wrist.
- Information about incidents was discussed for surgical services as part of clinical governance meetings each month as well as the medical advisory meeting (MAC). The report included learning and actions taken following incidents.
- Senior staff were aware of their responsibilities relating to the Duty of Candour legislation and were able to give us examples of when this had been implemented. The hospital had a duty of candour process in place to ensure that people had been appropriately informed of an incident and the actions taken to prevent recurrence. The aim of the Duty of Candour regulation is to ensure providers are open and transparent with people who use services and inform and apologise to them when things go wrong with their care and treatment.
- There was an area on the communication (comms) cell board on the ward and in theatres for the number of incidents during each month. This was available for both staff and for members of the public.
- The hospital reported there had been no patient deaths relating to surgery between April 2015 and March 2016. There was a process in place so that if a patient death occurred at the hospital, it would be reviewed and investigated through the hospital's medical advisory committee (MAC).

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

- The NHS Safety Thermometer assessment tool measures a snapshot of harms once a month (incidents such as falls, pressure ulcers, blood clots, catheter and urinary infections).
- Safety Thermometer information for NHS patients, between April 2016 and July 2016, showed there were no pressure ulcers, falls with harm or catheter urinary tract infections incidents reported by the hospital relating to surgical services.
- The hospital reported there were two incidents of venous thromboembolism (VTE) (a blood clot in a vein) between April 2015 and March 2016. Ninety five percent of patients were assessed for risk of VTE during the same reporting period.
- The hospital monitored surgical site infection rates, through the governance structures. Between April 2015 and March 2016, the hospital reported no surgical site infections for primary hip arthroplasty, other orthopaedic and trauma procedures and other surgery. They had one surgical site infection in the same reporting period for primary knee arthroplasty.

Cleanliness, infection control and hygiene

- Staff followed good practice guidance in relation to the control and prevention of infection in line with hospital policies and procedures. There were sufficient hand gels outside patient bedrooms. Hand towels and soap dispensers were adequately stocked. We observed staff following hand hygiene practice, bare below the elbow and using personal protective equipment, where appropriate.
- There was only one basin in the patient bedrooms we looked at. It is recommended that a minimum of one clinical hand wash basin is available in each single room, in addition to the general hand wash basin for personal hygiene in the en-suite facility (Health building note 00-09, Infection control in the built environment, Department of Health). There were no additional hand wash basins on the ward corridors for patients, the public or staff to use. Senior management staff said this was being looked into and an action identified to investigate the possibility of additional hand wash basins in patient bedrooms.
- Between April 2015 and March 2016, the hospital reported no cases of clostridium difficile, methicillin-resistant staphylococcus aureus (MRSA) or methicillin-susceptible staphylococcus aureus (MSSA).

- The ward used the 'I am clean' stickers to inform colleagues at a glance that equipment or furniture had been cleaned and was ready for use.
- Although the theatre areas we visited were visibly clean and free from odour, we observed that cleaning of the environment was not always as thorough as it should have been on the ward. For example, floors in the patient bathrooms were still dirty in the corners and grouting on the tiles were not as clean as they should have been. On the unannounced inspection, the bathroom floors had been thoroughly cleaned and new equipment ordered to ensure all the corners of the floors could be cleaned. This had also been added to the room cleaning checklist.
- One of the two operating theatres used a laminar flow system, intended to provide a uniform directional flow of air in the operating room with very little turbulence to minimise contamination of the surgical field with airborne microbes. This system is used widely in orthopaedic procedures to try and reduce the opportunity for surgical site infections (SSIs) to occur.
- Monthly hand hygiene audits were undertaken by staff being observed. Results were 100% across surgical services.
- Rooms used for patients at increased risk of cross infection displayed clear signage outside so that staff and visitors were aware of the increased precautions they must take when entering and leaving the room.
- We observed that the disposal of sharps, such as needles followed good practice guidance. Sharps containers were dated and signed upon assembling them and the temporary closure was used when sharps containers were not in use.
- We looked at the cleaning checklists for both theatres and they had been completed in full. Theatre had also been deep cleaned in August 2016 by an external company.
- We looked at the cleaning checklists for the ward and found that the majority had been completed. However, there were some areas that had not been fully checked week beginning 15 August 2016 and week beginning 22 August 2016.
- The ward was using the national colour coding scheme for hospital cleaning materials and equipment so that items were not used in multiple areas, therefore reducing the risk of cross infection.

Environment and equipment

- In order to maintain the security of patients, visitors were required to use the intercom system outside theatre to identify themselves on arrival before they were able to access the area and staff had access codes.
- Each clinical area had resuscitation equipment readily available. There were systems in place to ensure it was checked and ready for use on a daily basis. Records indicated that daily checks of the equipment had taken place on the ward and theatre areas.
- The hospital had an agreement in place with a neighbouring NHS acute trust for the supply of emergency blood if needed. A supply of O negative blood was kept on site in a dedicated fridge and staff carried out daily checks to ensure this was stored appropriately and kept within expiry dates. O negative blood can be given to anyone in an emergency regardless of their blood type.
- Throughout our inspection we did identify an environmental risk and hazard. Carpet in the ward corridor had holes which had been covered with sticky tape. This tape was, in places, lifting at the corners. We raised this with senior managers who were going to rectify the problem.
- There were systems to maintain and service equipment as required. Records indicated that defibrillator equipment had been checked and anaesthetic machines in theatres serviced regularly.
- Portable appliance testing had been carried out on the majority of electrical equipment regularly and electrical safety certificates were in date. However, there were three intravenous pumps that did not have up to date certificate in place. One was out of date since March 2016 and two since June 2016.
- The anaesthetic machines and monitors did not meet current new guidelines. This had been identified on the capital expenditure programme for the hospital and they were currently in the process of being ordered. However, the machines where still safe to use.
- There had been issues with the decontamination of equipment by a third party provider. The hospital was not always assured that the equipment returned was fully decontaminated as wrapping used had small tears. To lower the risk alternative equipment was sourced from neighbouring hospitals so operations were not cancelled. Meetings were taking place with the provider to rectify this issue.
- On the ward outside the ambulatory care area, portable oxygen cylinders were not stored in a locked room or

secured in a cage or against a wall. Health and safety best practice guidance is that oxygen cylinders should be stored securely in a well ventilated storage area or compound when not in use.

- There was carpet on the floor in some of the patient rooms and in the corridor on the ward. This may increase the risk of infection. This had been risk assessed and there was a programme in place to replace the carpets with appropriate flooring.
- Patient led assessments of the care environment (PLACE) are undertaken by teams of health care providers, and include at least 50 per cent members of the public (known as patient assessors). Results from the most recent PLACE were published in August 2016 using data collected between February and June 2016. The report compared the scores from the hospital site with the scores for the BMI organisation. Areas assessed included communal and ward areas but not theatres.
- The hospital site scored 93% for condition, appearance and maintenance which was slightly better than the organisational average of 92%.

Medicines

- We looked at the prescription and medicine records for five patients. Arrangements were in place for recording the administration of medicines. These records were clear and fully completed.
- Medicines requiring cool storage at temperatures below eight degrees centigrade were appropriately stored in fridges. Daily temperature checklists were consistently completed on the wards we visited. Staff were able to tell us the system identified to follow up if there were gaps in these records.
- Controlled drugs (medicines which are required to be stored and recorded separately) were stored and recorded appropriately. Access was limited to qualified staff employed by the hospital. Two nurses were observed following the correct procedures for the recording and administration of controlled drugs for a patient.
- Emergency medicines were available for use and records indicated that these were regularly checked and were in containers with tamper-seals in place.
- Where patients were able to, they administered their own medication. They had been provided with a lockable cabinet in which to store their medication, the patient was able to continue to take their medication at the times they were used to taking the medication at home. This meant that patients were given a choice and steps were taken to maintain their independence.
- Pharmacy staff were available for the ward Monday to Friday 8am to 2pm with out of hours support covered by an on-call pharmacist and support from the RMO. Take home medications were dispensed to the patients within 15 minutes of arriving at the hospital.
- There were monthly medicines management audits which looked at compliance with storage and stock levels of medicines. We looked at the findings for February 2016 to May 2016 and saw that surgical services were meeting all the standards.
- However, it was noted that the hospital training programme did not include regular mandatory medicines management training.
- Controlled drugs audits were undertaken on a quarterly basis. In March 2016, the ward and theatre areas showed 100% compliance with the standards. However, this dropped to 87% compliance in June 2016. From the information provided by the hospital no actions were recorded to improve standards.
- Between January and May 2016, an average of 89% of NHS patients had their medication reconciled by a member of staff within 24 hours of admission.

Records

- We reviewed 22 care records and found recent entries were legible, signed and dated. They were easy to follow and medical staff had detailed information for the patient's care and treatment.
- The hospital used paper-based records. Patient records included a range of risk assessments and care plans that were completed on admission and were updated throughout a patient's stay.
- The wards had lockable patient note trolleys. We observed that these trolleys containing patient notes were locked and kept at the nurse's station. This decreased the potential for patient confidentiality to be breached.
- The hospital undertook monthly medical records audits. We reviewed the information between January 2016 and May 2016 and found that in January 2016, the compliance rate with the overall identified set standards was 79% but this had increased to 92% in May 2016. The

standard that was not being adhered to all the time was the completion of risk assessments. From the information provided by the hospital we could not see any actions identified to improve standards.
- The patient information boards that were visible in ward corridors respected patient confidentiality by patient names not being used. Patient information boards were used to provide at a glance an overview of the key risks, medication and discharge plans for each patient.

Safeguarding

- Safeguarding policies and procedures were in place and staff knew how to refer a safeguarding issue to protect adults and children from abuse. The safeguarding lead was the Director of Clinical Services. Staff had access to advice out of hours and at weekends from the hospital on-call manager or the local authority duty social worker.
- Although the service did not provide care and treatment to children and young people under the age of 18, staff were aware that children attended the service as visitors, and so a policy in relation to safeguarding children was in place
- There were flowcharts in the clinical areas with instructions about what to do if staff had concerns or were worried about a child, young person or adult's welfare.
- Training statistics provided by the hospital showed that 99% of staff had completed safeguarding adult and children training, level one and 100% of staff had completed safeguarding level two training.
- Basic safeguarding training was included in induction training for all temporary staff before commencing work on the wards or in theatre
- PREVENT training was undertaken by staff which looked at protecting people at risk of radicalisation. The compliance rate was 99%.
- Not all staff working in surgery we spoke with had heard of female genital mutilation (FGM) although this was included in the safeguarding training. However, there was information available from the home office in the safeguarding folders on the ward and in theatre. Since October 2015, it is mandatory for regulated health and social care professionals to report 'known' cases of FGM, in persons under the age of 18, to the police. Whilst the service did not provide care to those patients under the age of 18, healthcare staff had a professional duty to report any concerns where a parent has had FGM and may have female children.
- There had been no reported safeguarding incidents relating to surgery at the hospital between April 2015 and March 2016.

Mandatory training

- Staff received mandatory training on a rolling annual, bi annual or three year rolling programme in areas such as infection control, information governance, health and safety and fire. This included temporary staff and doctors who had BMI healthcare as their designated body display on the general medical council website.
- Mandatory training included basic life support and immediate life support. Across the hospital 93% of staff had completed basic life support and 81% of staff had completed immediate life support training.
- At the time of our inspection, 88% of staff working in surgical services had completed their mandatory training. The target was 90%. However we noted that surgeons identified to undertake additional mandatory training through the hospital on top of their NHS mandatory training were only 30% compliant. For clinicians that had practising privileges, mandatory training was undertaken through their primary employer.
- The resident medical officers (RMOs) received a BMI induction by the organisation and provided them with appropriate training. For example, fire, infection and control and information governance training. Renewal of additional mandatory training was also organised and managed by the provider company and shared with BMI Gisburne when completed.

Assessing and responding to patient risk

- Patients were assessed by an anaesthetist and surgeon on the day of surgery to identify patients with any medical conditions or those deemed at risk of developing complications after surgery and a decision was made whether they could be operated on at the hospital.
- The World Health Organisation (WHO) safe surgery checklist identifies three phases of an operation: before the induction of anaesthesia (sign in), before the incision of the skin (time out) and before the patient

leaves the operating room (sign out). In each phase, a checklist coordinator must confirm the surgery team has completed the listed tasks before it proceeds with the operation.

- We observed three surgical procedures, all with appropriate handover from a ward nurse to the anaesthetic practitioner. The five steps to safer surgery checklist was completed in full, with all staff engaged for each stage, the sign in, time out and sign out.
- The anaesthetist was present during the patient details check and the preoperative checklist for the patients. There was interaction between the patient, anaesthetist and anaesthetic practitioner.
- Preoperative marking is required to promote correct site surgery, including operating on the correct side of the patient and/or the correct anatomical location or level. The national patient safety agency (NPSA) and the Royal College of Surgeons (RCS) strongly recommend that the mark should subsequently be checked against reliable documentation to confirm it is correctly located, and still legible. This checking should occur at each transfer of the patient's care and end with a final verification prior to commencement of surgery. All team members should be involved in checking the mark. This was completed for the procedures observed.
- There was a briefing session before the surgical list and a debriefing session after the surgical list. We observed a comprehensive team brief for both theatres. This included a full introduction of the team and requirements for the list including an appropriate discussion about the patients. A formal template was completed following each team brief and debriefing session.
- We observed theatre check of instruments where the health care assistant (HCA) read through a checklist and the scrub practitioner confirmed. This occurred prior to and following the procedure and followed best practice guidelines by the association for perioperative practice (AfPP) which recommends both practitioners must visually check, count aloud and in unison. Swabs and sundries were counted and recorded on a white count board.
- There was a full handover by theatre staff to the recovery team.
- Between January 2016 and June 2016, monthly audits showed compliance with the WHO surgical safety checklist was 100%.
- A number of risk assessments were completed as part of the pre-assessment and admission clinical pathway processes. For example, falls, manual handling, and nutrition. Nursing staff said these worked well and that issues were highlighted for them to be aware of. However, in one of the records we reviewed the falls risk assessment showed that the patient was at risk of falls but no actions had been highlighted in the notes.
- 2015. Between April 2015 and March 2016, 95% of patients had been screened for VTE.
- A national early warning score system (NEWS) was used throughout the hospital to alert staff if a patient's condition was deteriorating. This was a basic set of observations such as respiratory rate, temperature, blood pressure and pain score used to alert staff to any changes in a patient's condition.
- We reviewed the 22 patient records and found that six of these had not been completed consistently accurately. For example not all observations had been recorded so the score could not be calculated correctly. This meant there was a risk that staff may not accurately know when a patient was deteriorating.
- There was a procedure in place for a patient to be transferred to the local acute NHS hospital if their condition deteriorated. The hospital was a member of the Cheshire and Mersey Critical Care Network and had a formal written transfer agreement in place with the network to ensure patients could be transferred to a local acute trust if needed, as required by the Independent Healthcare Advisory Services (2015). Staff told us they had a number to contact the local trust if they required to transfer a patient, however if the patient was deteriorating fast they would call for an emergency ambulance to transfer. Between April 2015 and March 2016, there had been 13 unplanned transfers to another hospital. This was not high when compared to a group of independent group hospitals.
- There was a sepsis pathway and policy in place for the recognition and management of sepsis. Sepsis is a life threatening condition that arises when the body's response to an infection injuries its own tissues and organs.
- Within the patient's rooms there was a nurse call bell system and there was an additional light system to indicate which room the emergency had occurred in. We observed staff responding appropriately to an emergency call on the ward and this was well documented in the patient notes. One member of

theatre staff was trained in advance life support (ALS) and another member of staff was currently undertaking the training. The anaesthetist was also ALS trained and we observed that they were also present at times when a patient was in the recovery area. The RMO on duty was also ALS trained. This ensured that there was support in the theatre and recovery areas at all times and was in line with the hospital resuscitation policy.

- The recovery practitioner competencies for life support was unclear as the competency book stated that they needed to be basic life support trained but hospital policy required them to be immediate life support trained.
- Hospital policy outlined that consultants should assess patients post operatively until they are fit for discharge. Staff and a patient said this did not always happen. We raised this with the senior managers who immediately outlined the policy to the consultants and informed us that a review of the policy would be undertaken to ensure it was clear and robust. However, all patients were seen by the RMO post operatively.

Nursing staffing

- The hospital followed guidance on theatre staffing as directed by the AfPP (Association for peri-operative practice) guidelines. There was a policy which outlined the staff required for different grades of surgical procedures that was based on national guidelines.
- The use of bank and agency theatre nurses averaged 2% between April 2015 and March 2016 and for operating department practitioners (ODPs) and health care assistants the rate averaged 6 %. These were lower (better) when compared to other independent acute hospitals we hold this type of data for, in the same reporting period.
- At the time of the inspection there was one nurse vacancy in theatre and there was a recruitment programme in place.
- The ward had a planned nurse staffing rota and reported on a daily basis if shifts had not been covered. The hospital used an electronic staffing tool which looked at the acuity of patients and the skill mix required. If there were more health care assistants on duty than was required on the ward, they would then support the outpatient department or preoperative assessment clinics.
- There was a scheduling meeting held on a monthly basis which looked at the procedures listed for the next four weeks and the staffing required. This ensured that the correct number of skilled staff were available to support effective and safe patient care.
- The use of bank and agency staff on the ward averaged 11% between April 2015 and March 2016.
- Between January 2016 and March 2016, all shifts had been filled as planned.
- Between April 2015 and March 2016 the turnover rate for nursing and healthcare assistants was low. In theatre it was 2% and on the ward it was 1%.
- The ward displayed nurse staffing information on a board at the ward entrance. This included the planned and actual staffing levels. This meant that people who used the services were aware of the available staff and whether staffing levels were in line with the planned requirement.
- There was a structured handover each morning and evening between shifts which outlined key risks and patient information.

Surgical staffing

- Surgical procedures were carried out by a team of consultant surgeons and anaesthetists who were mainly employed by other organisations (such as in the NHS) in substantive posts and had practising privileges with the hospital. There were a total of 74 consultants at the hospital
- The consultants and anaesthetists were responsible for their individual patients during their hospital stay.
- Resident registered medical officers (RMOs) were available to provide medical cover when the consultant was not available. The RMOs were provided by an external company and worked 24 hours, five days a week for a week at a time. They were not permitted to leave the site during the working week. It was usually the same two doctors who rotated, with others covering for annual leave.
- The RMO we spoke with said although this rota was challenging it suited them, as it fitted in with their personal circumstances. They handed over patient information to the other RMO each Monday morning.
- Routine work undertaken by the RMO included, preoperative and postoperative checks, cannulation and prescribing medication. The RMO would be called for any emergencies if the consultant was not on site.

- The RMO said consultant support was good and it was always clear to him which consultant was responsible for each patient. They felt supported and had never had an issue when ringing a consultant with a query.
- RMOs had open access to the Director of Clinical Services and the ward and outpatient managers when they were on site. RMOs also had a 24 hour, seven day per week telephone clinical and non-clinical support service with the provider organisation.
- The RMOs on duty completed ward rounds regularly during the day and were encouraged to highlight any issues or concerns to nurses or the managers on duty.
- When a new RMO started their curriculum vitae (CV) was sent by the provider company to the Director of Clinical Services for review, agreement and sign off prior to them commencing work at the hospital. The CVs included evidence of employment history, references, general medical council (GMC) details along with occupational health information and training including advanced life support certificates.
- There was a surgeon or anaesthetist available who could get to the hospital premises within 60 minutes, as outlined in the hospital policy, in case there were any complications or patients needed to return to theatre out of hours. This was normally the person who had performed the procedure.

Major incident awareness and training

- There were documented major incident plans for the hospital and these listed key risks that could affect the provision of care and treatment. There were clear instructions for staff to follow in the event of a fire or other major incident.
- Staff were aware of what they would need to do in a major incident and had been involved in major incident exercises.
- The hospital had an emergency critical care transfer plan. The aim of the plan was to ensure effective emergency transfer processes were in place, in the event of a patient's condition deteriorating that necessitating their transfer into an appropriately specialised NHS unit for level two or three critical care support. We saw the plan set out procedures for staff to follow in the event of a patient deteriorating on the department. Staff we spoke with were aware of procedures to follow in the event of a deteriorating patient that included the recording of patient observations.

Are surgery services effective?

Good

We rated the surgical services as 'Good' for Effective. This was because: -

- Patients received care and treatment according to national guidelines such as National Institute for Health and Care Excellence (NICE) and the Royal Colleges of surgeons and nursing. Findings from performance reported outcomes measures (PROMs) and the National Joint Registry showed the majority of patients had a positive outcome following their care and treatment.
- The rate of unplanned readmissions following surgery was within expected levels when compared to other independent hospitals.
- Care and treatment was provided by suitably trained, competent staff that worked well as part of a multidisciplinary team. The majority of staff had completed their appraisals.
- Staff sought consent from patients prior to delivering care and treatment and understood what actions to take if a patient lacked the capacity to make their own decisions.

However,

- Staff had not completed Mental Capacity Act training as outlined in the hospital policy.

Evidence-based care and treatment

- The service used national and best practice guidelines to care for and treat patients. BMI corporate polices based on national institute for health and care excellence (NICE), national and royal college guidelines were available to staff on the intranet. A hard copy of all current policies was available from the senior managers.
- Audit was a standing agenda item at ward and theatre meetings. Actions and learning from audits was discussed, for example, patient allergies must be filled in on each page of the prescription chart that has medicines prescribed.
- The BMI corporate monthly clinical governance bulletins set out relevant NICE guidance, medical device alerts, drug alerts, patient safety alerts and facilities alerts. It also shared learning and best practice from other BMI hospitals.

- At bi-monthly Clinical Governance Committee meetings, NICE guidance was discussed
- There was an audit calendar which detailed the audits due each month, with a progress tracker next to them. Regular monthly audits included the WHO checklist, infection prevention and control and patient records.
- Regulations stated in the Department of Health (2016) Review of the Regulation of Cosmetic Interventions (2016) require that hospitals keep electronic details of implants used, which should be easily accessible in the case of a product recall. The hospital used a paper based system to record all implants used, however they had registered with the health and social care information centre (HSCIC) to be involved in the national breast and implant register when the system is up and running.
- Care pathways were in place for managing patients that needed care following a procedure for patients who received ambulatory care (ambulatory care is medical care provided on an outpatient basis). The care pathways were based on NICE guidance.
- Staff used integrated care pathways for surgical procedures such as for hip or knee replacement and these were based on national guidelines.
- The Theatre Management Policy referenced guidance from the Association for perioperative practice (AfPP) on staffing in theatres.

Pain relief

- Pain relief was managed on an individual basis and was regularly monitored. Patients told us they were consistently asked about their pain and supported to manage it.
- When patients had pain control issues the RMO, anaesthetist or consultant were called to reassess patients and amend medication prescription. The pharmacy team supported pain management at ward level.
- Pain relief was discussed with the patient at pre-assessment clinic and pain advice booklets were given to patients for use post operatively.
- Pain scores were recorded on the national early warning score (NEWS) chart and responded to accordingly.
- We reviewed six care records for pain assessments and found good evidence of pain assessment and timely administration of pain relief.
- A pain management audit was completed in February 2016 which showed good pain management for all day cases and inpatient episodes. This looked at medication charts and also speaking with patients.
- All medications for pain relief given on discharge were included on the discharge letter sent to the patient's GP.

Nutrition and hydration

- The hospital used relevant sections of the malnutrition universal screening tool (MUST) to assess patient's nutritional needs. This assessment was repeated post operatively and daily until the patient was ready for discharge. We saw evidence of this in the care records we reviewed.
- If a patient scored two due to low body mass index (an approximate measure of whether someone is over or underweight), had experienced ten percent or more weight loss in six months or had had little or no food in the last five days or more, they were referred to the dietician. The dietetic service was outsourced and the dieticians worked for a neighbouring trust.
- Food and fluid intake was monitored using food charts and fluid balance charts. Patients unable to feed themselves were assisted by the nursing team. Additional dietary advice or special requirements were discussed with the patient on arrival to the ward and daily throughout their admission.
- The majority of patients we spoke with said they were happy with the standard and choice of food available. If patients missed a meal as they were not on the ward at the time, staff were able to order a snack for them.
- There was a comprehensive selection of meals available from a menu which was available for patients.
- Patients told us they were offered a choice of food and drink and spoke positively about the quality of the food offered. Staff could provide 'halal' or 'kosher' meals if requested.
- We observed drinks were available and in reach for all patients.
- In the most recent PLACE report published in August 2016 the hospital scored higher (better) when compared with the BMI organisational average for food on the ward.

Patient outcomes

- The Private Healthcare Market Investigation Order (2014) requires every private healthcare facility to collect a defined set of performance measures and to supply that

data to the Private Healthcare Information Network (PHIN). Hospitals needed to collect this data from January 2016, ready for submission in September 2016. The hospital was working with BMI healthcare and was aware of the requirement.

- The hospital participated in the patient reported outcome measures (PROMS), national joint registry and the AQUA NHS orthopaedic audit. PROMS data were available for NHS patients who had hip, knee and groin surgery. This data indicated the service was higher (better) than the national average for knee and groin surgery with 97% was reported as improved and within the estimated range for hip surgery with 100% reported as improved.
- The Royal College of Surgeons (RCS) recommends that providers routinely collect and report on Q-PROMs for all patients receiving procedures such as breast augmentation (enlargement) and blepharoplasty(cosmetic surgery to the eyelids) . Q-PROMS are patient report outcome measures, which describe the level of patient satisfaction with certain operations. The hospital did not use the Q-PROMs recognised tool to collect patient satisfaction with the operation.
- Local outcome indicators were reviewed on a monthly basis which included unplanned readmissions within 28 days of discharge. Between April 2015 and March 2016, there had been five unplanned readmissions out of a total of 2964 procedures. This was not high when compared to a group of independent acute hospitals which submitted performance data to the CQC.
- Between April 2015 and March 2016, there had only been two unplanned returns to theatre.
- The hospital had started its participation in local Commissioning for Quality and Innovation (CQUIN) standards during 2016/17. These related to pre-operative care, shared decision making dementia patients communication policy, clinical guidance and quality standards and Advancing Quality (HK2016) for hip and knee replacement. The hospital reported that CQUIN targets for April 2016 to June 2016 (Quarter 1) had been achieved.

Competent staff

- Doctors working at the hospital did so under practicing privileges. Practicing privileges refer to medical practitioners not directly employed by the hospital who have permission to practice there. The hospital had a policy for granting and reviewing practising privileges. All doctors who worked under practicing privileges provided evidence of their disclosure and barring service (DBS) checks and indemnity insurance. This was verified by the hospital's medical advisory committee (MAC). We reviewed the personal files of doctors working at the hospital and saw that practicing privileges arrangements had been recorded.
- Between April 2015 and March 2016, there were two consultants whose practising privileges had been suspended. There were a number of reasons for this including not completing competency documentation.
- The majority of staff told us they had received their appraisal. Between October 2015 and the date of the inspection, 100% of nurses and health care assistants on the ward had received their appraisal, however only 63% of nurses and 59% of operating department practitioners and health care assistants in theatre had received their appraisal (year to date). However, the appraisal year was not due to finish until the end of September 2016 and plans were in place to complete these.
- Records showed doctors with practising privileges had an up to date appraisal.
- There was a robust system in place to ensure that surgeons undertaking procedures were competent. The Registered Manager reviewed all incidents, complaints, outcomes and appraisals for each surgeon to ensure they were competent to undertake the procedures listed.
- There were staff competencies kept on the ward and in theatre which included competencies in wound care and medicines administration.
- Newly appointed staff underwent an induction process. Staff we spoke with confirmed they had an adequate induction.
- Staff had been supported to undertake further training, for example a nurse was being supported to undertake a master's qualification and as part of their course had implemented a change in the management of waste in theatre.
- The hospital ensured that healthcare support workers undertook the care certificate. Two healthcare support workers from the ward had begun to complete the qualification. The care certificate is knowledge and

competency based and sets out the learning outcomes and standards of behaviours that must be expected of staff giving support to clinical roles such as healthcare assistants.
- In theatre there were a number of practitioners trained at different levels including five practitioners who had also completed the BMI surgical first assistant (SFA) training and two currently undertaking the training. An SFA is a theatre practitioner assisting the operating surgeon in place of a doctor. This was in line with the corporate policy and the perioperative care collaborative guidelines and ensured staff were competent to carry out additional tasks.
- The hospital had been assessed by local universities as providing a suitable training environment for students. Appropriate mentors were in place on the ward to support the students.

Multidisciplinary working (in relation to this core service only)

- Multidisciplinary team (MDT) working was established in surgical services. We saw a good example of MDT working at the theatre briefing session. This included nursing staff as well as doctors and healthcare assistants.
- Ward teams had access to the full range of allied health professionals and team members described good, collaborative working practices. There was a joined-up and thorough approach to assessing the range of people's needs and a consistent approach to ensuring assessments were regularly reviewed by all team members and kept up to date.
- A psychiatric service was available from a neighbouring NHS trust which provided advice and support to staff.
- Meetings about bed availability, staffing and theatre lists were held daily to determine priorities, capacity and demand. These were attended by both senior managers and senior clinical staff. These meetings had only recently been established and we observed that this did not take place during the inspection. Staff said this was due to pressures on the ward during the inspection.
- In line with the Royal College of Surgeons 'Good Surgical Practice (2014)' pre-operatively patient concerns and / or needs were discussed within the multi-disciplinary team at the patient's pre-admission visit. For example, a patient with safeguarding needs or complex needs were identified prior to surgery so that the necessary support could be identified for that patient.
- The hospital did not directly communicate with the patients' GPs on discharge. Patients were given a discharge letter which detailed the operation performed and the medicine the patient had been sent home with. Patients could choose to pass this letter on to their GPs if they wished. This occurred for all procedures. This practice is not in line with the recommendation for cosmetic patients made in the Review of the Regulation of Cosmetic Interventions (2014) which stated that details of the surgery and any implant used must be sent the patient's GP.
- Nursing and theatre staff told us it was easy to contact a consultant if they needed advice. Staff told us everyone worked together well as a team throughout the hospital, to provide good care and treatment for patients.

Seven-day services

- Whilst the hospital was not open seven days a week, it provided flexibility and performed surgery on days that were suitable for the patients. This often included operations being scheduled one Saturday in every four.
- The hospital had 24 hours a day theatre team on-call rota that was available to review all patients on a daily basis when the hospital was open.
- The on-site registered medical officer (RMO) was on site 24 hour a day when the hospital was open and would contact a patient's consultant to discuss any concerns.

Access to information

- Staff had access to the information they needed to deliver effective care and treatment to patients in a timely manner including test results, risk assessments and medical and nursing records.
- There were computers available on the wards we visited which gave staff access to patient and hospital information.
- Policies, protocols and procedures were kept on the hospital intranet which meant staff had access to them when required. However student nurses did not have access to the intranet.
- On the majority of wards there were files containing minutes of meetings, ward protocols and audits which were available to staff.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- The Royal College of Surgeons advice is that patients' consent is taken prior to surgery ensuring the patient

has sufficient time and information to make an informed decision. The specific timing and duration of the discussion should take into account the complexity and risks of the proposed procedure. A patient's consent should not be taken in the anaesthetic room.

- All 22 patient records we reviewed had signed consent forms present in the notes.
- During the inspection we observed that four patients attended the hospital for their operation and had not signed the consent form prior to admission. This meant there was a delay in commencement of the theatre list.
- Staff had the appropriate skills and knowledge to obtain consent from patients. The staff we spoke with were clear on how they sought verbal informed and written consent before providing care or treatment
- There was no specific policy in place which stipulated the good practice time scales of two weeks for a 'cool off' period when cosmetic surgery was booked. However the hospital told patients they could cancel the procedure at any time prior to the commencement of surgery and the consent policy stated that patients should be given time to reflect on information given to make an informed decision. There was a two stage consent process in place. This is in line with the RCS professional standards for cosmetic surgery (2016).
- If patients were highlighted that they may lack capacity on referral a capacity assessment was undertaken on the ward to identify any additional support required.
- The hospital had in place a Mental Capacity Act policy which incorporated Deprivation of Liberty Safeguards (DoLS) They aim to make sure that people in hospital are looked after in a way that does not inappropriately restrict their freedom and are only done when it is in the best interest of the person and there is no other way to look after them. The policy included capacity assessment and best interest forms for staff to complete. It also outlined training requirements for staff. This was a three yearly update for all clinical staff. However, from the training records provided by the hospital there was no record of any staff compliant with this training although the training was identified as available on the training matrix.
- There were no patients identified during the inspection that lacked capacity or had a DoLS in place

Are surgery services caring?

Good

We rated the surgical services at as 'Good' for Caring. This was because: -

- Patients told us staff were caring, kind and respected their wishes. We saw staff interactions with people were person-centred. People we spoke with during the inspection were complimentary about the staff that cared for them.
- Patients received compassionate care and their dignity and respect were maintained.
- Patients were involved in their care and kept informed of the care and treatment. Staff explained procedures to them

Compassionate care

- Surgical services were delivered by caring and compassionate staff. We observed staff treating patients with dignity and respect.
- All members of staff introduced themselves to the patients and we saw that staff respected a patient's privacy by always knocking on doors before entering
- We spoke with 17 patients and relatives throughout our inspection. All the patients we spoke with were positive about their care and treatment. Comments included 'prompt nursing care', 'it's a gem' and 'treated as an individual'.
- Patients said staff always introduced themselves.
- Patients we spoke with said they had received good information about their condition and treatment.
- Family members said they were kept well informed about how their relative was progressing.
- We saw staff regularly going into all of the patients' rooms to check on how they were recovering and ask if there was anything they needed.
- We saw staff holding a patient's hand during a cataract procedure and informed them that if they wanted anything or were in pain to squeeze their hand and they would check with the surgeon.
- All patients were contacted 48 hours following their surgery to check on their well-being and their pain control.

Good

Surgery

- The NHS Friends and Family Test is a satisfaction survey that measures patients' satisfaction with the healthcare they have received. The hospital collected test data for all NHS-funded patients that were admitted as inpatients or underwent day surgery.
- The test data between October 2015 and June 2016, showed the surgical services had consistently achieved scores of between 98% and 100% with response rates between 10% and 44%. This showed that patients were very positive about recommending the hospital to their friends and family. The patient scores and response rates were similar to the England average for independent sector NHS patients during this period.

Understanding and involvement of patients and those close to them

- Patient records included pre-admission and preoperative assessments that took into account individual patient preferences.
- Patients told us all staff explained what they were doing in a way they understood. If they did have any questions, they felt comfortable to ask. Patients said they were provided with a lot of information and staff explained this thoroughly.
- Discussions around the cost of procedures were always approached with sensitivity.
- We saw family members were encouraged to visit patients if they had to stay overnight and were included in conversations when appropriate.

Emotional support

- Staff provided ongoing support to patients when they were discharged from the hospital. If there were any issues which the patients were concerned about, they had the option to contact the staff and arrange for an appointment at the hospital, if required.
- We observed ward staff accompanying patients to the theatre and remaining with the patient until they had been fully anaesthetised. During this time, they provided emotional support and comfort to the patient.
- At discharge, patients were given an emergency contact telephone number should they need to speak to a member of staff about any concerns they had. Nursing staff called all patients two days after surgery to see how they were progressing with their recovery and how they were feeling.

Are surgery services responsive?

Good

We rated the surgical services as 'Good' for Responsive. This was because: -

- Services were planned and delivered to meet the needs of local people.
- There was planning by staff to ensure patients were admitted and discharged in a timely manner. There was sufficient capacity in the ward and theatres so patients could be seen promptly and receive the right level of care before and after surgery.
- The hospital achieved 96% against the 18 week referral to treatment standards for admitted NHS funded patients during each month between April 2015 and March 2016.
- Complaints about the services were resolved in a timely manner and information about complaints was shared with staff to aid learning.

However,

- There were times when the theatre list was delayed in the mornings.
- There was no adaptation of the environment for people living with a cognitive impairment such as dementia.
- There were no facilities for patients to have a shower if they were unable to get into the bath.

Service planning and delivery to meet the needs of local people

- The initial consultation was followed by a preoperative assessment. Where a patient was identified as needing surgery, staff were able to plan for the patient in advance so they did not experience delays in their treatment when admitted to the hospital.
- As part of the preoperative assessment process, patients with certain medical conditions were excluded from receiving treatment at the hospital.
- The exclusion contract criteria for NHS patients were no patients under the age of 18, no patients with a body mass index (BMI) exceeding 40, no patients with an incapacitating disease that posed a constant threat to life, for example cancer, patients who had previously experienced an adverse reaction to anaesthetics and patients who were undergoing treatment for a mental

health condition. For private patients all these criteria did not automatically apply and decisions were made on a case by case basis although there was a minimum age of 16 years for admission for a procedure.
- NHS funded patients requiring emergency surgical procedures, transplant surgery, treatment of malignant diseases and any procedures that were likely to require critical care were excluded from undergoing treatment at the hospital.
- There was sufficient capacity to provide care and treatment for patients undergoing surgery at the hospital. Planning and scheduling meetings took place at least weekly to monitor staffing and capacity issues so that patients could be managed and treated in a timely manner.

Access and flow

- The majority of patients were referred to the hospital by their general practitioner (GP) via the NHS 'choose and book' system.
- The inspection did not highlight any concerns relating to the admission, or discharge of patients from the ward or theatres. The patients we spoke with did not have any concerns in relation to their admission, waiting times or discharge arrangements.
- However, there were concerns about the delay in commencement of theatre lists in the morning. This was sometimes for up to an hour. This meant that patients were waiting longer than was needed and there was a risk that the theatre list may not always finish before the afternoon session was scheduled to begin. We observed this happened on each day of the inspection. To help improve standards, staff had commenced a daily meeting on the ward to discuss the following day's theatre list to help identify any issues or potential delays. During the inspection, this daily meeting did not go ahead and the implementation of the meeting was not fully embedded yet as it had only commenced a week prior to the inspection.
- Discharge planning was covered during pre-assessment to determine how many days patients would need on the ward as well as ascertaining whether patients were likely to require additional support at home when they were discharged.
- Patient records showed staff had completed a discharge checklist that covered areas such as medication and communication to the patient and other healthcare professionals, such as GPs, to ensure patients were discharged in a planned and organised manner.
- The hospital reported that between April 2015 and March 2016 there were 3,774 admissions for surgery. There had been 49 operations cancelled during this period. This showed that a relatively small proportion of operations (1.2%) were cancelled at the hospital. Where operations were cancelled, patients were treated within 28 days of their cancellation.
- The hospital reported that 96% of admitted NHS patients began treatment within 18 weeks of referral for each month between April 2015 and March 2016. Elective waiting times were reviewed by staff to identify patients approaching the 18 week wait period and these patients were prioritised so they could begin treatment prior to breaching the 18 week wait time target.
- There were 13 cases of unplanned transfer of an inpatient to another hospital between 1 April 2015 and 31 March 2016. There had been five cases of unplanned readmissions within 28 days of discharge in the same reporting period. Both these numbers are not high when compared to a group of independent acute hospitals which submitted performance data to the CQC.

Meeting people's individual needs

- Information leaflets about the services were readily available in all the areas we visited. Staff told us they could provide leaflets in different languages or other formats, such as braille if requested.
- Staff could access a language interpreter, if needed.
- The hospital did not provide any day case or inpatient surgical services for patients aged under 18 years.
- The preoperative assessment nurse told us the majority of patients admitted for treatment had the capacity to make their own decisions. The preoperative assessment process identified NHS and privately funded patients living with dementia or learning disabilities and this allowed the staff to decide whether they could accommodate these patients or refer them elsewhere.
- Dementia training was available for staff and 47 had completed the training.
- The ward area did not have pictorial signage, different coloured toilet seat or adaptations to the rooms that would have provided an aid for patients living with dementia.

- We asked one of the nursing staff how they would manage a patient with dementia They were able to give good, appropriate examples of how these patients were managed including completion of a risk assessment for dementia, ensuring they were given a quite space and letting their carer stay with them.
- In response to the cultural needs of staff and patients a quiet room for prayer or meditation was available.
- The layout of the hospital meant all areas were accessible for people in a wheelchair. However there were no facilities for patients to have a shower if they were unable to get into the bath in the bathrooms. There had been a walk in shower but this area was now being used as a store room and there were plans to make this permanently into a store area.
- A patient's relative told us that staff knew she was diabetic and made sure they had everything they needed including food when required.

Learning from complaints and concerns

- Information on how to raise complaints was visibly displayed in the areas we inspected.
- Patients told us they did not have any concerns but would speak with the staff if they wished to raise a complaint. Staff understood the process for receiving and handling complaints.
- The complaints policy stated that complaints would be acknowledged within two working days and investigated and responded to within 20 working days for routine complaints.
- Where the complaint investigation had not been completed within 20 working days, staff were required to send a holding letter explaining why a response had not been sent, followed by further holding letters every 20 days until the complaint was resolved.
- Where patients were not satisfied with the response to their complaint, they were given information on how to escalate their concerns with the Parliamentary and Health Service Ombudsman for NHS funded patients or the Independent Sector Complaints Adjudication Service (ISCAS) for privately funded patients.
- The hospital received 15 written complaints between April 2015 and March 2016. This is lower than the average of other independent acute hospitals that we hold this type of data for during the same reporting period.
- Hospital records showed all complaints had been resolved within the hospital's 20-day target. None of the complaints had been referred to the Ombudsman or ISCAS.
- Complaints were discussed at the clinical governance committee meetings and the hospital medical advisory committee meetings (MAC) to monitor how complaints were being handled.
- Staff told us that information about complaints was discussed during routine team meetings to raise staff awareness and aid future learning. We saw evidence of this in the meeting minutes we looked at.

Are surgery services well-led?

Good

We rated the surgical services as 'Good' for Well-led. This was because: -

- The hospital's vision and values had been cascaded across the surgical services and staff had a clear understanding of what these involved.
- Key risks to the services were recorded and managed through the use of local departmental risk registers. Audit findings and quality and performance were routinely monitored.
- There was a clear governance structure in place with committees for clinical governance, infection control, health and safety and medicines management feeding into the medical advisory committee (MAC) and hospital management team.
- There was effective teamwork and clearly visible leadership within the services. Staff were positive about the culture within the surgical services and the level of support they received from their managers. There was routine public and staff engagement and actions were taken to improve the services.

Vision and strategy for this this core service

- The hospital vision was part of the wider BMI healthcare vision which included; being recognised as the leading provider of complex surgical procedures, delivering the best patient outcomes and experience and constantly delivering quality services and care in a cost effective way.
- Staff were aware of the BMI vision and had seen it in the newsletter and on posters on the wall.

- There was a clear business plan for the hospital. There were objectives, for example, services and care are delivered in a streamlined and efficient way that minimises duplication and maximises utilisation and patient satisfaction is regularly monitored and areas for enhancing the patient experience are identified. Each objective had actions and timeframes identified.

Governance, risk management and quality measurement for this core service

- There was a clear governance structure in place with committees for medicines management, infection control and health and safety feeding into the clinical governance committee and medical advisory committee (MAC).
- The terms of reference for this meeting included representatives from doctors who had practicing privileges as members. We saw evidence that these doctors had attended the meeting which meant there was good clinical oversight of surgical services.
- The ward and theatre managers logged identified risks on local departmental risk registers and we saw that the local risk registers were up to date and reviewed on a regular basis. Key risks were placed on the hospital-wide corporate risk register. There were identified actions and timeframes for review to mitigate the risk in a timely way.
- Routine audit and monitoring of key processes took place across the ward and theatre areas to monitor performance against objectives. Staff were able to tell us how service performance was monitiored and key performance indicators were on display on staff notice boards.
- Performance results from the hospital were compared with other locations within the region and across BMI healthcare throught the corporate clinical dashboard. This enabled the hospital to review both their own results and compare this with hopitals of a similar size across BMI healthcare.
- In each area we inspected, there were routine staff meetings to discuss day-to-day issues and to share information on complaints, incidents and audit results. There was also a copy of the minutes in files for staff to read.
- The hospital had not drafted any plans to ensure that surgical cosmetic procedures were coded in accordance with SNOMED-CT. This is due to be fully implemented in the independent sector in April 2020. SNOMED-CT uses standardised codes to describe cosmetic surgical procedures, which can be used across electronic patient record systems.

Leadership / culture of service related to this core service

- Staff we spoke with said they were well supported by their managers who were visible. They also told us that the management team were approachable and they would feel comfortable raising any concerns they may have.
- All staff spoke positively about the leadership within the hospital and said they felt valued and respected. They enjoyed working in the team and enjoyed working at the hospital.
- The overall lead for the surgical services at the hospital was the Director of Clinical Services. The ward and day case areas were led by an acting Ward Manager. The Theatre Manager was responsible for the day to day management of the theatres. The Theatre Manager had been in post longer than 12 months.
- However the acting ward manager was new in post and also covered the outpatient services. There were concerns that this shared post was not allowing a complete overview of issues on the ward. The ward manager said that they tried to go on the ward each day but found it difficult to split the time between the ward and the outpatient department. This meant there was a risk that they were not aware of what was happening on the ward at all times.
- When raised with senior management, they said this was being reveiwed after the inspection. At the time of the unannounced inspection this shared post no longer existed and the Ward Manager post was going to be advertised. There were suitable arrangements in place to ensure there was management oversight of the ward in the interim period.
- All the staff we spoke with were highly motivated and positive about their work and described the managers as approachable, visible and provided them with good support. Staff told us there was a friendly and open culture.
- Staff said they felt empowered to raised concerns and have, on occasions, challenged consultant decisions.

Good

Surgery

- The overall staff sickness rates between April 2015 and March 2016 for ward and theatre staff was similar to other comparable independent hospitals during this period. Staffing levels were suitably maintained through the use of bank and agency staff.

Public and staff engagement

- Staff told us they routinely engaged with patients and their relatives to gain feedback from them. This was done formally through participation in the NHS Friends and Family test and by conducting monthly patient feedback surveys. Feedback from these surveys showed patients were very positive about using the hospital.
- Staff told us they received good support and regular communication from their managers. Staff routinely participated in team meetings across the ward and theatre areas. Staff spoke positively about the visibility and level of engagement they received from the hospital's senior management team.
- There was an 'above and beyond' recognition scheme in place to reward staff for their actions when they had done something which stood out. At the daily 'comms' cell there was a chart for recording team successes which was then cascaded to relevant teams.
- Whist the hospital did seek feedback from patients regarding their care; they did not perform quality measurements such as collect Q-PROMS information from patients as recommended by the Royal College of Surgeons (RCS).

Innovation, improvement and sustainability

- All the staff we spoke with were confident about the sustainability of the surgical services. They felt there was a stable workforce that worked well together and provided a good standard of care and treatment.
- The hospital was working with partner organisations to look into delivering endoscopy services for patients in an alternative environment that would meet all the standards as outlined by the joint advisory group.

Good

Outpatients and diagnostic imaging

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

Are outpatients and diagnostic imaging services safe?

Good

We rated Outpatients and Diagnostic imaging as 'good' for safe because;

- Patients and their relatives told us they were confident that there was sufficient staff available with the right skills to support them appropriately.
- Staff were supported to obtain the skills they needed to maintain the safety of patients and their relatives.
- Staff were encouraged to report safeguarding concerns and any incidents. These were investigated and lessons learnt reported back to staff in order that patient safety could be maintained.
- Equipment was checked and maintained to a standard to ensure the safety of both patients and staff.
- There were robust infection control processes in place and there had been no incidents of hospital acquired infection in the last 12 months.
- Medicines were correctly stored, administered and managed in order to maintain the safety of patients.
- Risks were identified and appropriate action taken to reduce any risks to patients, visitors and staff.

However,

- Carpeting and seating did not assist in maintaining good standards of infection control. This was being addressed by the service.
- The treatment record book in radiology did not record clearly the time and dose of the medication given.
- We observed that nasal endoscopes were being cleaned in the same room in which the treatment took place. Following discussion with senior managers, the service immediately ceased this practice and made arrangements to meet the risk assessment and policy for nasal endoscopy equipment to be cleaned in a separate area.
- Arrangements for the application of eye drops were unclear. We found there to be no assurance process or competencies for staff in administering eye drops. We were told that consultants checked that nursing staff were competent but there were no written competencies to provide evidence that staff were competent. We raised this with the senior management team and a new system was being developed to provide assurances that staff competence in administering eye drops was incorporated into the competency framework across the whole organisation.
- Compliance rates in mandatory training were below the hospital target of 90%. Compliance with training in physiotherapy was 86% and radiology was 77%.

Incidents

- All staff we spoke with described with confidence how they would recognise and report incidents, and explained they would receive feedback on the outcome of the incident in order to undertake any learning. We saw from BMI healthcare bulletins that lessons from incidents were shared across hospital sites.
- Findings from incidents were shared at team meetings and a department daily meeting at the start of each day and through staff safety huddles. The Manager of outpatients also explained that information from incidents was shared in emails and in newsletters. We saw minutes of meetings for the outpatient department (OPD) which included the diagnostic imaging

department and physiotherapy departments in which the outcomes and learning from incidents had been shared at meetings and changes in practice had been made.

- There were a total of 32 incidents reported for OPD. The Manager explained that staff were encouraged to report any incident. Incidents and accidents were reported through a paper based reporting system, which were reviewed and transferred to a computer system in order that the organisation could monitor any investigations into the incident.
- The service had not reported any Ionising Radiation (Medical Exposure) Regulations (IRMER) or magnet related events incidents in the 12 months prior to our inspection.
- Staff were familiar with the term, 'Duty of Candour'. The Duty of Candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support to that person. There were no incidents in which Duty of Candour actions had been required. Staff described how they would action any incidents in which they felt Duty of Candour was needed, and were clear that they would always inform their line manager for guidance and support.

Cleanliness, infection control and hygiene

- Patients and their relatives we spoke with were complimentary about the cleanliness of the OPD. All nine patients we spoke with reported they thought the department was clean.
- From April 2015 to March 2016, there had been no reported cases of healthcare associated infections that would place patients at risk of harm. Infections that could place patients at risk of harm include; Methicillin Resistant Staphylococcus Aureus (MRSA), clostridium difficile (C.Diff) or, Methicillin Sensitive Staphylococcus Aureus (MSSA). MRSA is a type of bacterial infection that is resistant to many antibiotics. MSSA is a type of bacteria in the same family as MRSA but is more easily treated. C.Diff is a form of bacteria that affects the digestive system and commonly associated with people who have been taking antibiotics.
- The outpatients, diagnostic imaging and therapy department were visibly clean, tidy and free from clutter. An infection control lead was available and had introduced a checklist for each area of the service. These were collected and reviewed on a monthly basis in order to make sure there was a consistent approach to cleanliness and prevention of infection.
- We inspected two treatment rooms and four of the six clinic rooms, the diagnostic imaging department and the therapy department. These all had hand washing facilities, disposable paper towels and personal protective equipment (PPE), such as gloves and aprons available to assist in the prevention of a spread of infection. We saw appropriate facilities for disposal of clinical waste and sharps, such as needles located in the outpatient and diagnostic imaging department.
- Clinical staff were observed to consistently meet, 'bare below the elbow' guidance and used appropriate PPE where needed. The last hand hygiene audit showed that staff were using appropriate hand washing techniques. There was a 100% level of compliance between April to June 2016.
- There was an appointed lead for Infection Prevention and Control (DIPC) who was responsible for coordinating audits. Staff we spoke with all confirmed they were aware of infection control audits and who to contact should they need guidance and support.
- There was a risk assessment and policy for nasal endoscopy. The policy stated the equipment was to be cleaned in a separate space to where the procedure had occurred in order to reduce any risks of the spread of infection. However, we observed that nasal endoscopes were being cleaned in the same room in which the treatment took place. Following discussion with senior managers, the service immediately ceased this practice, and made arrangements to meet the risk assessment and policy for nasal endoscopy equipment to be cleaned in a separate area.
- Seating within the waiting areas of the outpatient department and radiography department and some flooring did not assist in the prevention of the spread of infection. The seating and some flooring was not washable or wipe clean, so if it became soiled could present an infection risk. However, all flooring coverings and seating appeared clean, and daily inspection and cleaning of the outpatient area took place in line with their policy. Managers informed us a refurbishment of the outpatient areas was due to commence to address these findings.

Environment and equipment

Good

Outpatients and diagnostic imaging

- Patients and their relatives were complimentary about the appearance of the OPD. They told us the waiting areas were pleasant and relaxing.
- The main hospital building was a grade one listed building which appeared to be maintained, free from clutter and provided a safe environment for treating patients. The building housing the main outpatients, and diagnostic imaging and therapy department was well maintained. Consulting rooms were of a good size, well lit, free from clutter and provided a safe environment for treating patients.
- From observations, we saw that equipment was maintained, appropriately checked, and visibly clean. Medical equipment was checked and maintained by an independent company. Additional equipment and electrical equipment was tested and monitored by the onsite facilities team. We saw records to confirm that electrical equipment had been tested.
- Staff told us they always had access to equipment and instruments they needed to meet patients' needs, and confirmed any faulty equipment was either repaired or replaced promptly.
- Staff confirmed that they checked single-use sterile instruments in order to make sure they were in date. All the single use instruments were all within their expiry dates.
- The organisation maintained an asset register which was updated when equipment was removed or added. New equipment was added to the register and tested annually. We were informed there was no clear reporting system to make sure that the facilities department were informed when equipment was replaced on all occasions. We received assurances that a system would be implemented in the coming weeks that would notify the facilities department of any equipment changes in order that they could continue to monitor the safety of the equipment.
- The diagnostics imaging department carried out care and treatment in line with the Ionising Radiation (Medical Exposure) Regulations (IR(ME)R). Local radiation protection rules were available for staff to refer to. This ensured that patients were not exposed to excess levels of radiation
- We observed staff wore radiation personal monitoring badges that were monitored to ensure that staff were not exposed to unsafe levels of Ionising Radiation. We also observed safety guidance available for staff such as, 'stop and check' posters designed to make sure that staff maintain an awareness of their own safety. These posters were clearly displayed within the diagnostic imaging department.
- All diagnostics and imaging equipment had routine quality assurance and calibration checks in place to ensure the equipment was working effectively and protective gowns were clean and free from damage.
- Emergency resuscitation equipment was available in the areas we inspected and these were checked by staff. We examined this equipment and found that all items were in date and ready for use in an emergency situation.
- Patient-led Assessments of the Care Environment (PLACE) had been completed in 2015. Hospital PLACE scores from February to June 2015 showed the hospital scored the same or higher (better) than the England average for cleanliness, dementia, privacy, dignity and wellbeing. The hospital scored lower (worse) than the England average for condition, appearance and maintenance and food. Action to improve the appearance of the hospital had been taken, and funding had been approved for refurbishment.
- The hospital had backup generators in case of power supply to ensure services were not affected Managers informed us that regular testing of generators took place as part of the business continuity plan.

Medicines

- The service had current medicines management policies and procedures available in order that staff could be guided in the correct processes to manage medicines safely. Staff we spoke with confirmed they were informed via a computer system of any changes to policy.
- Each consultancy and treatment room had an in date copy of British National Formulary publications (BNFs), which provides staff with essential information regarding medicines, including any specific instructions, side effects and standard dose. The use of this resource assists in maintaining the safety of patients and provides staff with an opportunity to maintain their knowledge.
- Medicines that required refrigeration were stored within the pharmacy department in a locked fridge. Keys were

held by the senior member of staff and temperatures were checked and recorded routinely. We saw records that room temperatures were kept for medicines that could be stored at room temperature.

- There was an onsite pharmacy available from 8.30am until 3.30pm each day. The pharmacy undertook audits on the storage and administration of medicines in order to monitor the safe management of medicines. We saw that records were kept of those staff who had completed competencies in controlled drugs.
- We observed that prescription pads were kept securely. Records reflected that each prescription was logged with its number requested by a consultant. We observed them being signed out by two members of staff and recorded when a consultant requested one.
- Emergency medicines were in date, readily available and accessible for immediate use in tamper-proof containers.
- Staff competencies for continuous medicines management training updates were done by the service and a record kept on completion.
- Arrangements for the application of eye drops were unclear. We found there to be no assurance process or competencies for staff in administering eye drops. We were told that consultants checked that nursing staff were competent but there were no written competencies to provide evidence that staff were competent. We raised this with the senior management team and a new system was being developed to provide assurances that competence in administering eye drops was incorporated into the training framework across the whole organisation.
- We also observed an eye drops guidance form had been pre-signed by a medical practitioner. The form instructed staff to gain verbal consent from patients, and provide important safety advice. The form also instructed staff to dilate both eyes of the patient. On raising this concern, the pharmacy team stated this form did not meet their procedures. The form should not have been signed until the patient identifiers had been included, to avoid the potential risk of patients receiving the wrong treatment. The pre-signed form was immediately withdrawn from use.
- Treatment and medicines administered in the radiology department were recorded in a treatment records book. We saw that patient details, date and procedure undertaken were accurately recorded. However, we observed that although the specific strength of the medication was accurately recorded, the time and dose of the medication was not clearly recorded. We raised this with the radiology lead and amendments were made in the recording of medicines.

Records

- Patient records were stored securely, and access was limited to those who needed to use them.
- Patient records in the OPD were paper based. We reviewed 22 sets of patient's records. All records were legible, signed and dated. Records contained all the relevant information, including risks and benefits to care and treatment had been explained.
- Radiology information was available to clinicians who needed it. The service currently kept radiological images as a hard copy and not electronically. The radiology lead informed us they intended to implement an electronic Picture Archiving and Communication System (PACS) in September 2016. This would allow for shared access throughout the hospital and the other two hospitals that work together within the local cluster.
- Patient records were requested by the administration and clerical staff in advance of a clinic to allow sufficient time to identify any gaps or issues. Patient files were checked and set up by the healthcare assistants in advance of the appointment. This was done in order to make sure patient records were readily available and checked for accuracy and completeness. Records were taken back to the medical records storage area after the clinics. We were informed that consultants were not able to remove patient records from the hospital to ensure patient notes were always available.
- Staff told us they had no issues with accessing patients' notes for their clinics, and they could not remember a time when patient records were not available. Information provided by the hospital showed that from January to March 2016, no patients were seen without their medical notes being present.

Safeguarding

- Safeguarding policies and procedures were accessible to staff, which included both vulnerable adults and children guidance. Although the service did not provide care and treatment to children and young people under the age of 18, staff were aware that children attended the service as visitors, and so a policy in relation to

safeguarding children was in place. The policy included information and guidance for staff in relation to female genital mutilation (FGM). All staff we spoke with knew how to raise FGM as a safeguarding concern.
- Staff completed an online electronic learning training module as part of their mandatory training for safeguarding adults and children. At the time of our inspection, 100% of outpatient and diagnostic staff including reception staff had completed safeguarding training.
- Staff and managers we spoke with were able to explain the process if a safeguarding concern was identified and how they would make sure this was appropriately actioned.
- The service had not reported or received any safeguarding concerns within the reporting period.

Mandatory training

- Mandatory training was completed using an online electronic learning package. The training included basic life support, infection prevention and control, manual handling, fire safety and information governance. The electronic system monitored when staff were due training and notified them when training was due.
- Staff reported they were aware of what training was available and when they needed to complete it by. They told us they were encouraged and supported to complete the online training and to remain up to date with their training needs. Staff compliance with mandatory training was variable across the department. Outpatients' compliance with training was 100%, physiotherapy compliance was 86% and Radiology was 77% compliant with training. The hospital target was 90% and a plan was in place for the service to meet the target.
- A process was in place to ensure staff not employed directly by the service had received the appropriate mandatory training. For clinicians that had practising privileges, mandatory training was undertaken through their primary employer. The service monitored this at the clinician's bi-annual review. The term 'practising privileges' refers to medical practitioners being granted the right to practice in an independent hospital after being approved by the medical advisory committee (MAC).

Assessing and responding to patient risk

- The patient records we reviewed included an assessment of risks, and the actions that staff needed to take in order to recognise and reduce any individual patient risks. These included falls, moving and handling and Malnutrition Universal Screening Tool (MUST) score. In the patient records we reviewed, we saw that patient risk assessments were completed accurately.
- The service had a transfer agreement with the local NHS hospital in the event of a patient becoming acutely unwell. We saw a record that showed a patient had been appropriately transferred to hospital from the OPD.
- The department used daily safety huddles to disseminate information across the team. The information included any important patient safety information including support required.
- There were emergency procedures in place in the outpatient department including call bells to alert other staff in the case of a deteriorating patient or in an emergency. We tested a sample of the call bells and found they were functioning and responded to by staff. The hospital allocated staff to respond to an emergency with the resident medical officer.
- Emergency resuscitation equipment was available and all registered nursing staff on the outpatients department had undertaken immediate life support training (ILS). Staff told us that they retrained in ILS yearly. One member of staff reported they had recently undertaken this training and found it of value. Data provided by the hospital confirmed that all the registered nursing staff had completed ILS training.
- The physiotherapy department conducted risk assessments before they authorised the use of equipment in order to maintain patient safety, and meet their individual needs.
- The service had an independent annual audit of the imaging service. They had an appointed radiation protection supervisor and a radiation protection adviser (RPA) in accordance with IR(ME)R regulations.
- An IR(ME)R review of radiology equipment was undertaken every 12 months. The radiation protection supervisor conducted audits and produced risk assessments in accordance with IR(ME)R requirements.
- The diagnostic and imaging service routinely questioned patients of child bearing age to determine if

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they could be pregnant prior to being exposed to a radiological scan. We saw from the records we reviewed that the form used was appropriately completed and stored in the patient records.
- There was electronic signage in the radiology waiting area to inform patients that radiation exposure was taking place. We observed that the electronic signage was in working order.
- There was an up to date list of staff approved to request x-rays. There was guidance available on appropriate requesting of radiation diagnostic tests and staff were confident to challenge inappropriate requests.
- Staff involved in diagnostic imaging demonstrated an understanding of their role with regards to Ionising Radiation (Medical Exposure) regulations 2000 (IR(ME)R) and protecting patients from the risks of unnecessary exposure to radiation. Staff on the department had an IRMER file containing the regulations and guidance.

Nursing staffing

- Patients and their relatives told us they thought there was sufficient staff available on the department. They told us that staff attended to their needs quickly, and did not have to wait long before being seen.
- Staff we spoke with told us there were usually sufficient nursing staff to deliver care safely within the OPD. There were usually no nursing vacancies or sickness in the OPD, radiology or therapy department.
- The rate of sickness for nurses working in the outpatient department was lower than the average of other independent acute hospitals for the reporting period April 2015 to March 2016, except for July 2015 to September 2015 and January 2016.
- The rate of sickness for outpatients' healthcare assistants was 0% during the reporting period April 2015 to March 2016 except for September 2015, November 2015 and February 2016 when the rates were similar to the average of other independent acute hospitals. We were told by managers that any shortfalls in staffing were mitigated by utilising staff from the inpatient ward.
- Nurses generally worked from Monday to Friday. Staffing was planned according to the number of patients attending the clinics.
- There was no staff turnover or vacant positions for staff working in outpatient departments during the reporting period April 2015 to March 2016.

Medical staffing

- There were a total of 74 consultants who had been granted practising privileges to work at the hospital who had worked there for over six months. Practising privileges is a term used when doctors have been granted the right to practise in an independent hospital.
- Consultants had planned clinics that they attended every week. We saw in the incidents records that there was five occasions in the last 12 months when some clinics had to be cancelled due to the absence of the consultant. All the patients were contacted and received a rescheduled appointment within two weeks.
- Under the conditions of practising privileges, consultants working at the hospital had to be accessible, as necessary. Staff confirmed they were able to contact consultants when required and had not experienced any problems.
- Up to date lists of consultants who worked at the hospital were kept at the reception, which included contact numbers and their medical speciality. This ensured that consultants could be contacted if required by hospital staff.
- There was a Resident Medical Officer (RMO) within the hospital 24 hours a day with immediate telephone access to the responsible consultant if required.
- Patients and their relatives we spoke with told us they thought the medical staff were helpful, competent and skilled.

Major incident awareness and training

- Staff we spoke with were aware of the major incident policy and emergency procedures for a major incident such as a fire or adverse weather conditions. This was particularly relevant as there was a long country road to access the service which staff found difficult to negotiate at certain times of the year.
- BMI Gisburne was part of a large group of independently owned hospitals. A business continuity plan identified actions to manage any risks in the event of a disaster or a major event where the hospital's ability to provide essential services was severely compromised.

Are outpatients and diagnostic imaging services effective?

Not sufficient evidence to rate

We inspected but did not rate services for effectiveness.

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- Care and treatment within the outpatient and diagnostic imaging department was delivered in line with evidence-based practice. Policies and procedures followed recognisable and approved guidelines such as those from the National Institute for Health and Care Excellence (NICE).
- The hospital monitored patient outcomes through surveys to ensure patients were satisfied with the service they received. Patient satisfaction was benchmarked against other BMI healthcare hospitals. Information provided by the hospital showed that, in July 2016, the hospital ranked 18th out of 55 BMI healthcare hospitals.
- Staff were supported in their development using the appraisal process, which was undertaken annually with a mid-year appraisal every six months. Information supplied by the hospital showed that 100% of nursing and healthcare staff across the outpatients and diagnostics department had received their annual appraisal. Staff confirmed they received their appraisal.
- We observed good multidisciplinary working with effective verbal and written communication between staff. Staff confirmed there were good working relationships between physiotherapists, nurses, radiology staff and consultants.
- Patient Information was protected; records were kept in secure storage, and all computers were password protected. The hospital had a Caldicott guardian who was a senior person responsible for protecting the confidentiality of patient information and enabling appropriate information-sharing.

Evidence-based care and treatment

- Care and treatment within the outpatient and diagnostic imaging department was delivered in line with evidence-based practice. Policies and procedures followed recognisable and approved guidelines such as those from the National Institute for Health and Care Excellence (NICE). For example we saw guidance on Aseptic Non Touch Technique (ANTT).
- Clinical governance and quality bulletins provided all staff on the department with safety alerts, lessons learnt across BMI healthcare hospitals and information as to NICE guidance updates. We saw the information cascaded from senior managers to staff at all levels. The bulletins included actions required by managers with target and completion dates to implement changes.
- Staff had easy access to all the hospital policies and procedures using the department computers. All staff were aware of where policies and procedures were stored.
- We saw evidence in patient records of pathways for different treatments that were to be followed. The pathways provided staff with clear guidance to follow to enable them to care and treat patients. For example, pathways were in place for patients who were attending hospital for knee replacement.
- The hospital had an audit plan that set out for the year the audits to be completed for 2016. We saw from the audit plan that performance against each monthly audit was tracked and there was evidence that audit findings were discussed in Medical Advisory Committee (MAC) meetings to identify areas for improvement. For example the consent audit findings were discussed with actions for improvement.
- The radiology department had implemented the World Health Organisation (WHO) safety checklist for non-surgical interventional radiology. The safety checklist was audited every three months to ensure the checklist was being completed and was evident in patient notes. In the July 2016 audit, the department scored 100%. However, the sample size was very small and only sampled three patient records to ensure the WHO checklist was being used.

Pain relief

- There were processes in place to assess patients' pain levels and act appropriately. We saw evidence in records that pain was discussed during preoperative assessment to ascertain pain levels, causational factors and the effectiveness of pain relief.
- The hospital collected responses from patients through patient satisfaction surveys. The surveys asked patients to score the hospital in, 'was post-operative pain explained', 'were patients ever in pain' and 'did the hospital do everything to help control the pain'. Data supplied by the hospital showed that in July 2016, 100% of patients were satisfied that post-operative pain had been explained, and 96% of patients reported they were satisfied with assessed levels of pain and the hospital had done everything they could to help control pain.

Patient outcomes

- There were local audit programmes for outpatients, radiology and physiotherapy, with monitoring

arrangements in place to review findings. Audits included hand hygiene and medication turnaround time within 15 minutes. Results from the hospital hand hygiene results from April to June 2016 showed 100% compliance. The outpatients department scored 100% in the medication turnaround time within 15 minutes audit in February 2016.

- The hospital used a consulting room medicine management audit tool to ensure standards were maintained with regards to storage, temperature monitoring, administration and security of medicines on the department. The audit from February 2016 showed the department was achieving the required standards of the audit.
- On the radiology department, audits were carried out where radiation from medical exposure had the capability to cause harm to an unborn child. The aim of the audit was to ensure the pregnancy status of women of child bearing age had been documented. The audits from June 2016 looked at five random sets of records to ensure there was documentation of last menstrual period (LMP) and included an LMP date and pregnancy status. The audit found 100% compliance in LMP being documenting. We also saw in the patient records that a LMP form had been appropriately used to indicate that patients were being screened for LMP.
- Identification check audits were completed on a three monthly basis for patients receiving x- rays to ensure identification of patients was recorded appropriately. The audit findings from April and July 2016 showed 100% compliance with the audit.
- Diagnostic reference levels (DRL's) were displayed in the radiography department. DRL's means dose levels in medical radio- diagnostic practices. These levels are expected not to be exceeded for standard procedures when good and normal practice regarding diagnostic and technical performance is applied. An annual review was carried out by an external radiation protection advisor and its findings discussed in the annual radiation committee meeting. Results from the review found that all DRL's in place were lower (better) than the national average.

Competent staff

- Staff were supported in their development using the appraisal process, which was undertaken annually with a mid-year appraisal every six months. Information supplied by the hospital showed 100% of nursing and healthcare staff across the outpatients and diagnostics department had received their annual appraisal. Staff confirmed they received their appraisal with their line manager.
- All qualified staff within the radiography department were registered with the Health Professions Council (HPC) and maintained their registration with regular continuing professional development. A record of all professional development activities for each radiographer was kept on their personnel file on the department. There was evidence of training and annual assessment records for staff competency for radiographers.
- The hospital had a system in place to ensure qualified nursing staff continued to maintain their registration. Information supplied by the hospital showed 100% completion rate of validation of registration for nurses and for doctors working under practicing privileges.
- The hospital contributed towards a whole system appraisal or review for consultants, and kept logs of complaints, compliments, incidents and adverse events for each consultant to inform their NHS employer. The review took into account evidence of mandatory training and performance. For those consultants who worked privately a responsible officer was appointed through BMI healthcare to provide an appraisal and review service. A policy was available via the hospital intranet.
- Junior staff we spoke with in the therapy department reported that they received good support and guidance from the therapy manager and had the guidance they required to complete their competencies. These included assessing function and movement and correct walking aids and equipment.
- All new nursing staff to the hospital underwent an induction, completing competency paperwork. Induction periods were tailored to the needs of the individual and area of work. Staff informed us the induction was tailored to their needs.

Multidisciplinary working

- We observed good multidisciplinary working with effective verbal and written communication between staff. Staff confirmed there were good working relationships between physiotherapists, nurses, radiology staff and consultants.

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Outpatients and diagnostic imaging

- The therapy team added to the patient records to provide information to consultants with regards to treatment plans.
- We observed nurses working alongside consultants. Interactions were positive and professional.
- We observed a daily morning communication cell meeting, which was well attended by all departments throughout the hospital and included both junior and senior members of staff.
- All outpatient clinics were consultant led and did not employ specialist nurses. Referral to specialist nurses in the community could be made, if required, for patients.
- We observed positive working relationships between managers and the staff groups. Managers across the department had close professional relationships with the staffing groups and provided them with advice and guidance as required.

Seven-day services

- Outpatients provided a five day service from Monday to Friday. Clinics ran from 9am to 8pm. Once a month clinics would operate on Saturday, this included the therapy department and radiology.
- We saw evidence that radiology maintained an on call rota 24 hours per day, seven days per week.

Access to information

- Hospital staff received medical information regarding NHS patients from their GP as part of their referral process via the 'choose and book' system. Choose and book is a national electronic referral service which gives patients a choice of place, date and time for their first outpatient appointment in a hospital or clinic.
- Imaging results completed at other BMI healthcare hospitals were available electronically which made them easily available to staff in radiology. A new electronic Picture Archiving Communication System (PACS) was planned for September 2016. This would allow for improved storage, retrieval and accessibility to scans.
- Policies and procedures were available on the hospital shared hard drive and staff were aware of how to access them. Policies and procedures had been reviewed and updated.
- Each nursing station and consulting room had access to the hospital computer system.
- From May to June 2016, there were no patients who were seen in outpatients without all the relevant records being available.
- Patient records were paper based and stored centrally on site. Records from other BMI healthcare hospitals and NHS hospitals were requested three to four days in advance to ensure they were available for patient consultation. Records were transported to and from the hospital by a hospital courier to ensure there was no delay in receiving or providing records.
- Patient information was protected, records were kept in secure storage and all computers were password protected. The hospital had a Caldicott guardian who was a senior person responsible for protecting the confidentiality of patient information and enabling appropriate information sharing.
- Information from team meetings was emailed to staff and displayed in staff areas to read and sign. This ensured all staff had access to the latest information.
- Discharge letters and summaries were typed and sent to patients and their GP's. We were told this was not audited so data was not available to provide assurances that letters were provided to GP's within seven days.
- Patient responses from the inpatient questionnaire showed that, in July 2016, 98.6% of patients were satisfied that they received an information pack from the hospital.
- Information on the hospital website provided patients with the relative costs for treatment.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- We reviewed the records of twelve patient records who required a surgical procedure and found consent to the procedure had been documented in all records. Consent was also confirmed on the day of the surgery and this was documented in all the records we reviewed.
- In the June 2016 consent audit, the hospital scored 91% which was better than the hospital compliance target of 90%. There was a current consent policy in place and it had been reviewed. Staff informed us the consent policy was accessible through the hospital intranet.
- We spoke with seven staff who were able to explain that they would be able to access help and support with regards to the consideration of mental capacity and

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deprivation of liberty. Staff informed us it was rare that patients who attended outpatient clinics would have a severe impairment of the mind or brain that would limit their ability to make decisions for themselves.

- We saw training records supplied by the hospital that showed that all nursing staff and healthcare assistants (100%) on the outpatients department had received training in consent and had completed a course on dementia awareness.

Are outpatients and diagnostic imaging services caring?

Good

We rated Outpatients and Diagnostic imaging as 'good' for caring because;

- Patients and their relatives we spoke with told us they were supported by staff who they perceived were caring, compassionate and supportive to their needs.
- There was assistance and information available to help involve patients in the care they received.
- Staff were observed to interact with patients and their relatives in a supportive and caring manner.
- We observed that staff treated patients and their families with dignity and respect and that all private conversations took place in the treatment rooms to protect confidentiality.
- We observed staff giving reassurance to patients with additional support given when it was required, especially if patients were apprehensive.
- Chaperones were available to all patients attending the hospital and were always assigned to patients who attended for more intimate examinations.
- Patients who were paying for their treatment informed told us that they were informed about the costs of their treatment.

Compassionate care

- We spoke with 12 patients and their relatives who all told us that that they were treated with dignity and respect by all members of staff. Patients told us they found the staff polite, friendly and approachable. They told us staff were very friendly, caring and welcoming and calm in their approach
- We observed staff greeting patients on their arrival and introducing themselves. Staff were polite, friendly and helpful in their approach.
- The service offered patients the support of a chaperone. This person acted as a safeguard and a witness for patients during medical examinations or procedures. For clinics that involved examinations that were more intimate, a nurse was always assigned to support patients throughout.
- The hospital took part in the NHS Friends and Family Test (FFT), a survey which asks patients whether they would recommend the service they have received to friends and family. The hospital had a response rate of 44% and achieved a score of 99% in the last month of the reporting period. Although the response rate was low, patients and their relatives were scoring the service highly as a place that they would recommend for treatment.
- We observed that staff respected patient confidentiality and ensured discussions took place in treatment rooms for privacy. At reception, patients were not asked to provide confidential information to protect their confidentiality.

Understanding and involvement of patients and those close to them

- All patients and relatives we spoke with told us that care and treatments were explained to them and their relatives. Patients told us they felt involved in their care, their appointments were not rushed, and full explanations were given regarding care and treatment required.
- During our observations we saw staff reassuring patients and giving them time to understand the treatment they were due to have.
- Patients who were paying for their treatment were informed of the costs prior to consultation. The hospital website also displayed the costs of treatment in order for patients to be prior informed of costs.

Emotional support

- Patients and their relatives we spoke with told us they felt that they were supported by the service and given appropriate reassurance. Patients told us that the staff were caring and supportive.

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Outpatients and diagnostic imaging

- Throughout our visit we observed staff giving reassurance to patients with additional support given when it was required, especially if patients were apprehensive.
- Consultations rooms were private. This assisted in maintaining patient's dignity but also allowed space and time if the patient required it.

Are outpatients and diagnostic imaging services responsive?

Good

We rated Outpatients and Diagnostic imaging as 'good' for responsive because;

- All hospital referrals were screened by experienced senior nurses to ensure the needs of the local people could be met. Senior nurses were conversant with the hospital exclusion policy and explained that high risk patients with multiple co-morbidities may be referred on to other care and treatment centres based upon the complexity of their needs.
- Patients told us they received instructions with their appointment letters and were given written information, as needed. From the hospital patient survey in July 2016, 100% of patients reported that the information pack sent out to them gave them all the information they needed.
- Information sent to patients was sent to them in formats to meet their individual needs. Referrals from the initial source highlighted special circumstances to enable the hospital to respond appropriately. For example if patients required information in another format then this could be arranged including large font text for those people with sight impairment.
- Patients had a choice of appointments available to them through the 'choose and book' service. This allowed patients to be able to attend appointments at a time best suited to their needs. Clinic times were available up to 8pm during the week. We observed reception staff booking in patients and found they offered appointment times to suit the needs of the patients. We saw that reception staff were polite and professional.
- Information leaflets were available to patients regarding their treatment. Staff either sent the leaflets in appointment letters or gave them to patients to take away. If patients required leaflets in different languages they would arrange with an external company for the leaflet to be translated. There were leaflets available to patients in all waiting areas.

However,

- The environment had not been suitably adapted to respond to the needs of patients living with dementia. For example signage was not clear, and there were no quiet spaces for patients who may be feeling anxious, agitated or confused.

Service planning and delivery to meet the needs of local people

- In the year April 2015 to March 2016, 79% of the patients who attended the department were funded by the NHS. This showed that local people were given a choice of where they wanted to have their treatment, and resulted in local people, deemed to be low clinical risk, receiving timely interventions; freeing up bed capacity at local NHS hospitals. We were told that admission process and care provided was the same for self-funded patients and NHS patients.
- All hospital referrals were screened by experienced senior nurses to ensure the needs of the local people could be met. Senior nurses were conversant with the hospital exclusion policy and explained that high risk patients with multiple co-morbidities may be referred on to other care and treatment centres based upon the complexity of their needs.
- There was limited signage throughout outpatients and diagnostic imaging departments to support patients in locating the right clinic area. We were told that signage was limited as the building was grade one listed. This meant the hospital was limited in making changes to the interior or exterior of the building. Due to the limited signage, staff escorted patients to the required clinic room for treatment. Throughout the inspection we saw nurses directed and took patients to the clinic rooms to ensure they found their way.
- Patient waiting areas had a relaxed atmosphere and reading material was available for patients whilst waiting.
- Patients told us they received instructions with their appointment letters and were given written information,

as needed. From the hospital patient survey in July 2016, 100% of patients reported the information pack sent out to them gave them all the information they needed.

- Information was available to patients about who to contact if they had any concerns about their care. Additionally there was a wide variety of information leaflets available in all areas of the hospital.
- There was free car parking at the hospital for patients and visitors with an over spill car park for those attending at the busiest times.
- There was wheelchair access throughout the outpatients department.
- There was sufficient seating in waiting areas.
- Patient waiting areas had access to toilets and there was a toilet adapted for patients who were living with a disability.
- Free tea and coffee and water coolers were available across the department so patients could help themselves.
- Information sent to patients was sent to them in formats to meet their individual needs. Referrals from the initial source highlighted special circumstances to enable the hospital to respond appropriately, for example if patients required information in another format then this could be arranged, including large font text for those people with sight impairment.
- A hearing loop was available for those patients with a hearing impairment.
- Information regarding patients' needs was captured using patient satisfaction questionnaires. These were routinely collated and benchmarking took place across all BMI healthcare hospitals.
- Patient-led assessments of the care environment (PLACE) between February 2015 and June 2015, were the same or better than the England average for cleanliness, dementia and privacy and dignity. However, the hospital scored worse than the England average in food, and condition, appearance and maintenance. We were told by senior staff that a maintenance programme was on going, but was limited due to the grade one nature of the building. We were told during the inspection that some carpets were imminently going to be replaced.

Access and flow

- The hospital had scheduled clinics with set specialities on a weekly basis. There were 14,763 attendances to outpatients between April 2015 and March 2016. All clinics were held at the hospital and no services were offered at a patient's home.
- There was some provision for telephone preoperative assessment; however this service was limited to patients who required less invasive procedures. However, any patient who had multiple co-morbidities required a face to face consultation to ensure their health needs could be met.
- Patients had a choice of appointments available to them through the 'choose and book' service. This allowed patients to be able to attend appointments at a time best suited to their needs. Clinic times were available up to 8pm during the week. We observed reception staff booking in patients and found that they offered appointment times to suit the needs of the patients. We saw that reception staff were polite and professional.
- Patient waiting times were not displayed, however nursing staff kept patients informed of any delays in being seen. During the inspection we did not find any appointments that were late.
- The department had developed a text reminding service to decrease the number of patients who did not attend (DNA). A simple text reminder was sent to patients two days prior to their appointment to minimise the number of patients who did not attend. DNA rates for the department were below the target of 5% from April to July 2016. In July 2016, they reported there were 0% of patients who did not attend appointments. Patients who did not attend their appointment were contacted and sent another appointment.
- The department met the referral to treatment standard of 95% for non-admitted pathways from April 2015 to March 2016. For the whole reporting period the referral to treatment waiting times were above 95%. Non-admitted pathways mean those patients whose treatment started during the month and did not involve admission to hospital.
- The department met the national standard of 92% for referral to treatment rates each month for incomplete pathways between April 2015 and March 2016. Incomplete pathways are waiting times for patients waiting to start treatment at the end of the month.
- Referrals to other departments within the hospital, for example, to the therapy team were paper-based

referrals. These were completed by the referring consultant and then passed to the therapy team for triage. Appointments could be made whilst the patient was at the hospital at a time to suit their needs.

- Managers informed us that appointment length was determined upon triage. Patients with complex needs and new patients often required longer appointments than those patients who required a follow up appointment. We saw that clinics did not over run and patients we spoke with told us they had enough time to ask questions and were involved in their care and treatment. In the hospital satisfaction survey in July 2016, 100% of patients reported that they were involved in their care and treatment.
- The hospital monitored patient outcomes through surveys to ensure that patients were satisfied with the service they received. Patient satisfaction was benchmarked against other BMI healthcare hospitals. Information provided by the hospital showed that in July 2016 the hospital ranked 18th out of 55 BMI healthcare hospitals. This was an increase in rank from 25th in the previous month.

Meeting people's individual needs

- Information leaflets were available to patients regarding their treatment. Staff either sent the leaflets in appointment letters or gave them to patients to take away. If patients required leaflets in different languages they would arrange with an external company for the leaflet to be translated. There were leaflets available to patients in all waiting areas.
- Staff used both telephone and face to face interpreting services for patients whose first language was not English. We were told by managers that they had seen a steady rise in the use of translators as the population demographics had changed. The hospital had an interpreter policy that had been reviewed and updated.
- Transport services were not offered by the hospital, however we were told that patients were informed of how to book transport to the hospital through their GP if it was required.
- The hospital could easily be accessed by patients who had a physical disability. The outpatient department was easily accessible and there was access to disabled toilet facilities.
- Vulnerable adults, such as patients living with a learning disability and those living with dementia were identified at the referral stage, and steps were taken to ensure they were appropriately cared for. This included seeing the patient at the start of clinics and extra staffing to support the patient, if required. We were informed that a discreet symbol was used in patient notes to identify a patient with dementia if they required more support. However, we did not see this in use during the inspection.
- We reviewed the patient exclusion policy and saw that, under the equality impact assessment, the policy did not affect one group of people less or more favourably than another including those patients with learning, physical, sensory disabilities or impairment and mental health disorders.
- The department had not suitably adapted or changed the environment to cater for patients living with dementia. For example, there were no quiet areas, and signage was not always clear.
- Posters were displayed throughout the department, encouraging patients to ask if they would like a chaperone. We were informed that patients were offered chaperones, and all patients attending for an intimate examination were chaperoned.
- Seating in the waiting areas included high back armchairs to help support those patients with mobility issues.
- The layout of the reception desks and waiting areas meant there was no privacy line and so conversations could easily be overheard. We were informed by reception staff they did not ask private confidential information and all information was asked to be written down by the patients to protect their confidentiality. We observed that confidential information was not discussed at the reception desk.
- We observed a daily department huddle discussion of specific patients due to attend the outpatients department that day. We saw that staff discussed each patient who was attending, to ensure patients received the appropriate support they required.
- Two patients we spoke with were concerned about the driveway to the hospital. They reported that it was in poor condition due to the number of pot holes. The hospital managers were aware of the issues with the driveway and awaited funding to be granted for repairs.

Learning from complaints and concerns

Good

Outpatients and diagnostic imaging

- The hospital had a complaints policy in place that was due for review in 2018. Staff and managers were aware of the policy and where to find it using the hospital intranet.
- Initial complaints were dealt with by clinic managers in the outpatients department in an attempt to resolve issues locally. However, if this could not be resolved then the complaint would be escalated to the senior management team.
- Information about how to raise a complaint was displayed throughout the hospital. All staff reported they tried to resolve complaints at a local level first but knew how to escalate complaints to managers, if needed.
- The Hospital Manager was the individual responsible for overseeing all complaints within the hospital. The personal assistant to the Hospital Manager co-ordinated and collated responses, supporting the heads of department in investigating any complaints.
- From April 2015 to March 2016, there had been 15 complaints made to the hospital. The complaints tracker was collated to support reviewing of any trends or themes and provided outcomes and learning.
- The hospital aimed to acknowledge the complaint within two days of receipt and to have a final response within 20 days. We saw evidence that all complaints, for June and July 2016, had been responded to within the appropriate timescales.
- Complaints were an agenda item on the clinical governance meetings and learning actions were discussed and cascaded back to staff in all departments.

Are outpatients and diagnostic imaging services well-led?

Good

We rated Outpatients and Diagnostic imaging as 'good' for well-led because;

- Staff on the department were aware of the hospital vision and told us they wanted to deliver the best possible patient outcomes and experience.
- The hospital had a risk register which highlighted risks associated with the daily operation of the hospital. Risks had been identified and actions taken to mitigate the risks in a number of areas including infection control, patient safety, leadership and work force risks. Risks were discussed at governance meetings and the register had been updated.
- Risk assessments were completed for each department and rated from Red to Green. We saw evidence that a risk matrix was used to score the severity of the risk. Files with risk assessments were also kept by departmental managers.
- We saw positive and friendly interactions between staff, managers and the senior management team.
- In the BMI healthcare staff survey 2015, 94% of staff would recommend the hospital as a place to work. This was better than the national average of 70%.

However,

- Although risk assessments on the radiology department had been reviewed by the radiation protection supervisor in 2016, records provided by the provider indicated there was no clear evidence that they had been reviewed by the radiation protection advisor.

Vision and strategy for this this core service

- The hospital had aligned itself with the BMI corporate vision. The vision encompassed patient outcomes and experience, financial success and to be an employer of choice.
- Staff on the department were aware of the hospital vision and told us they wanted to deliver the best possible patient outcomes and experience. We saw the vision for the hospital was posted on the walls on the department.
- Managers and staff were aware of the areas of environmental improvement required to fulfil the vision of the hospital. These included replacement of carpeted areas and remedial action to repair the driveway to the hospital following patient complaints.

Governance, risk management and quality measurement for this core service

- The hospital had a risk register which highlighted risks associated with the daily operation of the hospital. Risks had been identified and actions taken to mitigate the risks in a number of areas including infection control, patient safety, leadership and work force risks. Risks were discussed at governance meetings and the register had been updated.

Good

Outpatients and diagnostic imaging

- Risk assessments were completed for each department and rated from red to green. A risk matrix was used to score the severity of the risk. Risk assessments included carpeting in the department, risk of sharps injury, and no picture archiving system in radiology. We saw that these risks had recently been reviewed in 2016.
- We saw documented evidence in the radiography department that radiation risk assessments had been completed for the use of mobile radiography, patient assistance during radiography, radiation risk assessment for C-arm fluoroscopy unit, and radiation risk assessment for radiographic examinations in the x-ray room had been updated for 2016. However, although the risk assessments had been reviewed by the radiation protection supervisor, they did not show evidence that they had been reviewed by the radiation protection advisor on an annual basis. The risk assessment stated the radiation protection advisor should review every 12 months.
- There was an Ionising Radiation Safety Policy in place that had been reviewed in 2016. The policy set out the governance arrangements and the roles and responsibilities of those staff involved in radiological interventions.
- Managers of the department attended clinical governance meetings on a monthly basis and minutes of these meetings were available and were attended by all departments.
- Staff across the department were aware of the need to report incidents and complaints. Incidents and complaints were investigated and discussed in clinical governance meetings. Learning objectives were cascaded back to staff through daily safety huddles and meetings.
- The hospital held meetings through which governance issues were addressed. The meetings included the Medical Advisory Committee (MAC) meeting, clinical governance meetings, and staff team meetings. A daily communication cell meeting was held, attended by staff from all departments to discuss and highlight any concerns. We attended a daily communication cell meeting and found it was well attended by staff from all departments and all levels of seniority and covered issues or findings across the whole hospital. We observed that this information was circulated once the meeting had finished.
- The hospital worked with the local clinical commissioning group (CCG) to ensure their performance targets were being met. Senior managers met with commissioners to review the hospital's performance via their results of specific measured outcomes for quality and innovation (CQUIN). Measured outcomes of quality included referral to treatment times, friends and family test, and did not attend appointment rates (DNA).
- Procedures were in place to ensure consultants holding practicing privileges were valid to practice. There were procedures in place to ensure all consultant's requests to practice were reviewed by the Medical Advisory Committee (MAC). We saw from reviewing the MAC meeting minutes that practicing privileges were discussed and included those practicing privileges that had been suspended, appraisals outstanding, and insurance certification renewal for consultants.
- All policies were approved at local and corporate level. Staff had access to policies in hard copy and on the hospital intranet and signed a declaration to confirm they had read and understood the policy relevant to their area of work. Policies had been reviewed and updated and included recognition and management of sepsis. The sepsis policy included a flow chart and screening tool so staff could follow the protocols required to maintain patient safety.
- The department had service level agreements (SLA's) with several different organisations. These organisations provided services to the hospital to ensure the hospital was able to function. These services included pathology and medical equipment maintenance. Contracts were in place and review dates documented.

Leadership / culture of service

- All staff told us managers of the service were approachable and supportive. We observed managers to be present on the department providing advice and guidance to staff and interactions were positive and encouraging.
- We saw positive and friendly interactions between staff, managers and the senior management team.
- Staff described the culture at the hospital as being open and honest and felt they were listened to by senior managers.
- The managers of the outpatients, radiology and therapy services were visible in the departments and we observed a supportive management culture.

Good

Outpatients and diagnostic imaging

- All staff we met were welcoming, friendly and helpful. They were proud of where they worked and said they were happy working for the service. We observed staff practice and saw they were polite and professional with all patients and families.
- Managers had a good knowledge of performance in their areas of responsibility and they understood the risks and challenges to the service.
- Managers provided hands on support during times of staffing shortages. Whilst on inspection, we observed that the manager of outpatients covered clinics to sure the continuity of services.
- Many staff had worked within the hospital for many years and the staff turnover was 0% for the past two years up to March 2016. All staff reported they enjoyed working at the hospital.

Public and staff engagement

- The views of patients were actively sought within outpatients and diagnostic imaging using the NHS Friends and Family Test (FFT) and patient satisfaction questionnaires. Results from the FFT for NHS funded patients showed that, in the reporting period October 2015 to March 2016, the hospital average FFT score was 99% of patients would recommend the hospital. The hospitals FFT scores were similar to the England average of NHS patients across the period October 2015 to March 2016.
- The hospital website provided patients with a forum to leave feedback about their care and treatment. For example one patient reported they had received 'first class care'.
- Staff were rewarded for exemplary performance through a 'above and beyond' staff reward programme. Anyone could nominate another member of staff for any reason. Every month the executive team decided who received the award which was a letter of thanks and a bottle of wine. The staff awards were posted on the department wall.
- In the BMI healthcare staff survey 2015, 94% of staff would recommend the hospital as a place to work. This was above the national average of 70%.
- The Hospital Manager conducted quarterly staff forums to gather views from the staff across the hospital. For those staff who wished to ask questions in confidence an 'Ask David' form could be completed. Staff we spoke with reported they did not really use this system as all the senior managers were friendly and approachable, and felt they were able to raise questions and concerns at any time.

Innovation, improvement and sustainability

- The hospital had a strategic business plan for 2016 that set out strategic priorities and highlighted key risks and a quality improvement plan. We saw from the plan that risks such not having a Picture Archiving Communication System (PACS) in radiology was highlighted. PACS is a healthcare technology for the short and long term storage, retrieval, management, distribution and presentation of medical images.
- The department was due to be refurbished to include an improved flooring to replace carpeting in reception areas and corridors and new decoration to public areas to enhance patient experience.
- Managers were aware of their current performance and through monthly meetings discussed how performance could be improved. Service improvements or areas of service non-compliance was discussed at governance meetings and actions needed. For example, in the June 2016 meeting minutes, late running of clinics were to be incident reported. Staff confirmed, and we observed incident logs that any late running clinics were recorded as an incident.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider SHOULD take to improve

- The hospital should ensure that all patient bedrooms and bathrooms are thoroughly cleaned and audited on a regular basis.
- The hospital should take action to replace carpeting and seating to assist in maintaining good standards of infection control.
- The hospital should ensure that portable appliance testing is carried out on all electrical equipment.
- The hospital should ensure that oxygen cylinders are stored in line with guidelines when not in use.
- The hospital should ensure that all observations are correctly recorded.
- The hospital should ensure that all staff have an up to date appraisal.
- The hospital should ensure that all patients are seen post operatively by the consultant
- The hospital should ensure that the daily meetings between ward and theatre staff take place
- The hospital should consider appropriate signage and environment for people living with dementia or a cognitive impairment.
- The hospital should take action to improve the reviewing of risk assessments in radiology.
- The hospital should develop a competency programme for staff in the administration of eye drops.
- The hospital should take action to improve the compliance rates with mandatory training to ensure the staff have the up to date knowledge and skills to care and treat patients.
- The hospital should consider including medicines management as part of the mandatory training programme.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

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