

BMI The Sandringham Hospital

Quality Report

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This report describes our judgement of the quality of care at this location. It is based on a combination of what we found when we inspected and a review of all information available to CQC including information given to us from patients, the public and other organisations

Ratings

Overall rating for this location

Good



Are services safe?

Requires improvement



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 The Sandringham Hospital is operated by BMI Healthcare Limited. The hospital has 24 beds, 20 of these were single rooms and two double rooms. The hospital has converted a previous double room into an ambulatory day case suite.

Facilities include two operating theatres which were laminar flow (a system of circulating filtered air in order to reduce the risks of airborne contamination), one was for major operations such as joint replacements and the other operating theatre undertook minor procedures and endoscopies. The recovery area had two bays. There was also X-ray, outpatient and diagnostic facilities.

The hospital carries out a range of elective surgery including orthopaedics, general surgery, urology, ophthalmology, ear nose and throat (ENT), vascular, gynaecology, cosmetic and plastic, oral and maxilla-facial and dermatology. There are facilities to take plain film X-rays and ultrasound scanning, other imaging are provided by the adjacent NHS provider. We did not inspect the MRI or CT scanning services as these are provided and managed by another registered provider.

The hospital provides surgical procedures and a range of outpatient consultations for adults aged 18 and over, to privately funded, insured and NHS patients.

We inspected this service using our comprehensive inspection methodology. We carried out the announced part of the inspection on 18 and 19 January 2017, along with an unannounced visit to the hospital on 2 February 2017.

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

The main service provided by this hospital was surgery. Where our findings on surgery for example, management arrangements, also apply to other services, we do not repeat the information but cross-refer to the surgery core service.

We rated the both core services, and the hospital as good overall. However, we found that safety in surgery required improvement.

To get to the heart of patients' experiences of care and treatment, we ask the same five questions of all services: are they safe, effective, caring, responsive to people's needs, and well-led? Where we have a legal duty to do so we rate services' performance against each key question as outstanding, good, requires improvement or inadequate.

Services we rate

We rated the hospital as good overall, with surgery and outpatients and diagnostic imaging services rated as good, we inspect but do not rate the effectiveness of outpatients and diagnostic imaging.

Are services safe at this hospital?

- Clinical areas at the hospital that had not been refurbished were not compliant with current Health Building guidance. Plans were in place to address this.
- Access to theatres was through a push pad system to release the door which staff locked when theatre were not in use. This meant the area was not secure when patients were in the department which could put patients at risk due to unauthorised access.
- The hospital complied with the completion of the five steps to safer surgery checklist. However, we saw staff not giving their full attention during the completion of the checklist.
- Staff we spoke with knew, and appeared knowledgeable and confident about reporting incidents. However, there were inconsistencies in the recording of the evidence of completion of the action plans following investigations of 'incidents.
- An additional patient incident had been included and recorded in one never event investigation report. This reportable incident which had not been investigated in its own right or identified learning from it.

Summary of findings

- Not all staff had completed the acute care competencies for clinical care as recommended following a serious untoward incident for delay in the response to assessing and responding to a deteriorating patient.
- Staffing levels and skill mix were planned, implemented and reviewed to ensure patients received safe care and treatment at the time of inspection.
- Medicines, including medications requiring low temperatures, were stored and administered safely in fridges.
- Staff understood the principles of the duty of candour and could give examples of learning from incidents.
- All patient areas were visibly clean. Performance showed effective safe care was delivered for example, there were no infections such as Meticillin Resistant Staphylococcus Aureus (MRSA) and Clostridium Difficile (C.Difficile).
- Emergency resuscitation equipment was available and all nursing staff had undertaken basic life support training.
- Data provided by the hospital stated staff were 100% compliant with mandatory training.
- All the staff we spoke with were knowledgeable about their role and responsibilities regarding the safeguarding of vulnerable adults and children and of the referral process.

Are services effective at this hospital?

- Patient care and treatment reflected relevant research and guidance, including the Royal Colleges and National Institute for Health and Care Excellence (NICE) guidance.
- There was an effective multidisciplinary team approach to care and treatment. This involved a range of staff working together to meet the needs of patients using the service.
- For surgical staff between October 2015 and September 2016, 100% of nurses and healthcare assistants working in inpatient areas had received an appraisal. The operating department showed a rate of 80% completion against a hospital target for completed appraisals of 100% for the same period.
- Patients were given guidance on fasting prior to surgery which was based on best practice.
- In outpatients and diagnostic imaging participation in national audits and clinical audits was minimal.
- Staff were aware of their responsibilities surrounding consent and staff understood their responsibilities under the Mental Capacity Act 2005 (MCA).
- Where patients had capacity to consent a two stage consent process was used following a recommendation from a never event. However, we found this process was not always being followed.
- Practising privileges were not being reviewed as per hospital policy. This meant the appropriate systems and processes were not in place to ensure consultants with practising privileges met required standards to practice.

Are services caring at this hospital?

- Patients received clear information prior to their appointment and were able to ask questions and receive appropriate responses during their appointment.
- Feedback from patients and those important to them was extremely positive about the care they had received and the way staff treated them. Staff demonstrated a culture of caring for patients.
- All staff treated patients with dignity and respect as well as helping them to cope emotionally with their treatment and care.
- In outpatients services patients received clear information prior to their appointment and were able to ask questions and receive appropriate responses during their appointment.

Are services responsive at this hospital?

- Surgical waiting times, delays and cancellations were minimal and managed appropriately.
- Waiting times for outpatient and diagnostic imaging appointments were within national guidelines and staff took action to facilitate the flow of patients through the hospital.
- Outpatients services tried to tailor services to the needs of patients wherever possible offering out of hours and telephone appointments. Individualised needs of patients were taken into consideration when planning care.
- Patients could access services quickly if needed. In house and sub-contracted diagnostic imaging services were available to patients in a timely way, well within national NHS target times.

Summary of findings

- Complaints about services were responded to within the hospital's timescales. There was evidence of sharing and learning from complaints.
- There were systems in place to identify patient's needs, for example those living with dementia or patients with a learning disability. However, there was not a dementia strategy in place.
- We did not see provision made available for patient information leaflets in large print and formats other than written English.
- The hospital did not monitor how long patients waited for appointments once they arrived in clinic. (In clinic wait times.)

Are services well led at this hospital?

- BMI The Sandringham Hospital had clear corporate and organisational values which put patients first. Staff we spoke to demonstrated these values.
- Governance arrangements mostly supported the services to improve quality, learn from incidents, monitor performance and mitigate risks. However, we found some risks that had been on the risk register for prolonged periods.
- There were clearly defined and visible leadership roles in place with senior staff providing motivation to their teams.
- Changes had been made to service delivery following feedback from staff, patients and consultants.
- The hospital had an open culture with an approachable leadership team. There was a sense of friendliness and companionship within the staff group. This extended through all grades of staff.
- Incident action plans were not clearly defined as completed in the reports, the senior management team told us they would review the process.
- There was no specific outpatient or diagnostics strategy or costed action plan. This meant their objectives were unclear and there was no progress monitoring to ensure that objectives were achieved.

We found areas of outstanding practice in surgery:

- Physiotherapists offered treatment to patients both before and after joint surgery. They ran an enhanced recovery programme which was a dedicated programme of rehabilitation offered to all inpatients following hip and knee surgery. This programme provided a personalised rehabilitation and individual goal setting.
- The BMI group aimed for patient's average length of stay for hip and knee replacement surgery to be no longer than 3.5 days. Total average length of stay for hip and knee surgery for the BMI The Sandringham Hospital for July 2016 was 2.3 days respectively.

However, we also found the following issues that the service provider needs to improve:

Importantly, the provider must:

- Ensure that all staff had completed the acute care competencies for clinical care as recommended following a serious untoward incident for delay in the response to assessing and responding to a deteriorating patient.

In addition the provider should:

- The provider should ensure all incident investigations have a clear completion date stated on the action plans.
- The provider should ensure the clinical environment is compliant with HBN 00-09 infection control in the built environment.
- The hospital should take action to ensure the theatre departments' access is safe for patients whilst in the department.
- The provider should consider making available, patient information leaflets in large print and formats other than written English.
- The provider should ensure all staff comply with the Five steps to Surgery process.

Summary of findings

- The provider should consider a written policy or treatment criteria for patients living with dementia or patients with a learning disability is available, evidenced based, ratified and up-to-date as a reference point for staff.
- The provider should ensure staff are aware of the business continuity policy in the event of lift breakdown when on generator power backup.
- The provider should ensure that the consent and whistleblowing policies are up-to-date.
- The provider should ensure the two stage consent process is followed, as a recommended following a never event.

Professor Sir Mike Richards
Chief Inspector of Hospitals

Overall summary

BMI The Sandringham Hospital is operated by BMI Healthcare Limited and is part of a network of 59 hospitals across England, Scotland and Wales.

The hospital opened in 1990 as a purpose built hospital. It is a private hospital based in Kings Lynn which is adjacent to a local acute NHS hospital.

The hospital provides outpatient consultations and a range of surgical procedures for adults aged 18 and over, to privately funded, insured and NHS patients. Nobody under the age of 18 is treated at BMI The Sandringham Hospital.

The hospital provides private, insured, self-pay and NHS services. NHS funded care is mostly through the NHS electronic referral system.

There are administration and management teams on site.

The hospital has had a registered manager in post for three years.

Summary of findings

Our judgements about each of the main services

Service

Rating

Summary of each main service

Surgery

Good



Surgery was the main activity of the hospital. Where our findings on surgery also apply to other services, we do not repeat the information but cross-refer to the surgery section.

We rated this service as good because it was effective, caring, responsive and well-led, although it requires improvement for safety.

Outpatients and diagnostic imaging

Good



We rated outpatients and diagnostic imaging services as good overall. We rated outpatients and diagnostic imaging services as good for being safe, caring, responsive and well-led.

We inspected, but did not rate the service for effectiveness.

Summary of findings

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Good



BMI The Sandringham Hospital

Services we looked at:

Surgery; and Outpatients and diagnostic imaging.

Summary of this inspection

Our inspection team

The team that inspected the service comprised a CQC Inspection Manager and three other CQC inspectors, a specialist advisor with expertise in surgery.

The inspection team was led by a CQC Inspection Manager.

Information about BMI The Sandringham Hospital

BMI The Sandringham Hospital has one ward with 24 beds and is registered to provide the following regulated activities:

- Diagnostic and screening procedures
- Family planning
- Surgical procedures
- Treatment of disease, disorder, or injury since 2011

BMI The Sandringham Hospital provides surgical and outpatient services for various specialties to both private and NHS patients. All patients are admitted and treated under the direct care of a consultant and medical care was supported 24 hours a day, seven days a week by an onsite resident medical officer (RMO).

In the reporting period October 2015 to September 2016 there were 2,061 inpatient and day case episodes of care recorded at the hospital; of these 35% were NHS-funded and 65% other funded.

There were 10,912 outpatient total attendances in the reporting period; of these 52% were NHS-funded and 48% were other funded.

There were 63 consultants working at the hospital under practising privileges. We inspected this service using our comprehensive inspection methodology. We carried out the announced part of the inspection on 18 and 19 January 2017, along with an unannounced visit to the hospital on 2 February 2017.

There were two never events reported during the period October 2015 to September 2016 which were categorised as causing moderate harm. Never events are serious patient safety incidents that should not happen if the healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious harm or death but neither need have happened for an incident to be a never event.

Before our inspection, we reviewed performance information from and about the hospital. We also held a focus group at the BMI The Sandringham Hospital which was attended by 17 staff these included therapists, nurses, operating department practitioners, pharmacy staff, radiology and support staff.

Overall, we reviewed 12 care records and spoke with 17 patients, four relatives and 38 staff including nurses, medical staff, consultants, operating department practitioners, therapy, supporting staff and senior managers. We also received 92 'tell us about your care' comment cards which patients had completed prior to our inspection.

We interviewed the senior management team and the general medical representative of the Medical Advisory Committee.

The Registered Manager of the hospital was the Controlled Drug Accountable Officer.

Services provided at the hospital under service level agreement:

- Computerised tomography (CT) and magnetic resonance imaging (MRI).
- Decontamination of endoscopes.
- Clinical and or non-clinical waste removal
- Interpreting services
- Grounds Maintenance
- Laser protection service
- Laundry
- Maintenance of medical equipment
- Pathology and histology
- Radiation Protection Advice
- RMO provision

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?

We rated safe as requires improvement because:

- Clinical areas at the hospital that had not been refurbished were not compliant with current Health Building guidance.
- Access to theatres was through a push pad system to release the door which staff locked when theatres were not in use. This meant the area was not secure when patients were in the department which could put patients at risk due to unauthorised access.
- The service complied with the completion of the five steps to safer surgery checklist. However, we saw staff not giving their full attention during the completion of the checklist.
- Staff we spoke with knew, and appeared knowledgeable and confident about reporting incidents. However, there were inconsistencies in the recording of the evidence of completion of the action plans following investigations of 'incidents'.
- An additional patient incident had been included and recorded in one never event investigation report. This reportable incident which had not been investigated in its own right. The additional incident did not have a separate investigation or identified learning from it.

However, we also found:

- Staffing levels and skill mix were planned, implemented and reviewed to ensure patients received safe care and treatment at all times.
- Medicines, including medications requiring low temperatures, were stored and administered safely.
- Staff understood the principles of the duty of candour and could give examples of learning from incidents.
- All patient areas were visibly clean. Performance showed a good record of accomplishment in safety for example, there were no infections such as Meticillin Resistant Staphylococcus Aureus (MRSA) and Clostridium Difficile (C.Difficile).
- Emergency resuscitation equipment was available and all nursing staff had undertaken adult immediate life support (ILS) training.
- Data provided by the hospital stated staff were 100% compliant with mandatory training.

Requires improvement



Summary of this inspection

- All the staff we spoke with were knowledgeable about their role and responsibilities regarding the safeguarding of vulnerable adults and children and of the referral process to the safeguarding lead.

Are services effective?

We rated effective as good because:

- Patient care and treatment reflected relevant research and guidance, including the Royal Colleges and National Institute for Health and Care Excellence (NICE) guidance.
- There was a good multidisciplinary team approach to care and treatment. This involved a range of staff working together to meet the needs of patients using the service.
- Staff mostly had the right qualifications, skills, knowledge and experience to do their job.
- For surgical staff between October 2015 and September 2016, 100% of nurses and healthcare assistants working in inpatient areas had received an appraisal.
- Staff followed guidance on fasting prior to surgery which was based on best practice.
- In outpatients and diagnostic imaging participation in national audits and clinical audits was minimal.
- Staff were aware of their responsibilities surrounding consent and staff understood their responsibilities under the Mental Capacity Act 2005 (MCA).

However, we also found:

- Not all staff had completed the acute care competencies for clinical care as recommended following a serious untoward incident for delay in the response to assessing and responding to a deteriorating patient.
- Staff told us patients consented for surgical procedures using a two stage consent process following a recommendation from a never event. However, we found this process was not always being followed.

Good



Are services caring?

We rated caring as good because:

- Patients received clear information prior to their appointment and were able to ask questions and receive appropriate responses during their appointment.
- Feedback from patients and those important to them was extremely positive about the care they had received and the way staff treated them. Staff demonstrated a culture of caring for patients.

Good



Summary of this inspection

- All staff treated patients with dignity and respect as well as helping them to cope emotionally with their treatment and care.
- Patients were supported and involved as partners in their care. Staff explained care and treatment in a way patients understood.
- The provider had achieved high scores in patient feedback from both the NHS Friends and Family test and the hospital's satisfaction survey.

Are services responsive?

We rated responsive as good because:

- Surgical waiting times, delays and cancellations were minimal and managed appropriately.
- Waiting times for outpatient and diagnostic imaging appointments were within national guidelines and staff took action to facilitate the flow of patients through the hospital.
- Outpatients services tried to tailor services to the needs of patients and offered out of hours and telephone appointments. Individualised needs of patients were taken into consideration when planning care.
- Patients could access services quickly if needed. In house and sub-contracted diagnostic imaging services were available to patients in a timely way, well within national NHS target times.
- Complaints about services were responded to within the hospital's timescales. There was evidence of sharing and learning from complaints.
- Waiting times for outpatient and diagnostic imaging appointments were within national guidelines and staff took action to facilitate the flow of patients through the hospital.

However, we also found:

- There was no clear written policy or treatment criteria for patients living with dementia or patients with a learning disability.
- We did not see provision made available for patient information leaflets in large print and formats other than written English.
- The hospital did not monitor how long patients waited for appointments once they arrived in clinic (in clinic wait times).

Good



Are services well-led?

We rated well-led as good because:

Good



Summary of this inspection

- The BMI group vision was 'We aspire to deliver the highest quality outcomes, the best patient care and the most convenient choice for our patients and partners as the UK leader in independent healthcare'.
- BMI The Sandringham Hospital had clear corporate and organisational values which put patients first. Staff we spoke to demonstrated these values.
- Governance arrangements mostly supported the services to improve quality, learn from incidents, monitor performance and mitigate risks. However, we found some risks that had been on the risk register for prolonged periods.
- There were clearly defined and visible leadership roles in place with senior staff providing motivation to their teams.
- Changes had been made to service delivery following feedback from staff, patients and consultants.
- The hospital had an open culture with an approachable leadership team. There was a sense of friendliness and companionship within the staff group. This extended through all grades of staff.

However, we also found:

- Incident action plans were not clearly defined as completed in the reports which the senior management team acknowledged and would address
- The strategy for outpatients was not fully developed. There was no specific outpatient or diagnostics strategy or costed action plan. This meant their objectives were unclear and there was no progress monitoring to ensure that objectives were achieved.
- Practising privileges were not being reviewed as per hospital policy. This meant the appropriate systems and processes were not in place to ensure consultants with practising privileges met required standards to practice.

Detailed findings from this inspection

Overview of ratings

Our ratings for this location are:

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

Notes

1. We are currently not confident that we are collecting sufficient evidence to rate effectiveness for outpatients and diagnostic imaging.

Surgery

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

Summary of findings

The main service provided by this hospital was surgery. Where our findings on surgical services for example, management arrangements – also apply to other services, we do not repeat the information but cross-refer to the surgical section.

Are surgery services safe?

Requires improvement 

We rated safe as requires improvement.

Incidents

- Staff reported incidents through the hospital's electronic reporting system. This system had recently replaced a paper incident reporting system.
- Staff we spoke with knew, and appeared knowledgeable and confident about reporting incidents. They told us they had received training on the newly introduced incident reporting system.
- Staff told us there was a 'no blame' culture in the service and they felt empowered to report incidents without fear of reprisal. Staff gave examples of when they might report incidents such as falls and medication errors.
- BMI The Sandringham Hospital reported 103 clinical and 26 non-clinical incidents under the collective subject title of surgery and inpatients for the period October 2015 to September 2016. Clinical incidents were categorised as ten moderate, 23 low, and 70 no patient harm. The ward manager stated they encouraged staff to report all clinical and non-clinical incidents with examples of changes to operating theatre lists through to false fire alarms.
- There were two never events reported during the period October 2015 to September 2016 which were categorised as causing moderate harm. Never events are serious patient safety incidents that should not happen if the healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious harm or death

Surgery

but neither need have happened for an incident to be a never event. The two never events were a wrong site surgery, and incorrect procedure performed. Both were investigated in line with the organisations incident management policy. Some of the recommendations included the re-issue of the safer surgery policy, additional 'stop before you block' posters displayed in the anaesthetic room, further staff training, re-checking of the consent form after it has been signed (two stage consent) and alerts attached to the patients details if they have the same surname.

- From information submitted we saw an additional patient incident had been included and recorded in one of the never event investigation reports. This reportable incident had not been investigated in its own right which meant a separate investigation did not take place or learning identified. We spoke with the senior management team who told us they had not considered this was a separate incident as it had happened at the same time as the never event. The management team told us they would review this further.
- Staff told us they discussed incidents and shared learning and any recommendations from the incidents at team meetings. We reviewed meeting minutes from the ward (October 2016, November 2016, December 2016 and January 2017) and the theatre department (November 2016 and January 2017) incidents were a standing item on the agendas. There was evidence of sharing and discussion.
- Staff we spoke with demonstrated learning from incidents. For example, we were told there was up-dated training on the use of the National Early Warning System (NEWS) for all staff following a serious untoward incident of delayed actions to respond to a deteriorating patient. NEWS have been developed to enable early recognition of a patient's worsening condition by grading the severity of their condition and prompting nursing staff to get a medical review at specific trigger points as recommended by the Royal College of Physicians (RCP).
- The hospital reported no patient deaths for the period October 2015 to September 2016.
- There was an effective system in place for the distribution of alerts from the National Patient Safety Agency (NPSA). The NPSA leads and contributes to improved, safe patient care by informing, supporting and influencing the health sector.

- There was a being open and Duty of Candour policy (review August 2017) and a flow diagram outlining key steps of being open and applying the duty of candour. Staff we spoke with were aware of these. The Duty of Candour is a regulatory duty that requires providers of health and social care services to disclose details to patients (or other relevant persons) of 'notifiable safety incidents' as defined in the regulation. This includes giving them details of the enquiries made, as well as offering an apology.
- We reviewed three investigation reports and found them to demonstrate compliance with Duty of Candour requirements. The investigation reports included action plans to prevent recurrence through sharing and learning, both locally and cross-organisational. However, from the data submitted there were inconsistencies in the recording of the evidence of completion of the action plans. We spoke with senior management about the inconsistencies and they told us they would review the process.

Clinical Quality Dashboard

- The Clinical Quality Dashboard is an equivalent to the NHS safety thermometer. The NHS Safety Thermometer is an improvement tool for measuring, monitoring and analysing patient harm and 'harm free' care. Data collected on a single day each month indicates performance in key safety areas. It focuses on four avoidable harms: pressure ulcers, falls, and urinary tract infections in patients with a catheter, and blood clots or venous thromboembolism (VTE).
- Data provided indicated 100% of surgical patients had been screened for risk of developing VTE and no patients had developed venous thrombosis (blood clots in the leg) or pulmonary embolism (blood clots in the lungs) whilst an inpatient at BMI The Sandringham Hospital. These conditions are a complication of immobility and surgery, which may be life threatening but are preventable with assessment and prophylactic (preventative) treatment.
- VTE risk assessments were recorded for all patients in the reporting period January 2016 to December 2016; 95% is the target rate for NHS patients.
- We reviewed nine sets of patient notes, all of which had a VTE risk assessment completed.
- The hospital reported no incidents of inpatient falls within the reporting period March 2016 to October 2016.

Surgery

- Data provided by the hospital indicated there had been no incidences of pressure ulcers or urinary tract infections in patients with a catheter in the reporting period April 2016 to October 2016.
- Safety thermometer information was not displayed in the clinical areas. This meant patients and the public could not see how the ward was performing in relation to patient safety.

Cleanliness, infection control and hygiene

- The ward, theatres, endoscopy and recovery areas were visibly clean and tidy. This included clinical areas, corridors, bathrooms, offices and storage rooms.
- The hospital reported no incidents of hospital acquired MRSA (Methicillin-resistant *Staphylococcus aureus*), MSSA (Methicillin resistant *Staphylococcus aureus*) or *Clostridium difficile* (C Difficile) the period October 2015 to September 2016. These are infections, which are difficult to treat due to their resistance to antibiotic therapy.
- The hospital had an infection control policy which included hand hygiene and MRSA screening.
- The corridor and most of the bedrooms were fitted with vinyl flooring for ease of cleaning. There were two double rooms and a single room which were carpeted with short pile carpet. The single room was out of use due to a stain, this carpet was due for replacement. Health Building Note (HBN) 00-09 Infection control in the built environment states in clinical areas where spillages are anticipated (including patient rooms, corridors and entrances) carpets should not be used in these areas. We were told there was an on-going replacement programme with a phased integration and the carpets were due to be replaced with synthetic flooring. This was on the risk register.
- A standard procedure for cleaning the carpets if spillages occurred was in place and staff knew how to access this. There was also cleaning equipment used to clean the area. Staff told us if they could not remove a stain they would close the room and the patient would be moved to another room.
- The majority of chairs used by patients had a fabric covering which meant staff could not wipe clean if soiled or after each patient use. This did not comply with HBN 00-09 Infection control in the built environment 3.133 which states soft furnishings (for example, seating) used within all patient areas should be chosen for ease of cleaning and compatibility with detergents and disinfectants. They should be covered in a material that is impermeable, preferably seam-free or heat-sealed. Fabric that becomes soiled and stained cannot be adequately cleaned and will require replacement. We were told there was an on-going replacement programme. This was on the risk register with a phased integration.
- There was an identified infection control lead who held monthly meetings with staff members to discuss infection control related practice. We saw meeting minutes (April 2016 and September 2016) where topics such as audit results, infection related incidents and training was discussed.
- We saw evidence of an infection control annual work programme for 2015 to 2016.
- We saw completed cleaning audits for patient rooms (January 2017) and ward areas (January 2017).
- We reviewed a completed weekly cleaning record (up to 16 January 2017) for the ward area which included equipment such as the commodes, fridges, shower chairs, raised toilet seats and dressing trolleys'. We found 'I am clean' labels applied to identify when this had been undertaken.
- We saw cleaning schedules for the theatre department for the past three months, all were completed and signed.
- The theatre department undertook a six monthly deep cleaning rota. We saw evidence of a deep clean having been undertaken for the theatre department for June 2016 and November 2016.
- The access to theatres had a room known as the 'air lock' room where one door had to be closed before the other one opened. These meant patients would enter the theatre environment via a single accessed room. When a procedure had commenced, movement in and out of theatres was restricted. This minimised the infection risk.
- We saw staff adhering to procedures in line with national guidance to minimise the risk of infection to patients undergoing surgical procedures, for example, skin preparation and the use of sterile drapes.
- We observed staff following the local policy and procedure when scrubbing, gowning and gloving prior to surgical interventions. This minimised the infection risk.

Surgery

- The hospital reported no surgical site (wound) infections for the period October 2015 to September 2016. However, one recording of a surgical site infection was inconsistent with wider reporting to a national body.
- Cleansing gel was available at the entrances to each area, in corridors, on reception desks and in each room; patients and visitors were encouraged to use it by staff. Posters were prominently displayed encouraging staff and visitors to cleanse their hands and the process to follow to do this effectively. We observed staff and patients using the cleansing gel in line with the information provided.
- Staff were 'bare below the elbow' to allow effective hand washing. The 'bare below the elbow' dress code requires staff to wear short sleeves or ensure that long sleeves are securely rolled up and any wrist watches and jewellery (other than a plain metal wedding band) must be removed.
- Hand hygiene audit results for ward staff from January 2016 to September 2016 showed a compliance of 100% for January 2016, August 2016 and September 2016 with effective hand washing. Compliance was between 70% and 90% for the remaining months.
- The theatre department staff demonstrated 100% compliance for five out of eight months with effective hand hygiene. However, compliance was 60% in February 2016 with non-return of audit results for March 2016 and May 2016. This demonstrated an overall improvement for the following months (June 2016, July 2016, August 2016 and September 2016).
- There were clinical sinks in two patient rooms and one on the corridor near the nurses' station. The remainder of the sinks were non-clinical which did not comply with HBN 00-09 Infection control in the built environment. The location and provision of clinical wash-hand basins should ensure that they are all readily available and convenient for use. This was identified on the hospital risk register and a replacement programme was being undertaken with a phased integration.
- Changing into surgical scrubs and theatre caps was a requirement of all staff and visitors to theatre. Our observations during inspection confirmed this was adhered to.
- Protective equipment, such as gloves and aprons, were available and we observed staff using these and washing their hands between patients.
- Of the two operating theatres one had higher levels of air filtration (laminar flow). This was particularly important for joint surgery to reduce the risk of infection. We saw evidence the filtration system was regularly maintained, cleaned and tested, last reported testing and approval was March 2016.
- The hospital had a decontamination arrangement with an adjoining acute hospital for the cleaning of the endoscopes.
- We observed sterile suction equipment pre-assembled at each patient's bed space, which meant sterile packaging had been broken and equipment was not sterile. We raised this with the ward manager who told us staff did not replace the equipment between patients unless used. We raised this with the senior management team who told us it was for ease of use in an emergency, however, they told us they would look at alternative methods to prevent the risk of infection. During our unannounced visit all packaging was sealed and unbroken.
- Clinical waste was removed from the hospital into a storage area outside. This was locked and away from the public access. All storage bins we checked were secure.
- We saw evidence that water testing for Legionella was undertaken and was documented as clear for October 2016. In addition, we saw the water services disinfection certificate confirming compliance for October 2016. Legionella is a waterborne bacterium which causes legionnaires disease.

Environment and equipment

- The hospital has two operating theatres, one of which was used for procedures not requiring a general anaesthetic such as endoscopy procedures. One of the theatres was laminar flow. Laminar flow provides incoming air blown straight down through micro filters above the operating table. The downward airflow prevents air masses from mixing in the work area and increases the cleanliness of the air.
- Access to theatres was through a push pad system to release the door which staff locked when theatres were not in use. Visitors and patients could access this area easily. This meant the area was not secure when patients were in the department which could put patients at risk due to unauthorised access. We discussed this with the senior managers who told us a swipe card system was being considered. Senior managers had recorded this on the hospitals risk register.

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- During our unannounced visit we observed notices to instruct staff to call for attention using a push button operated bell before entering the theatre area. There were also defined markings on the floor to alert staff to restricted access to theatres.
- There was a link corridor to another acute hospital. A number combination lock secured this. We were told only authorised people had access to the code. There was a paper signature sheet attached to the internal facing door before staff left the BMI The Sandringham Hospital, for staff to sign out if they were leaving. We were told this was to monitor staff movement for fire regulation purposes. However, there was no monitoring of this door for signing in purposes so the system was not robust with regard to monitoring staff movement into and out of this exit.
- A resuscitation trolley was clearly visible in the surgical ward area. The resuscitation equipment and emergency transfer bag on the ward and in the operating theatres had been checked daily by staff and was safe and ready for use in an emergency. Single-use items were sealed and in date, and emergency equipment had been serviced.
- There was an ambulatory care room which was a converted double bedroom. The room was used for patients on an outpatient basis who underwent procedures such as eye surgery and bladder investigations. The room was equipped with one high and seven low back fabric chairs. There was a door leading to a bathroom with a toilet and a sink. The room did not offer any separate changing rooms or facilities to recline or lie down if feeling unwell. We spoke with a senior manager who told us there were reclining chairs ordered but a bed was available in another room if required. An adjacent room was used to separate male patients from female patients. There was a separate room used to admit patients or to share confidential information. On our unannounced visit there were five wipeable, reclining chairs for patient use.
- There were two anaesthetic trolleys in adjacent operating theatres. We saw checks were complete in accordance with hospital and anaesthetic society guidelines. A difficult airway trolley with a single use difficult airway endoscope was available at all times.
- A third party company serviced and maintained all equipment including loaned equipment.
- All patient equipment we looked at had been routinely checked for safety with visible electrical safety stickers demonstrating when the equipment was next due for service. This included infusion pumps, blood pressure and cardiac monitors as well as patient moving and handling equipment such as hoists.
- Staff were aware of the process for reporting faulty equipment.
- We saw evidence of an equipment list which recorded the equipment replaced between December 2015 to December 2016 which included theatre time lapse clocks, operating table, and a physiotherapy couch. There was also an equipment replacement list for the same period which included operating theatre lights, fabric chairs, carpets in all clinical areas and dual purpose taps.
- Surgical instruments were readily available for use and staff reported there were no issues with supply. Instruments could be prioritised for a quick return if required. The hospital had an agreement with the adjoining acute hospital for sterile services and supplies.
- Surgical instruments were compliant with Medicines and Healthcare products Regulatory (MHRA) requirements. There were systems and process in place to provide traceability of all surgical equipment used. We saw evidence of this within the patient care record.
- Registers of implants, for example hips and knees, were kept by theatres; these ensured details could be quickly provided to the health care product regulator if required.
- There were piped medical gases on the ward and in the theatre suite. Portable oxygen cylinders were available for the transfer of patients from the theatre suite to the ward which were kept securely as required by Health and Safety Executive (HSE) guidance.
- There was a lifting hoist available with a maximum weight of 175 kgs. There was a range of weight related slings for the hoist. An external company washed and maintained these.
- Patient-led assessments of the care environment (PLACE) audits were completed annually. These had shown improvements. In the 2015, Patient-led assessments of the care environment (PLACE) the hospital scored 97% for cleanliness. This was below the national average of 98%. PLACE is a self-assessment of non-clinical services which contribute to healthcare delivered in both the National Health Service (NHS) and

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independent/private healthcare sector in England. The programme encourages the involvement of patients, the public and bodies, both national and local, with an interest in healthcare in assessing providers.

- There was a panic alarm for staff to use which was situated at the nurses' station. This alerted a monitoring company who contacted the police if this was required.
- Closed-circuit television was in operation above the front door. A screen was visible to ward staff at the nurse's station. Staff could operate a front door release from the nurses station to control and monitor access to the premises during out-of-hours.
- The risk register stated that endoscopes were 17 years old and there was a risk of failure during treatment. They were checked pre and post procedure.
- Within endoscopy, we saw evidence of regular maintenance and calibration of the specialist equipment. This included checking the white light balance of each endoscope prior to use. White light balance ensures the clarity of images during endoscopy.
- There was limited storage space on both the wards and the theatre department. We saw equipment being stored in a closed bed space in the theatre recovery area curtained off from view.
- There were two lifts to assist patient movement to the first floor to access the theatre department and the pre-assessment clinic. There was an alarm in the lift to use in the event of a breakdown.

Medicines

- Pharmacy services were available within the hospital Monday to Friday 9am to 3pm.
- There was no official on call arrangement for a pharmacist; however staff could contact the pharmacist out of hours if required. Should the pharmacist not be available there was a contingency plan in place whereby staff would contact the pharmacy department at another BMI hospital.
- All stock medications were ordered from, and delivered, to a location it was required for. The majority of stock was analgesia (pain relief) with a small stock of other medications commonly used by the speciality services within the hospital.
- Administration of medication was recorded on a prescription chart.
- We looked at prescription and medicine administration records for five patients on the ward. We saw appropriate arrangements were in place for recording

the administration of medicines. These records were clear and fully completed. The records showed patients were getting their medicines when they needed them and as prescribed. Records of patients' allergies were recorded on the prescription chart.

- Controlled drugs (CDs) used for patients receiving post-surgical care on the wards and use in theatres were kept in secure cupboards within locked rooms. CDs are prescription medicines that are subject to stricter legal controls under The Misuse of Drugs Act, 2001. We saw accurate records which showed that CDs were routinely administered, and the CD stock counted and checked by two registered nurses.
- The pharmacist delivered all of the controlled drugs who checked them in with a member of the theatre staff.
- The pharmacy team visited all inpatients during their stay, checked the administration chart and all the medications the patient was taking (medicine reconciliation) to ensure correct medication was administered.
- Medicines that required storage at low temperatures were kept in dedicated fridges. Of the two fridges checked, all had the required temperature monitoring sheets completed correctly. The minimum, current and maximum room temperatures were monitored and recorded. We saw temperatures had been consistently and appropriately recorded on the wards and in theatres.
- Non-stock medications were ordered from a pharmacy warehouse with a standard turnaround time of the next day depending on when the drug was ordered which could take up to two days.
- A pre-labelled stock of medication was available for staff to give to patients on discharge.
- One department at a time was audited monthly for medicines management. We saw an audit for the theatre department (October 2016) and the ward area (May 2016). There were actions following the audits such as advising staff to record actions when temperature recording of a drugs fridge is out of range, ensuring the drugs fridge is locked and correct storage of sterile fluids.
- The pharmacy team prepared any additional non-pre-labelled medicine known to be essential for the patient for upcoming elective surgery for tablets to take home (TTOs) when discharged at the weekend.

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- There was no BMI policy for antimicrobial stewardship; however, there was antibiotic prescribing guidance (review 2019) for reference. The pharmacist we spoke with was aware of this and how to access it.
- Antibiotics were routinely prescribed for orthopaedic procedures.
- There was a spare emergency drug box in the theatre department and the ward area. There were 'emergency bricks' available in the event of a patient having a cardiac arrest or anaphylaxis event. These were grab boxes which contained the recommended emergency drugs needed to treat these conditions. Cardiac arrest is a sudden, sometimes temporary stop of the hearts function. Anaphylaxis is an acute allergic reaction which the body has become sensitive to.
- Consultant staff used private prescription pads; these were stored securely and recorded to maintain a record of usage.

Records

- The hospital reported records were always available for patient consultations or treatment during the period October 2015 and September 2016.
- All patient records were in paper format. The hospital does not have any specific digital health facilities.
- We reviewed seven sets of nursing and medical records. Records were legible, accurately completed and up to date.
- Integrated care records for day case surgery and long stay surgery were in use. These covered the entire patient pathway from pre-operative assessment to discharge; they included comprehensive care plans for identified care needs.
- All staff were required to read and accept the BMI information security policies and report any breaches in line with the incident reporting system. Staff told us they signed to confirm they had read the hospitals policies and procedure documents.
- All records were stored securely in locked cabinets or draws. If records were stored in the patients' room this was with the written consent of the patient and recorded in the notes at the time of admission.
- Staff used pre-printed handover sheets and conducted a patient bedside hand over between shifts.
- Risk assessments were completed in each record. These included pressure ulcers, malnutrition and a home environment assessment; this was particularly

important for patients undergoing joint replacement surgery. All clinical risk assessments followed national guidance, for example, the use of a recognised score for the prevention of pressure ulcers.

- Patient records were multidisciplinary and we saw where nurses, doctors and allied health had written in the record.
- There was a data protection policy (next due for review November 2019) and an information security awareness guide (due for review April 2018) for staff to reference. These outlined the processes for sending patients identifiable data via email. Staff told us there was a secure email address which was used to send patient identifiable information to GPs.
- Confidential waste bins were situated in the ward area. We observed staff using these to dispose of confidential information.

Safeguarding

- All clinical staff had completed adult safeguard training to level two. The Director of Clinical Services had completed safeguard training at level three and took the lead for safeguarding. All staff knew who the safeguarding lead was and told us they would always approach them for guidance. Safeguarding training for children has different levels Level one for non-clinical staff, level two which is the minimum level required for non-clinical and clinical staff who have some degree of contact with children and young people and/or parents/carers. Level three is for Clinical staff working with children, young people and/or their parents/carers and who could potentially contribute to assessing, planning, intervening and evaluating the needs of a child or young person and parenting capacity where there are safeguarding/child protection concerns.
- The hospital reported one safeguarding concern in the period October 2015 to September 2016 where appropriate processes were followed which resulted in a referral to the local safeguarding authority.
- All staff had access to the provider's adult safeguarding policies and procedures via their intranet. Safeguarding resource folders were available on the ward; these included flow diagrams to assist staff in following the safeguarding process and help line numbers.
- Staff we spoke with had a good understanding of how to protect patients from harm and abuse. They understood the process and who to refer concerns to.

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Mandatory training

- Mandatory training was mostly completed using an on-line electronic system, although practical sessions such as infection prevention, manual handling and intermediate life support was a face-to-face module taught by a trainer.
- There was an expectation that all staff completed their annual mandatory training. Data provided by the hospital stated staff were 100% compliant with mandatory training requirements. Where training needs were identified but not yet completed for example, a new starter awaiting date for completion training dates were booked or reasons recorded why training was not completed.
- Subjects covered within mandatory training were based on professional need and included information governance, anti-bribery, equality and diversity, safeguarding, documentation, acute illness management (AIM), health and safety, manual handling, waste management, environment management, dementia awareness, infection prevention and control, blood transfusion, resuscitation (basic or advanced) and medical gasses. The hospital had a matrix, which indicated the required frequency of training.
- All staff were allowed two hours each month to complete mandatory and eLearning training.
- Compliance for bank and other contract staff completion of mandatory training was recorded at 93%. Managers recorded the training completion on an electronic system.

Assessing and responding to patient risk

- Patients saw their named consultant at each stage of their patient journey. Patient's needs were assessed throughout their stay and in line with their care pathway.
- A resident medical officer (RMO) was on duty 24 hours a day, seven days a week to respond to any concerns staff may have about a patient's medical condition.
- Surgical procedures were only performed on patients in accordance with the hospital's admission criteria. Anaesthetists and pre-assessment nurses calculated the patient's American Society of Anaesthesiologists (ASA) grade as part of their assessment of patients about to undergo a general anaesthetic. The ASA is a system

used for assessing the fitness of a patient before surgery and is based on five different levels with level one being the lowest risk. Out of the seven records we reviewed all of the scores were documented.

- The pre-operative assessment nurse had direct access and contact details of the consultants and the anaesthetist, so any issues in relation to a patient's condition could be escalated at the pre-operative stage. The hospital only undertook procedures for patients graded as ASA levels one to three.
- A nurse assessed patients in pre-assessment clinics prior to surgery. Any additional information required was communicated to the ward and theatre staff prior to the patient's admission. At the time of our inspection 100% of patients had been pre-assessed.
- The Five Steps to Safer Surgery safety checklist was in daily practice and adhered to the Association of Anaesthetists of Great Britain and Ireland (AAGBI) guidance. Five Steps to Safer Surgery is a surgical safety checklist. It involves briefing, sign-in, timeout, sign-out and debriefing, and is now advocated by the National Patient Safety Agency (NPSA) for all patients in England and Wales undergoing surgical procedures.
- We reviewed sample audits undertaken in theatre, which included a review of the Five Steps to Safer Surgery checklist completion. Results for January 2016 to December 2016 showed the checklist was completed satisfactory in all areas, 100% of the time for eight out of the 12 months, the four remaining months showed a compliance rate between 94% and 99%. Observations during our inspection showed this process was carried out in six out of the seven records we looked at.
- During our observation of the process we saw staff not giving their full attention during the completion of the checklist. We saw staff setting up an infusion device, a surgeon continuing to prepare and talk to the patient during the 'time out' stage.
- Information following an investigation of a never event demonstrated a lack of adherence to procedure of the safety checklist. This involved a theatre team administering an anaesthetic to a patient in preparation for their operation without a consultant surgeon being present in the department. We alerted the hospital management team of our findings and they told us they would review this.
- There was a separate Five Steps to Safer Surgery safety checklist for patients undergoing cataract procedures. This was in line with NPSA guidance.

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- There were policies in place to manage the deteriorating patient including monitoring the acutely ill adult patient with potential to deteriorate (under review), an emergency transfer of patient's policy (review July 2018) and a flow charts for the transfer of patients to theatre and the critical care/high dependency unit in an adjoining acute hospital. All staff we spoke with were aware of the transfer flow chart and policy.
- Processes and service level agreements were in place to transfer patients to an adjacent acute hospital if their condition deteriorated.
- We reviewed staff files and saw evidence of completed and on-going competencies. However, we found three out of 12 staff had not completed the acute care clinical competencies as recommended in the action plan following a serious untoward incident. There seemed to be no reliable system to monitor and have oversight of the paper based system. Senior management told us they would address this and ensure all staff would complete these.
- The hospital used a system to record routine physiological observations such as respiratory (breathing) rate, blood pressure, temperature and pulse in order to monitor patient's physical condition. The hospital used the national early warning scores (NEWS) as recommended by the Royal College of Physicians (RCP) throughout the ward and in theatre recovery to monitor patients and identify when their condition may be deteriorating. This ranged from increasing the frequency of observations to an urgent review by the patient's consultant or their anaesthetist. Early warning scores have been developed to enable early recognition of a patient's worsening condition by grading the severity of their condition and prompting nursing staff to get a medical review at specific trigger points.
- Within theatre recovery, NEWS commenced as the patient woke from their anaesthetic and observations were undertaken before the patient returned to the ward.
- There was a 'recognition and management of sepsis' policy (due for review August 2017) which included a sepsis care pathway which staff were aware of. Sepsis is a severe infection that spreads in the bloodstream. Staff told us they would alert the RMO if there was any deterioration in a patient's condition and administer prescribed treatment as required.
- The patients named consultant managed medical input. We were told of a patient who had been assessed prior to surgery who required a medical opinion, the RMO referred this case to the named consultant who arranged for further assessment to be undertaken.
- There was an admission, patient selection or exclusions policy.
- A hospital policy was in place for the emergency management of cardiopulmonary resuscitation this was in line with national guidance.
- An anaesthetist remained on site at all times when patients were in the recovery room post operatively.
- On discharge, staff gave patients a comprehensive discharge booklet which was specific to the surgery they had undergone. This contained the contact details for the hospital so they could call if they experienced any problems. Staff told us if patients did contact the ward following discharge with problems or for advice they would speak to the RMO or pharmacist. Staff recorded advice and conversations in a folder and documented these in the patients' notes.
- A supply of blood was available by local arrangement with the adjoining NHS hospital for use in an emergency. Patients undergoing specific surgery, for example hip and knee replacement, were grouped and saved to allow cross matching in a timely way if blood was needed.
- A small proportion of surgery was cosmetic. A senior staff member told us the consultant would manage their patients from admission to discharge allowing for a 'cooling off' period and refer for any psychological assessment prior to surgery. A 'cooling period' is an agreed length of time in which someone can decide on whether to proceed with surgery or not. This is in line with nationally accepted best practice.
- There was a policy in place should a patient experience a major haemorrhage (a major haemorrhage is an excessive blood loss which can be life threatening). These included a massive haemorrhage procedure (due for review May 2017) with a flow chart for staff to reference.
- There was a 'block box' used in theatre which contained the required equipment needed and 'stop before you block' information within it. Staff marked the site of the block after the patient was in theatre. Each time staff moved or repositioned a patient, staff repeated the 'stop before you block'. 'Stop before you block' is a National Patient Safety Agency (NPSA) initiative aiming

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to reduce the incidence of wrong sided-nerve block during regional anaesthesia. This practice was the result of action recommended following a never event at the hospital.

- There was an on-call theatre team available every day.
- There was a pre-operative assessment policy (review 2018). This included information related to roles and responsibilities of different grades of staff, training, the process, documents and record keeping.

Nursing and support staffing

- Staffing levels were calculated according to the number of patients on the ward at any one time. The number of patients to planned staffing numbers were as follows, a ratio of six patients required one registered nurse, nine patients required one registered nurse and one health care assistant (HCA), and 12 patients required two registered nurses and one HCA. Patients requiring a higher level of supervision or one to one nursing care had their healthcare needs assessed on a shift-by-shift basis and staffing levels were adjusted in line with their needs.
- The hospital used the corporate (BMI) approved nursing dependency and skill mix tool 'safer levels of nursing care' (SLNC) based on National Institute for Health and Care Excellence (NICE) guidance. The management used the tool when planning staffing requirements five to ten days in advance; these were reviewed daily by a senior nurse.
- The ward manager calculated staffing levels on a two weekly basis, checked and adjusted following the weekly capacity meeting and daily as required depending on changes and or patient requirements.
- Staff turnover for the reporting period October 2015 to September 2016 was 23.7% for inpatient nurses. There was no staff turnover for health care assistants (HCA's). Staff turnover refers to the number or percentage of staff who leave an organisation and are replaced by new employees.
- Within the inpatient departments, there was an establishment of 6.5 Whole Time Equivalent (WTE) registered nurses and 1.4 WTE health care assistants (HCA). As of January 2017 inpatient staffing vacancies was one registered nurse.
- The hospital employed bank staff to fill vacant shifts and agency staff as required in accordance with the SLNC

tool. The ratio of bank to agency use for the period July 2016 to September 2016 was 12 bank nurses to one agency nurse. No agency HCAs were employed during this period.

- Staffing levels in theatre were calculated using the Association for Peri-operative Practice guidance (AfPP) which required a minimum of two scrub practitioners, one circulating staff member, one registered anaesthetic assistant practitioner and one recovery practitioner. We reviewed theatre staffing allocation sheets and staff off-duty which confirmed the required staffing used.
- As of October 2016 within the operating theatre department there was an establishment of one WTE registered nurse. There were eight support staff within the operating theatres consisting of five operating department practitioners (ODPs) and four HCA's. All theatre practitioners were on the register of health and care professionals (HCPC). In addition, there were two bank theatre practitioners working within the department as required. In addition there was a further two contracted full time Theatre Practitioners (Registered Nurses) and three bank Theatre Practitioners.
- All staff received a two-week hospital induction where they were supernumerary. Supernumerary means they were in addition to the ward staff numbers. New starters completed all of the recommended e-learning, read policy documents and familiarised themselves with the general ward duties under the supervision of a mentor. We saw evidence of staff files with completed mandatory competencies and on-going learning.
- We saw evidence of repeated training for an acute illness management course (AIMS) following a recommendation from an incident investigation. All of the registered nurses had completed this course.
- Department leaders had a minimal patient caseload to allow for unpredictable or unplanned events and so they could support nursing staff where required.

Medical staffing

- There were two resident medical officers employed for the hospital through a corporately agreed agency. These doctors were selected on their relevant experience into managing the types of patient within the hospital. They were required to have up to date Adult Advance Life Support certification.

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- A Resident Medical Officer (RMO) provided 24-hour medical and surgical cover for all patients. Processes were in place to ensure the RMO received adequate rest.
- If a patient was required to return to theatre out of hours because of complications, an on-call system was in place to notify staff quickly.
- As of October 2016, there were 63 consultants who had been granted practising privileges with more than six months service in post at the hospital. 'Practising privileges' is a term used in legislation and defined in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 as 'the grant, by a person managing a hospital, to a medical practitioner of permission to practise as a medical practitioner in that hospital'.
- It was a requirement of BMI healthcare's practising privileges policy for all surgeons and anaesthetists to remain available by telephone or in person at all times when they had patients within the hospital. For the period October 2015 to September 2016, 13 practising privileges had been removed due to retirement, relocation or other commitments; none had been suspended or required supervised practice.
- There were systems, processes and standard operating procedures to support effective handover between the RMO, consultants and other clinical staff. They were reliable and appropriate to keep patients safe.
- Consultants visited in-patients at least once every 24 hours and were available via telephone 24 hours a day, seven days a week whilst they had patients in the hospital. Staff we spoke with told us the consultant could attend within 30 minutes of being called. If they planned a period of absence a fellow consultant would be identified to cover.
- Nursing staff informed us they had no difficulties in obtaining help quickly if it was needed to review a patient's care. We saw evidence of a consultant contact list which was up-dated and circulated every time there was a change. Staff were aware of this arrangement.

Emergency awareness and training

- There was a comprehensive business continuity plan in place. It detailed how staff should respond to, for example, loss of heating, loss of gas, adverse weather conditions, lift breakdown and bomb threat. The document contained useful contacts with telephone numbers and most staff knew how to access these if required.

- Routine fire drills took place, this allowed staff to rehearse their response in the event of a fire. Staff we spoke with told us there had been a fire evacuation drill the day before our inspection.
- Fire evacuation plans were visible and accessible for all staff at the nurses' station. Staff we spoke with knew where the fire exits were and what they had to do.
- Staff told us there was an emergency generator back-up system for the hospital; however, the lifts could not operate with the generated power. The business continuity plan included staff action cards to use in the event a passenger lift failed with a person in it. Most of the staff knew how to access the business continuity plan but were not aware of this information.

Are surgery services effective?

Good 

We rated effective as good.

Evidence-based care and treatment

- Theatre provision followed guidance from the Royal College of Anaesthesia for the provision of anaesthetic services which included an appropriately trained and experienced anaesthetist throughout all general and regional anaesthetics.
- Care and treatment was delivered to patients in line with National Institute of Health and Care Excellence (NICE) and Royal Colleges guidelines, for example the Royal College of Surgeons. Staff assessed patients for the risk of venous thromboembolism (VTE) and took steps to minimise the risk where appropriate, in line with venous thromboembolism: reducing the risk for patients in hospital NICE guidelines [CG92]. The hospital followed NICE guidance for preventing and treating surgical site infections (SSI) NICE guidelines [CG74].
- Reducing the risk of venous thromboembolism (VTE) was part of the care pathway for major operations. This included the use of anti-embolism stockings and medical prophylaxis. Prophylaxis is a treatment or medicine designed and used to help prevent a disease from occurring. Patients who had received a planned hip or knee operation for example had this in place.

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- Surgeons only performed operations they carried out at the NHS acute trusts where they were employed. This ensured they were competent and confident in undertaking the procedures.
- A comprehensive care record was in place for all patients who were either day case surgeries or overnight with a length of stay of 24 hours or longer. This included the Malnutrition Universal Screening Tool (MUST), pressure sore assessment and falls risk assessment. Pathways also included anaesthetic room care, surgical safety checklist, theatre notes including traceability recordings, theatre notes and post-operative care. Out of the seven records we reviewed all elements were completed. MUST is a five-step screening tool to identify adults at risk of undernutrition or obesity.
- During our inspection, we reviewed five different policies and procedures these were a mixture of paper and electronic based. We found them all to be up to date. This demonstrated that patients were receiving evidence based care and following current guidance.
- The hospital undertook endoscopies. The unit was not Joint Advisory Group (JAG) accredited for endoscopy procedures due to the decontamination of the equipment not being carried out on site. The JAG Accreditation Scheme is based on the principle of independent assessment against recognised standards. It was developed for all endoscopy services and providers across the UK in the NHS and Independent Sector.
- Local audits were undertaken; these included patient health records, consent, hand hygiene, controlled drugs and infection prevention and control. CDs are prescription medicines that are subject to stricter legal controls under The Misuse of Drugs Act, 2001.
- There were evidence based care bundles in place which included prevention of surgical site infections, peripheral intravenous cannula and urinary catheter care. A care bundle is a structured way of improving the process of care and patient outcomes based on the most recent evidence.

Pain relief

- Staff discussed pain management with patients as part of the pre-assessment process and staff implemented any actions following this. Patients were provided with a

booklet 'your guide to pain control' which included general information about pain relief before and after surgery, important questions before you go home, alternatives to medication and types of painkillers.

- Staff recorded the patients' pain using a scale of one to three as part of the NEWS chart. A score of three was severe pain, two was moderate, one was mild pain and nought indicated no pain. The resident medical officer (RMO) reviewed this and prescribed analgesia (pain relief) as required. We observed a member of staff assessing a patient's pain and re-assuring them in their response.
- We observed staff regularly reviewing patients' experience of pain in the recovery area post-surgery. Staff administered pain relief as prescribed and evaluated its effect.
- The hospital used a number of different medicines for relieving pain post-operatively dependent upon the surgery. Information about the medicine prescribed, including how to use it and any side effects was given to patients.
- The pharmacy team reviewed and advised staff and patients on pain management. We saw evidence of pharmacy reviews of the medication record.
- The hospital's patient satisfaction survey during the period June 2016 and August 2016 showed 96% to 97% of patients thought staff did everything they could to control their pain.

Nutrition and hydration

- A nutritional assessment (MUST) was completed for all patients admitted for surgery. This assessment was repeated daily until a patient is discharged. Out of all of the records we reviewed all had completed nutritional assessments. MUST is a five-step screening tool to identify adults, who are malnourished, at risk of under nutrition, or obese.
- Staff followed guidance on fasting prior to surgery which was based on best practice. This permitted healthy patients requiring a general anaesthetic to eat up to six hours prior to their surgery and to drink water up to two hours before.
- There was a fasting before anaesthesia policy (due for review June 2019), staff we spoke with were aware of this.
- We saw anaesthetic staff prescribing medication to ensure effective management of nausea and vomiting should this occur.

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- After surgery, there were accurate and complete records to show fluid intake and output was monitored. Where there were concerns we saw nurses followed protocol and scanned patients' bladders, seeking medical advice as needed, to prevent post-operative urinary and kidney dysfunction.
- The ward kitchens had sufficient food stocks to enable staff to supply sandwiches, soup, toast and cereals if patients were hungry at any time.
- Staff told us they could refer patients to a dietician through the named consultant if this was required.
- Water jugs were available to all patients in their rooms. We saw and patients told us these were changed regularly.
- The hospital's patient satisfaction survey during the period June 2016 and August 2016 showed 93% to 94% of patients satisfied with the provision of catering services.
- There were no reported readmissions within 28 days of discharge. Hospitals are required to measure emergency readmissions within 28 days of discharge from hospital following admission for selected conditions such as knee and hip replacements.
- The hospital reported two unplanned returns to the operating theatre for the period October 2015 to September 2016.
- Regular meetings with the Clinical Commissioning group (CCG) took place where patient outcomes were discussed based on finding of the Standard Acute Contract (SAC) audit. We saw meeting minutes for April 2016 and September 2016 which included agenda items such as BMI The Sandringham Hospital performance, quality, contract negotiations, finance and quality schedules.
- The hospital collected the data for the breast implant registry to register compliance.
- We saw evidence of an audit schedule for 2016 which included 13 internal audits including consent, hand hygiene, medical records, blood transfusion, pain management, controlled drugs and same sex accommodation. We saw evidence (March 2016) of an action plan from a consent audit outlining actions to be taken, with the identified person responsible for completion, target and completion date.
- BMI The Sandringham Hospital submitted data to the Private Healthcare Information Network (PHIN) in accordance with legal requirements regulated by the Competition Markets Authority (CMA). PHIN is an independent, not-for-profit organisation that publishes trustworthy, comprehensive data to help patients make informed decisions regarding their treatment options, and to help providers improve standards.
- Record keeping audit provided by the hospital demonstrated from January 2016 to September 2016 there was between 81% and 92% compliance for completion of the patient health record. This included the recording of items such as notes security, completion of the GP details, address and next of kin information.
- The BMI group aimed for patient's average length of stay for hip and knee replacement surgery to be no longer than 3.5 days. Total average length of stay for hip and knee surgery for the BMI The Sandringham for July 2016 was 2.3 days respectively.

Patient outcomes

- Patient reported outcome measures (PROMS) for hip and knee replacements (NHS patients only) for the period April 2015 to March 2016 were within the estimated range and the England average.
- Patient reported outcome measures (PROMS) for groin hernia repair (NHS patients only) for the period April 2015 to March 2016 were within the estimated range and the England average.
- The hospital was undertaking three locally developed commissioning for quality and innovation (CQUIN) in 2015/16. These included the use of the Edmonton Frailty Tool, National Early Warning Scores (NEWS) and pain management. The Clinical Commissioning Group (CCG) awarded a partial achievement at Quarter four. A CQUIN is a payments framework and encourages care providers to share and continually improve how care is delivered and to achieve transparency and overall improvement in healthcare. For the patient this means better experience, involvement and outcomes.
- There were six unplanned transfers of patients to other hospitals during the period October 2015 to September 2016. This was not high when compared with other independent acute hospitals and was consistently a low rate per 100 inpatient and day case attendances in this reporting period. All unplanned transfers were reported as incidents, investigated and actions taken to prevent a reoccurrence.

Competent staff

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- Data provided by the hospital for the period October 2015 to September 2016 showed all substantially employed qualified staff and health care assistants (HCA's) at ward level had completed annual appraisals. However, the operating department showed a rate of 80% completion against a hospital target for completed appraisals of 100%
- Two operating department practitioners had completed the Surgical First Assistant (SFA) training, an additional two staff commenced training in December 2016 and two further staff members were due to start the training in February 2017. Staff were required to complete competency folders for the Association for Perioperative Practice (AfPP), we saw evidence of two completed files. A surgical first assistant works closely with the surgeon to facilitate the procedure and process of surgery. They undertake classroom and on the job training before being deemed competent.
- Nursing staff undertook further competency-based training to ensure they had the relevant skills to care for patients. There were two systems for recording and monitoring staff training and their competencies. Mandatory training records were held electronically and clinical competencies were recorded on a paper based system in each staff folder.
- Staff were positive about access to further training and development courses. Courses were available externally or online.
- New staff were supernumerary (treated as additional staff) for two weeks and went through a probationary period and induction process. New staff induction included orientation to the environment, policies and guidance, equipment competencies and mandatory training completion. All staff required a signatory sign-off by senior nursing staff.
- We saw evidence of equipment competencies completed for all ward staff.
- The management team supported the nursing staff through revalidation. We saw evidence of nursing staff undertaking the revalidation process and the theoretical support which had been in place. Revalidation is a mechanism for doctors, nurses and midwives practising in the UK to prove their skills are up-to-date and they remain fit to practise.
- Staff told us staff they had attended an additional course, Acute Life-threatening Events-recognition and treatment (ALERT) for early detection and treatment of the deteriorating patient.
- The Resident Medical Officer (RMO)
- The RMO received an induction by the BMI The Sandringham Hospital and a specific role induction by the other RMO.
- Nursing staff across the service told us they did not have formal line management or clinical supervision but felt they were able to contact senior members of staff for help and guidance at any time. A formal clinical supervision strategy had been tried previously but staff preferred to have a more informal approach to discuss with peers and senior members of staff as required.
- All bank staff undertook an induction and completion of all mandatory training. We saw evidence of bank nurse competency files of completion of the training.
- The hospital provided the staff with a 'continuity of care pocket book'. Some of the information included was hand hygiene, safeguarding, whistleblowing and infection management.

Multidisciplinary working

- A multidisciplinary team (MDT) approach was evident throughout the service. There was effective daily communication between multidisciplinary teams within the ward and theatres. Staff told us they had a good relationship with consultants and the resident medical officer (RMO).
- Patient records showed there was routine input from nursing and medical staff and allied health professionals, such as physiotherapists.
- Physiotherapists offered treatment to patients both before and after joint surgery. They ran an enhanced recovery programme which was a dedicated programme of rehabilitation offered to all inpatients following hip and knee surgery. This programme provided a personalised rehabilitation and individual goal setting.
- We observed multi-disciplinary team working in theatres. We saw the theatre staff worked effectively together with the surgeon and the anaesthetist.
- When patients were discharged, the hospital worked well with external services. Staff sent a letter electronically to the patient's GP to inform them of the treatment and care provided.
- The pharmacy team gave all medications on discharge which were sent to the GP on the discharge letter. The pharmacy team discussed with the patient and carers the discharge medications.

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- We observed a multi-disciplinary meeting to discuss a patient's increased care requirements for discharge post joint surgery. The physiotherapist liaised with a community care service to enable a safe discharge for the patient.

Seven-day services

- Surgery was performed Monday to Friday 8am to 6pm, and alternate Saturdays 8am to 4pm.
- Consultants practising within the hospital were responsible under practising privileges for care of their patients 24 hours a day, seven days per week.
- There was a resident medical officer (RMO) in the hospital 24 hours a day with immediate telephone access to on-call consultants.
- There was an on-call rota for key staff groups, including theatre staff, senior managers, radiology and nursing staff.
- Physiotherapy services were available seven days per week.
- There is no documented on-call arrangement for radiologists. For cases requested out of hours the appropriate radiologists were contacted for availability and authorising of requests.

Access to information

- There were comprehensive, paper based, integrated care records for each patient. These included evidence based risk assessment tools, multi-disciplinary evaluation notes, observation charts, anaesthetic and theatre records. This enabled consistency and continuity of record keeping throughout the patient's stay, supporting all staff to deliver effective care.
- Staff had access to information they needed from electronic and paper based sources such as policies, incident reporting forms, test results and medical records.
- There were computers available on the ward and the theatre areas, which gave staff access to patient and hospital information for example standard operating procedures (SOP's). Staff told us that these were limited and often had to wait to use them.
- Images, for example x-rays were available for use by theatres during operations.
- Staff gave all patients a discharge folder that contained a contact card for the ward, copy of their consent form, appointment card, and any other relevant information.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- There was a consent policy (due for review September 2016) available to staff electronically.
- Following a never event a two stage consent process was introduced. We found all patients were consented on at least a single occasion, however the two stage process was not robustly implemented.
- Staff told us patients consented for surgical procedures using a two stage consent process which was a recommendation following a never event. Patients completed the consent form confirmed with their consultant during outpatients appointments, this allowed time to consider the procedure planned before admission. On the day of surgery, a qualified member of the healthcare team reviewed this information with the patients and signed to confirm it was correct. We reviewed seven consent forms four were not compliant with the two-stage consent process. Data from a consent audit for September 2016 and December 2016 demonstrated that on 11 out of 20 occasions the stage two consent process was not completed.
- We observed good checking processes of a patient's identification prior to going into theatre.
- We saw a policy for Deprivation of Liberty Safeguards (DoLS) and Mental Capacity Act (MCA) 2005 (review 2018). Staff were aware of how to access this. DoLS is part of the Mental Capacity Act 2005 which aims to make sure people in such places as care homes and hospitals are looked after in a way that does not inappropriately restrict their freedom.
- Staff we spoke with had received training about consent and the Mental Capacity Act 2005 (MCA). Staff stated if they had concerns about a patient's capacity they would refer the issue to a senior member of staff. Senior members of staff were aware of their responsibilities under the Mental Capacity Act 2005.
- Staff told us patients who may lack capacity to make an informed decision about surgery were extremely rare. Any difficulties would be identified at the pre-admission assessment and if any consideration was needed this would be undertaken at this stage.
- Staff were aware of the hospital policy on consent. Consent was sought from patients prior to the delivery of treatment. We found, one consent form referred to

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operation risks in abbreviations and the term 'etc' was used. General Medical Guidance (GMC) states that information must be given in terms the patient understands.

- The policies for the resuscitation of patients and 'Do Not Attempt Cardiopulmonary Resuscitation' (DNACPR) decisions were clear (review December 2016). Unless otherwise stated, all patients who had a cardiac arrest were to be resuscitated.
- During our inspection there were no patients requiring Deprivation of Liberty Safeguards, Mental Capacity assessments or

Are surgery services caring?

Good 

We rated caring as good.

Compassionate care

- Patient satisfaction dashboards were displayed in public areas. These gave a snapshot of information relating to questions asked about the arrival process, consultants, nursing care, accommodation, catering, the discharge process, quality of care and patient expectations. We saw copies from October 2015 to September 2016 which demonstrated an 80% trend of excellent care for this period.
- A BMI inpatient postcard questionnaire was given to inpatients and those attending as day cases. We looked at 12 feedback cards from patients on the ward during our unannounced inspection. All stated the care they received was excellent and all would recommend BMI The Sandringham to friends and family.
- We looked at 45 Care Quality Commission 'Tell us about your care' cards for the inpatients ward and. All, without exception were very positive about the care they received at BMI The Sandringham Hospital.
- Staff ensured confidentiality and privacy by knocking before entering a patient's room and kept the door closed while providing care. We observed staff introducing themselves when they met a patient for the first time.
- We saw patients' bed curtains were drawn and doors closed when staff cared for patients on the ward and in the theatre and recovery area. A light was used outside of each room when a member of staff was providing care to a patient. This was a further measure used to maintain patient's privacy and dignity and to inform other staff care was being carried out and they should not be disturbed.
- We observed patients remaining covered in the anaesthetic room, operating theatre, recovery areas and during transfers between the ward and theatre areas for their dignity.
- Dignity and respect featured highly at the BMI The Sandringham Hospital. Patients were treated with kindness, dignity, respect and compassion. Patient feedback scores for the question 'are you treated with respect and dignity' averaged 100% for the period from June 2016 to August 2016. Staff told us they received feedback related to patient satisfaction; we saw evidence of this in the ward meeting minutes.
- We observed the bedside handover; staff closed each room door during each patient handover to ensure privacy of confidential information. Any visitors present were asked to leave until handover was completed unless the patient gave permission for information to be shared.
- An example of compassionate care was provided where a patient had experienced a traumatic event in the past, and was anxious when attending a pre-assessment clinic. A porter and ward clerk spent time reassuring the patient and both ensured they were on shift when the patient was admitted, they remained on duty longer than planned and provided support throughout the admission.
- Friends and Family test results provided for the period April 2016 to September 2016 showed 98% of those responding to the question 'would you recommend the service to family and friends' answered yes. The response rate averaged 67% of patients attending for treatment.
- Of the four patients we spoke to without exception, all were impressed with the level and quality of care they had received. Comments were 'care could not have been better'; 'everyone did their best to make my stay as comfortable as possible' and 'nursing care brilliant'.
- We observed a physiotherapist compassionately talking with and encouraging a patient to stand and walk following joint surgery.
- Theatre staff offered a patient their choice of music to listen to whilst undergoing surgery under a local anaesthetic. A local anaesthetic affects a restricted area of the body.

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- We observed a member of the nursing staff discussing with a patient their pain relief management in a sympathetic manner.

Understanding and involvement of patients and those close to them

- Patients and relatives told us they felt involved in their care. They told us they received full explanations of all procedures and the care they would need following their operation. The hospital's patient satisfaction survey, for the period between June 2016 and August 2016 showed 100% of patients said they were involved as much as they wanted to be in decisions about their care and treatment. We observed staff explaining to patients exactly what would happen after their operation and we saw examples of written information was given to patients to take home, such as information about using eye drops following cataract surgery.
- Patient records we looked at included pre-admission and pre-operative assessments; these took into account individual patient preferences.
- Discharge planning was considered pre-operatively and discussed with patients and relatives to ensure appropriate post-operative caring arrangements were in place.
- Staff were clear about the risks and benefits of the planned treatment and patients understood how their recovery would progress. We saw evidence of a physiotherapist giving information to patients in the pre-assessment process the expectation of a two day stay post joint surgery.

Emotional support

- Staff in all areas showed sensitivity and support to patients and understood the emotional impact of them having to be admitted for surgery.
- We observed staff giving reassurance to patients. For example, we witnessed staff encouraging a patient as they mobilised following joint surgery.
- Patients told us the staff were understanding, calm, reassuring and supportive and this helped them to relax prior to undergoing surgery.
- We saw a nurse offer re-assurance to a patient following joint surgery.

Are surgery services responsive?

We rated responsive as good.

Service planning and delivery to meet the needs of local people

- BMI The Sandringham Hospital had two operating theatres carrying out elective (planned) surgery. The top five operations performed for the period October 2015 to September 2016 were phacoemulsification of lens implant (cataract surgery) 431, arthroscopy on the knee (key hole investigation or surgery) 175, hip replacement 145, hernia repair 118 and knee replacement surgery 110.
- The provider was registered with various insurance companies, providing access to treatment for patients who had private healthcare insurance. Additionally, patients could opt to pay for treatment themselves. Information provided demonstrated 64% of patients were from the NHS, 25% were funded by private healthcare insurance and 11% of patients were self-pay.
- The hospital had a policy, which outlined the inclusion and exclusion criteria for patients. Patients with an American Society of Anaesthesiologists (ASA) physical status score of four or greater were not treated. The patients admitted to the hospital had an ASA score of one to three. Patients admitted had a low risk of complication and their post-surgical needs could be met through ward-based nursing care.
- There were a number of service level agreements in place for services required to support the hospital for example the provision of Magnetic Resonance Imaging (MRI) and Computerised Tomography (CT) scans by an external provider.
- There were no facilities for emergency admissions; commissioners and the local NHS trust were aware of this.
- Patients had an initial consultation to determine whether they needed surgery, followed by pre-operative 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.
- The admission process and care provided was the same for self-funded patients and NHS patients.

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Access and flow

- Each week there was a planning meeting chaired by the Director of Clinical Services where the next four weeks admissions and theatre cases were discussed to ensure all the requirements for each individual patient were available. We observed this meeting which was attended by theatre and ward, physiotherapists, radiographers, process leads and booking staff to ensure a holistic approach was achieved with patient care.
- For the period October 2015 to September 2016 BMI The Sandringham Hospital had 2061 patients who attended the operating theatre of which 1525 patients attended for day case procedures.
- Two patients had an unexpected return to the operating theatre and six patients required unplanned transfers to another hospital. The hospital had a service level agreement (SLA) with an adjacent NHS acute hospital to facilitate transfer for specialist care if needed.
- The hospital reported nine cancelled procedures for the period October 2015 to September 2016. All patients were offered another date within 28 days of the cancellation.
- The hospital had a framework for managing NHS-funded elective access to consultant-led care and treatment, which was set out in a Referral to Treatment (RTT) Access Policy. RTT is a key target for NHS-funded patients, stipulating that no patient should wait longer than 18 weeks. For the period October 2015 to September 2016, 90% of NHS patients were admitted for treatment within 18 weeks. This did not quite meet the national (admitted) target with 94% of NHS funded patients being treated within 18 weeks from referral.
- The nature of the private work at the hospital enabled choice for patients in respect of when they choose to access treatment. There were no waiting lists and patients were given a 'cooling off' period following consultation based on clinical need or urgency of the surgery required.
- There was a dedicated on-call theatre team for emergency surgery and returns to theatre consisting of theatre practitioners, Operating Department Practitioners (ODPs) and a recovery nurse.
- There were staggered admission times for surgery. This meant there was a reduction in patients waiting times for surgery.
- Low occupancy rates on the ward meant patients who needed to have an extended length of stay because they were not fit to go home could do so.
- There was a 24 hour on-call service with the response of attendance by a consultant within 30 minutes of the call.
- Admission, transfer and discharge of patients from the ward and theatres were managed appropriately. The patients we spoke with did not have any concerns in relation to their admission, waiting times or discharge arrangements.
- Discharge tablet packs were available on the ward for the use of out-of-hours discharge.
- A central booking team managed the process of admission following a patient's visit to their consultant, which ensured a seamless process.
- There was a current discharge policy. Staff gave patients a discharge summary to take home which was also electronically sent to the patients GP.
- Patients undergoing joint surgery were part of the enhanced recovery programme. This involved setting patient expectations for a two day discharge and identifying any needs pre-operatively. Therapy goals were set for each post op day and the patient was discharged on the second day with a follow up rehabilitation class a week later for a knee replacement and four weeks later for total hip replacement surgery.

Meeting people's individual needs

- Dates for surgery were discussed with patients at their initial outpatient appointment. Patients were able to choose to have their operations at times suitable for them.
- Nursing staff recorded information on patients' additional needs during the patient's pre-assessment, for example the ability to understand reading and writing. They gave patients information leaflets about their planned procedure or treatment during their appointment or the hospital sent the leaflets to patients with their outpatient appointment letter. The patient information leaflets were written in English only. We did not see provision made available for patient information leaflets in large print and formats other than written English.
- The hospital had no clear written policy or treatment criteria for people with a learning disability. The hospital had recognised the increase in patients living with dementia and were in the process of supporting these

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patients. For example, there was a blue coloured toilet seat in the outpatients area. However, the ward area had no additional facilities specifically for patients living with dementia.

- There were specific questions related to patients living with dementia in the patients care record.
- For patients whose first language was not English, telephone and face to face interpreting facilities were available. However, there was no information on general display related to the availability of interpreting services.
- If there was a delay in a patient going to theatre this was communicated to the nursing staff, communicated to patients, documented in the care record and patients were given fluids accordingly. Menus to meet the needs of different cultures were available on request.
- There was disabled access on the ground floor and in the pre-assessment area, and a lift to the first floor.
- Patients received sufficient information prior to their planned surgery. They were provided with both verbal and written information to ensure they understood the planned procedure and had clear expectations about their admission to hospital. Risks were explained to them.
- A digital video disc (DVD) was given to all hip and knee surgery patients to inform them of what to expect before and after surgery and to remind them of the exercises they need to undertake. Patients we spoke with had received this at the pre-assessment clinic and told us how useful they and their carers had found it.
- The pharmacy team saw all inpatients Monday to Friday to offer any advice or guidance required.
- The patients we spoke with commented positively about the food. The hospital provided three meals a day for in-patients. There was provision for patient with special dietary requirements.
- Large font medication labels and instructions on taking medications were available for patients who had undergone eye surgery.
- A medication summary was supplied for all patients who had received joint surgery if this was needed.
- The hospital had a chaperone policy in place. A chaperone is a person who accompanies a patient during an examination, for example a female would be accompanied by a female member of staff when being examined by a male member of staff. Staff we spoke

with told us every time a chaperone was required they were asked to assist. We observed a member of staff offering to chaperone a patient who was being seen by a consultant.

- All patients were cared for in individual rooms with private en-suite facilities, which helped maintain their privacy and dignity.
- Larger patient bedrooms were available for relatives to stay with patients if they wished.
- Patients were able to telephone the ward after discharge, for further help and advice on their return home.

Learning from complaints and concerns

- How to complain leaflets were included in information folders in the patients' room, these were also available in the ward and outpatient's areas. All information was in English only.
- Staff were aware of the advice to give to patients who expressed the wish to complain.
- A report provided by BMI The Sandringham Hospital for the period October 2015 to September 2016 showed 29 complaints received, of these 13 related to surgical services, two complaints were general in origin.
- Analysis of complaints was completed. The majority of complaints related to communication/information provided to patients and charges for treatment.
- There were policies and procedures in place relating to complaint handling. This included ensuring all complaints were logged and reported. BMI complaints policy required a written acknowledgement within 48 hours and a written response within 20 working days.
- No complaints within this period were referred to the independent advisory service.
- The executive director was responsible for overall management of complaints. If the complaint related to clinical care, the response was overseen by the director of clinical services or clinical lead.
- We reviewed the handling of two surgical complaints. We found timely responses were provided and apologies extended to patients where required. However, one complaint response to a relative included confidential information regarding the patient without consent from the patient being obtained. In another example consent had been obtained from the patient before responding to a relative, so inconsistent practice was followed.

Surgery

Are surgery services well-led?

Good 

We rated well-led as good.

Leadership / culture of service related to this core service

- The executive team at BMI The Sandringham Hospital included an executive director (ED) who was the registered manager of the service, supported by a director of clinical services and a director of operations. At the time of our inspection the director of operations was a vacant post to be recruited into. The director of operations was responsible for administration and the support services for example catering, reception, housekeeping and porters. The senior management team shared these responsibilities until the position was recruited into. The director of clinical services oversaw theatres, the wards, physiotherapy, pharmacy and the diagnostic services. The executive team reported to the regional management team of the BMI organisation.
- The operating department was overseen by the theatre manager, who was also responsible for sterile services. The nurse manager was in charge of the wards, outpatients department and pre-assessment.
- There was a sense of friendliness and companionship within all grades of staff.
- There was a culture of pride across all staff groups. Senior managers spoke very highly of the care provided and there was mutual respect between medical and nursing staff. One member of staff told us 'family members have had treatment at the hospital and were very happy with the care provided'.
- All of the department leaders we spoke with said they were proud of their team.
- Staff we spoke with told us they felt able to speak out and there was a culture of openness within the hospital.
- All staff spoke positively about the director of clinical services and the executive director and commented they feel listened to. The executive director held informal, monthly sessions for staff to ask questions and find out information.

- There was a long service award scheme and an employee of the month. Staff we spoke with spoke positively of these. Two staff members told us they had both been awarded employee of the month recently.
- Staff told us the senior managers walk around the departments regularly and are accessible and approachable.
- Staff told us the organisation reimbursed them for attending hospital meetings in their own time.
- The hospital paid for staff car parking permits.
- The BMI group offered the heads of department to attend national groups to offer support, share practice and ideas. We spoke with several managers who found these beneficial and worthwhile.
- Staff we spoke with told us they felt supported by the senior management team. They told us they found the monthly staff forums run by the Executive Director informative and useful, they felt able to ask questions, felt listened to and involved.

Vision and strategy for this this core service

- The BMI group vision was 'We aspire to deliver the highest quality outcomes, the best patient care and the most convenient choice for our patients and partners as the UK leader in independent healthcare'.
- The local BMI The Sandringham Hospital vision was 'by delivering a consistent level of high patient care and optimum clinical outcomes, we will be the local hospital of choice.' Staff we spoke with were aware about the corporate and local vision for the hospital.
- There were financial plans in place or under development to improve the estate and hospital facilities. These included a rolling replacement of all non-clinical sinks, the removal of carpets in all clinical areas and options to purchase and replace endoscopic equipment in theatres. All of these were projects which were on the hospital risk register. Information provided demonstrated that quotes were being obtained for the purchasing of the endoscopic equipment and the replacement programme had a phased integration.

Governance, risk management and quality measurement

- There was a clear governance structure in place with committees such as clinical governance, senior management and heads of department feeding into the medical advisory committee (MAC) and hospital management team.

Surgery

- There was an established clinical quality, governance and risk management strategy with clearly defined roles to support the delivery of good quality care. For example, learning from complaints and incidents was discussed at monthly leadership meetings, quarterly Medical Advisory Committee and clinical governance meetings. Information was then disseminated at departmental staff meetings.
- The Medical Advisory Committee (MAC) met quarterly and provided clinical advice and guidance. A range of specialties were represented at the meetings. Topics discussed included incidents, complaints and reviews of surgical procedures. Minutes of meetings showed there was oversight maintained of the practice of individual consultants and actions were taken to ensure they were fit to practice. A policy and procedure was in place which described annual review of practising privileges, an audit against required content was also conducted in October 2016.
- We looked at processes relating to consultants working under practising privileges. This is how competence in the speciality is understood and limits to practice applied. The MAC committee maintained oversight and discussed where consultants applied to practice at the hospital.
- We looked at processes relating to consultants working under practising privileges. This is how competence in the speciality is understood and limits to practice applied. We reviewed three consultant files.
- Procedures to ensure suitable practicing privileges were not being robustly followed. Our review of records and results of the hospital audits showed that practising privileges were being reviewed and signed off by the hospital manager without all of the required checks being in place. Many consultants had worked at the hospital for many years and some gaps were historic but some gaps were for up to date checks that should be in place.
- The hospital risk register had 76 risks. The top five risks identified by the hospital were roof repairs, lift failure when the generator was operational, lack of fire training, 17 year old endoscopes and unsecured theatre access. Staff and managers demonstrated an awareness of these.
- Risk registers were in place for all areas. Department leaders we spoke with knew and were seen to be managing risk pertinent to their clinical areas.
- There was a clear governance structure for the surgical service which oversaw quality, audit and risk activity performance. Staff we spoke with told us they would feel able to raise concerns to either the ward manager or the matron.
- We saw evidence of a range of BMI dashboards were used to monitor performance. These included a quality, safety, health and environment, complaints and information security incidents.
- We observed a morning communication cell which facilitated the sharing of information from hospital performance, daily departmental activity and key issues to any incidents, feedback or concerns. Representation from all staff groups attended such as heads of departments, Director of Clinical services, reception staff, housekeeping staff and porters. Messages and issues could be escalated and cascaded in a single day throughout the hospital. Staff we spoke with told us they found this a useful way to communicate and felt able to contribute.
- We saw communication boards throughout the hospital which included information on specific topics such as training requirements and dates, health and safety, governance, patient satisfaction results and celebrating hospital successes and achievements.
- All incidents were shared with all clinical heads of department and shared with the clinical staff in meetings and placed on a governance board for all staff to view. Incidents were a standard item on the agenda for the ward and theatre department.
- Of the incident reports we saw it was not clear as to the status of the evidence of completion and future assurance of the action plans. We spoke with the senior management regarding the evidence of completion and future assurance following the investigations.

Public and staff engagement

- Staff commendations received through patient feedback were followed up by the Executive Director. Staff we spoke with told us they were notified if they were named in a compliment by a patient or relative.
- An inpatient and outpatient postcard questionnaire was given to inpatients and those attending as day cases. The results were published and shared monthly along with actions taken for improvement. Data provided by the hospital showed 98% of patients or carers would recommend the service to family and friends.

Surgery

- There was no public and patient engagement policy, however, the hospital held patient focus groups every three months or more frequently if required. We saw evidence of the terms of reference for these which determined membership, purpose of the group, administration arrangements and meeting frequency of the group.
- There was a staff suggestions box for anonymous comments. The theatre manager reviewed all suggestions and acted upon accordingly.
- As a result of patient and carer feedback post hip and knee replacement surgery a produced an informative digital video disc (DVD) for all hip and knee replacement patients had been produced and given out to patients before surgery.
- Monthly departmental meetings were undertaken for the ward, theatre areas and physiotherapy team. There were meeting folders available in the staff rooms for staff to reference.
- We observed a good use of notice boards to display information for both staff and patients.
- Staff were actively encouraged to contribute their opinion to the running of the hospital. Staff told us more investment into the theatre environment such as improved lighting and flooring was because of their suggestions.
- We were told the hospital team hold social events for staff. Staff told us they attended social events arranged by the hospital management.
- Quality Health Feedback was discussed at staff forums. Annual patient-led assessments of the care environment (PLACE) indicated improvements on the previous year.
- The hospital had positive relationships within the local health economy including commissioners and a local acute hospital trust.

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 safe as good.

Incidents

- Between October 2015 and September 2016 there were no reported never events for the outpatient or diagnostic imaging department. Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.
- In the reporting period October 2015 to September 2016 four clinical incidents and one non-clinical incident occurred within outpatients and diagnostic imaging. As part of the clinical incident reporting, the imaging service carried out a wrong side hip scan in 2015. As a result, the Director of Clinical Services wrote to the referring clinician reminding them of their obligations. Staff also implemented the BMI 'Pause & Check' system, and placed reminder signs in the imaging suite.
- We reviewed all of the above incidents which were recorded on the risk register and saw there were appropriate actions in place to mitigate against them. For example, it was identified the main x-ray unit was 14 years old. We saw that monthly quality assurance checks were done on the equipment and yearly servicing. There were also plans to replace the x-ray unit when funding became available.

- The diagnostic imaging service learned from incidents. The imaging service carried out a wrong side hip scan in 2015. As a result, the Director of Clinical Services wrote to the referring clinician reminding them of their obligations. Staff also implemented the BMI 'Pause & Check' system, and put reminder signs in the imaging suite. The diagnostic service asked their radiation protection advisor for advice. The advisor told them the hospital did not need to report this incident for Ionising Radiation (Medical Exposure) Regulations 2000 (IR(ME)R) purposes.
- Staff we spoke with were aware of how and when to report incidents through the electronic reporting system. This had been newly implemented and replaced a paper based system of reporting incidents. Staff told incidents were reported, investigated, discussed and learnt from at team meetings, training sessions and clinical governance meetings.
- Staff within the outpatients department (OPD) told us of an open, 'no blame' culture when reporting incidents. However, nobody we spoke to could remember when an incident last happened in OPD.
- Staff were knowledgeable about the Duty of Candour policy and could describe what actions needed to be taken when applying Duty of Candour.

Cleanliness, infection control and hygiene

- The outpatients, diagnostics and imaging and physiotherapy departments were visibly clean, tidy and free from clutter. Rooms in which procedures took place, such as ear, nose and throat (ENT) examinations, and ophthalmology had wipe clean floors. The outpatient waiting area carpet was worn. The hospital planned to replace the carpet and other items such as

Outpatients and diagnostic imaging

cloth chairs, which were difficult to keep clean as part of the outpatients refurbishment during 2017 and going forward. This was a rolling programme with no target date for completion.

- A standard procedure for cleaning the carpets was in place if there was a spill of any type of liquid staff told us the housekeeping team would respond within 15 minutes and would clean the area concerned. If the liquid or spillage could not be removed the treatment room would be closed and the patient would be relocated to another room.
- BMI The Sandringham Hospital used disposable curtains in all the treatment and consulting rooms, these were dated according to when they were put up and when they were to be changed.
- Hand washing facilities and hand gels were available in all clinical areas.
- Staff adhered to the 'bare below the elbows' guidance and used appropriate personal protective equipment (PPE) when required whilst delivering care. PPE such as gloves and aprons was readily available for staff in all clinical areas.
- Domestic and clinical waste was stored securely and disposed of appropriately. All sharps bins were assembled correctly, signed and closed when not in use.
- Between October 2015 and September 2016 there were no reported cases of healthcare-associated infections such as Methicillin Resistant Staphylococcus Aureus (MRSA), clostridium difficile (C. difficile) or, Methicillin Sensitive Staphylococcus Aureus (MSSA) for the outpatients and diagnostic imaging department. MRSA is a bacterium responsible for several difficult-to-treat infections. MSSA differs from MRSA due to the degree of antibiotic resistance. C. difficile is an infective bacteria that causes diarrhoea, and can make patients very ill.
- Monthly hand hygiene audits from October 2016 to December 2016 showed that nurses washed their hands on 100% of observed opportunities during patient interaction in the outpatients department. Data also showed that for October 2016 physiotherapists washed their hands on 100% of observed opportunities during patient interaction.
- All equipment in x-ray/fluoroscopy and ultrasound was thoroughly cleaned once a day and wiped down in between patients. Specialist wipes were used in ultrasound.
- BMI The Sandringham Hospital's hand hygiene monthly audit for diagnostic imaging in May 2016 showed that a

- small minority of consultant radiologists were inconsistent with hand washing practices before and after seeing a patient. The hospital addressed this by reminding the consultants to hand wash systematically.
- The outpatient service identified the risk from infectious diseases and implemented standard precautions. Patients who were known to have infectious diseases were seen last in the outpatient department (OPD).
- The single sex and disabled toilet on the ground floor outpatient area were clean on the day of our inspection.

Environment and equipment

- The outpatient department (OPD) was located in the hospital's main entrance. Patients were required to book in at the main reception desk prior to being directed to the outpatient specific waiting area on the ground floor. All patient waiting areas were visibly clean with sufficient seating for patients and their relatives. There were five outpatient consultation rooms, one treatment room and one scanning room.
- Clear signage was in place indicating the location of fire exits and evacuation route maps were displayed in all areas.
- Within the consulting rooms, staff had access to emergency buttons to call for assistance. There was also an emergency button under the main reception desk. However staff were not sure who would respond once it was pressed. One staff member told us it was the police, while another staff member told us it was security from the neighbouring acute NHS hospital. We raised this with the manager of outpatients who said they would investigate and inform staff accordingly.
- All treatment rooms not in use were locked therefore restricting access to medical equipment for unauthorised personnel.
- Single-use, sterile instruments were used where possible. The single use instruments we saw were all within their expiry dates.
- BMI The Sandringham Hospital was in the process of improving its environment and equipment. In 2016 it acquired new ultrasound equipment. During our inspection we saw the diagnostic suite did not have a defibrillator, however one was available on the ward so was accessible. We were told that a bid for funding had been submitted to update the x-ray room and obtain a defibrillator. The risk register showed the medical gas

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store was not secure and there was potential for theft. Data showed the provider was in the process of obtaining quotes for replacement steel doors to secure the storage room.

- Managers told us diagnostic equipment maintenance was provided through an annual contract with the equipment manufacturer. The manufacturers provided a same day response if there was any unexpected breakdown. Staff checked equipment daily for faults and a nominated BMI radiographer carried out in-depth quality assurance checks on imaging equipment at least once a month. The quality assurance programme for diagnostic equipment was highlighted as best practice in the independent radiation protection audit in 2016.
- The diagnostic imaging service had a risk which was managed on a day to day basis but not resolved. There was a fixed height patient imaging table which was approximately a metre high, this made it difficult for some patients to use. The risk was managed by using two members of staff to ensure that patients were kept safe when using portable steps to climb up to or get down from the imaging table. When we inspected, the diagnostic imaging lead was researching an adjustable platform to help patients get onto the table, which was potentially more stable. The risk presented by the fixed patient imaging table had been on the risk register for five years and BMI The Sandringham Hospital had not replaced the table during that time.
- The service provided protective equipment including lead aprons which were screened for damage once a year by scanning them with the fluoroscopy machine. The service had recently bought new lead aprons.
- The diagnostic imaging service had examples of good radiation protection practice. Specific areas of radiation protection best practice highlighted in the 2016 radiation protection audit were the quality assurance programme for equipment, the internal compliance audit schedule and, most recently, an enhanced training regime for staff in radiation safety.
- The hospital had arrangements to ensure that staff used personal protective equipment in imaging and they replaced lead aprons and other protective equipment when necessary.
- The imaging suite had a kit for dealing with allergic reactions (anaphylaxis); however the resuscitation trolley was located on the in-patient ward.
- Medicines in the OPD and radiology were stored, managed, administered and recorded securely and safely.
- Medicines that required refrigeration were stored in locked fridges, keys were held by the senior member of staff. Staff checked and recorded fridge temperatures daily, including actions in the event of out of acceptable range temperatures.
- Outpatients could have their medication dispensed by the pharmacy, or if out of hours take a private prescription to a local pharmacy.
- Consultants had access to private prescription pads within the outpatient department. Each prescription pad was signed in and out prior to, and at the end of clinic lists. Prescription numbers were logged with the specific prescription number and relevant patient number by the prescribing clinician/nurse to prevent the misuse of prescription paperwork and maintain a clear audit trail.
- Up-to-date medicines management policies and procedures were available for staff to access.
- Medicine levels were checked twice weekly by the pharmacy and ordered regularly.
- BMI The Sandringham Hospital ran a 'virtual pharmacy' model. The model meant that all medicinal stock was held in the appropriate departments such as the ward and in the outpatients department, as there was no central pharmacy store or dispensary. Deliveries of medicinal stock for the hospital were received by the pharmacy team and distributed to the appropriate departments after processing.
- The virtual pharmacy was a pharmacy technician-led service. The pharmacy team comprised of one pharmacy technician working 30 hours per week and one pharmacist working 10 hours per week. Data request to check hours.
- In the absence of the pharmacist, clinical pharmacy support was provided from staff at other BMI hospital pharmacies, with BMI The Park Hospital being the primary support.
- When the pharmacy was closed, nursing staff supplied pre-labelled to take away (TTA) packs of routinely used medicines to patients being discharged from the hospital, as well as those attending outpatient clinics.
- Consultants in OPD used private prescription pads; these were stored securely and a record of usage was maintained.

Medicines

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- Patients were asked to complete a pre-clinic questionnaire, which included information about the medicines they were currently taking. If necessary, additional information could be obtained from the patient's GP.

Records

- Medical records were kept confidentially and securely. There was a medical records storage department where records were filed and stored, and the transfer of records was tracked and traced.
- During our inspection access to the medical records storage room was locked and restricted to authorised personnel only. Therefore, medical records were stored in line with 'The Records Management Code of Practice for Health and Social Care 2016'.
- The hospital had a policy of keeping records on site, and ensuring they were readily accessible. The last medical records audit showed were no instances of medical notes not being available for patient consultations or treatment during the period October 2015 and September 2016.
- There was a system in place to ensure that medical records generated by consultants were available to other staff. The incident database showed no incidence of medical records being taken off site.
- Records within the OPD were paper based. We reviewed five sets of patient's records. All were legible, signed and dated. Records contained all relevant information including referral and follow up information.
- All patients seen in the department had a referral letter prior to consultation from a GP, optician or other healthcare professional.
- The medical records staff collated clinic lists 24 hours in advance. Notes were then stored securely within the clinic area. Staff told us that accessing notes was not problematic.
- There was a data protection policy and an information security awareness guide. These outlined the procedures for e-mailing patients private information.
- Confidential waste bins were situated in the outpatient and x-ray areas.

Assessing and Responding to Patient Risk

- The imaging service had a range of procedures to manage risk, including minimising the risk of radiation to females of childbearing age. It defined women of child bearing age as being between 12 and 55 and

recorded the last menstrual period data on the imaging computer system. Staff told us that if there was any uncertainty the patient was pregnant, they would not carry out the scan. However, if the patient was unconscious and the procedure was urgent, they would scan the patient.

- An audit of pregnancy status undertaken by the radiology department showed that in November 2016, 88% of patients had their pregnancy status checked before x-ray. The imaging lead reminded the radiographers about checking patient's pregnancy status, discuss it in the departmental meeting and planned to re-audit compliance a year later.
- Patients saw their named consultant at each stage of their patient journey. Patient's needs were assessed throughout their stay and in line with their care pathway.
- A resident medical officer (RMO) was on duty 24 hours a day, seven days a week to respond to any concerns staff may have about a patient's deteriorating medical condition. Staff informed us that if a patient deteriorated in the department the resident medical officer (RMO) would assess the patient. An example of this was seen during our inspection, when a patient suddenly felt very un-well, we saw they were taken into one of the treatment rooms and the RMO fast bleeped.
- Emergency resuscitation equipment was available and all nursing staff had undertaken basic life support training.
- Nurses within the pre-assessment clinic completed comprehensive health risk assessments prior to admission for surgery. In the event of a deteriorating patient, an agreement was in place for emergency transfer to the NHS acute hospital which was linked to BMI The Sandringham Hospital through a connecting walkway.
- Imaging suites had warning lights to show when imaging involving radiation was taking place. Staff locked the entry doors to the imaging suite when a procedure was under way.
- Diagnostic imaging staff reduced risk by checking against an amended version of the World Health Organisation (WHO) safety checklist. The checklist identifies three phases of an operation, each corresponding to a specific period in the normal flow of work: 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

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each phase, a checklist coordinator must confirm that the surgery team has completed the listed tasks before it proceeds with the operation. This ensured they went through the same safety checks for every diagnostic imaging patient who needed an injection or invasive procedure and there were small number of these patients each month. The diagnostic lead audited compliance with the checklist monthly and staff were 100% compliant.

- We saw staff followed a 'six point' checklist prior to using any radiology equipment. This confirmed the correct patient site and type of investigation.
- The radiation protection advisor for the hospital was located at the NHS acute trust. The hospital had a contract with the NHS acute trust for this advice and for patients requiring medical physics treatments. The advisors carried out an annual radiation protection audit. The imaging service had a radiation protection supervisor who was also the manager, for x-rays and ultrasound scanning.
- The imaging service had a range of local policies and procedures to ensure that it met the Ionising Radiation (Medical Exposure) Regulations 2000 (IR(ME)R). It had an Ionising Radiation Safety Policy which outlined governance arrangements, roles and responsibilities, training arrangements and the terms of reference of the radiation protection committee. They had a procedure to correctly identify the patient to be exposed to ionising radiation. This prevented any unnecessary radiation exposures.
- The imaging service made sure that requests for radiation diagnostic tests were made in line with IR(ME)R. A protocol, updated in October 2016 listed medical professionals who could request and refer. This ensured requests met patient's clinical needs.
- The diagnostic imaging service was mostly proactive about managing risk, however, there was a fixed height patient imaging table which was approximately a metre high, this made it difficult for some patients to use. The risk was managed by using two members of staff to ensure that patients were kept safe when using portable steps to climb up to or get down from the imaging table. When we inspected, the diagnostic imaging lead was researching an adjustable platform to help patients get onto the table, which was potentially more stable. The

risk presented by the fixed patient imaging table had been on the risk register for five years and BMI The Sandringham Hospital had not replaced the table during that time.

Safeguarding

- All clinical staff in OPD and radiology had completed adult safeguard training to level two. The Director of Clinical Services had completed safeguarding of children training at level three and was the lead for safeguarding. All staff knew who the safeguarding lead was and how to make a safeguarding referral to them.
- All the staff we spoke with were knowledgeable about their role and responsibilities regarding the safeguarding of vulnerable adults and children and of the referral process to the safeguarding lead.
- We spoke with two members of staff within the OPD who reported that safeguarding training included awareness of female genital mutilation (FGM).
- Consent and safeguarding policies in use were based on national guidance and current regulations.
- The provider had processes in place to ensure the right patient received the right radiological scan at the right time, as a result of the error mentioned previously. BMI The Sandringham Hospital had a local employer's guidelines for medical exposures issued in July 2016 which outlined the procedure for identifying patients, including the use of corroborative evidence for unconscious patients, or those with language or learning difficulties. This ensured the right patient received a scan. Use of BMIs 'pause and check' system and improved referral letters following a wrong site scan incident reinforced procedures to ensure that radiographers scanned the correct area of a patient's body.

Mandatory training

- The hospital delivered mandatory training using a combination of online electronic learning packages and face to face learning. The training included basic life support, infection prevention and control, manual handling, fire safety and information governance.
- All staff were expected to complete their annual mandatory training. Data provided showed staff were 100% compliant with mandatory training. BMI The Sandringham Hospital also delivered mandatory training to 93.5% of bank and agency staff across the hospital.

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- A process was in place to ensure staff not employed directly by the provider had received the appropriate mandatory training. For clinicians who had practising privileges mandatory training was undertaken through their primary employer.
- All staff were allowed two hours each month to complete mandatory and electronic learning and training.

Nursing staffing

- Staffing levels in the outpatient department were planned in conjunction with clinical need and clinic patient numbers.
- Overall staffing establishment of one point eight full time equivalent nurses including a nursing sister and two full time equivalent healthcare assistants.
- Outpatient clinics were staffed with appropriate numbers of staff, this was determined on how many consultants and patients were attending clinics. The skill mix of staff was considered, for example there were two administrative staff to support patients booking in for appointments, as well as follow up appointments and preparing letters.
- Use of bank and agency nursing staff in outpatient and diagnostic imaging departments was lower than the average for independent acute hospitals from October 2015 to September 2016. It peaked at 7% in November 2015.
- There was no use of bank and agency health care assistants in outpatient and diagnostic imaging departments until July 2016 when some bank staff were used.
- Data showed the increase in bank staff from July 2016 until the end of September was due to the need for more chaperones for consultant clinics. The figure at the time of our inspection was zero as the provider was in the process of recruiting a full-time health care assistant to assist with this duty.
- Staff told us normally where there was a need for additional chaperones extra health care assistants would be rostered on to work. The same would apply for the treatment rooms and clinics where an additional registered nurse would be required to work.
- The provider asks consultants for a minimum of four working days to submit their clinic lists in order to staff the department accordingly

Medical staffing

- There were 63 doctors and dentists employed, or practising under rules and privileges for the provider, all of which had their registration validated in the reporting period (October 2015 to September 2016).
- The diagnostic imaging team comprised of the lead radiographer who was also the manager, a part time radiographer, a bank radiographer and a radiology assistant. There was a vacancy for a bank radiographer. There was a reduced team of radiologists as out of seven trained consultant radiologists, three left in July 2016 and the hospital had not replaced them, although a radiologist was applying to join the hospital. This did not impact on patients because evening appointments or extra dates were scheduled from the remaining radiology staff. Work could also be outsourced to other staff and radiology departments within the BMI hospitals group.
- If a consultant was unable to attend the hospital, it was the hospital's responsibility to make suitable cover arrangements with another practitioner in the same speciality with practising privileges at the hospital. Patients told us that this was effective and that they did not have to wait for another appointment.
- The outpatient service had a folder which contained the details of all consultants and their specialty, contact number, clinic requests and medications they required for their clinics to run effectively. This meant staff were able to contact them easily. Hospital staff were also able to make contact with consultants via their secretaries if required.
- There was a Resident Medical Officer (RMO) within the hospital 24 hours a day with immediate telephone access to the responsible consultant if required.

Emergency awareness and training

- BMI The Sandringham Hospital 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. Managers we spoke with were aware of the business continuity plan.
- There was clear information available to patients and staff regarding fire procedures. Staff were aware of the evacuation procedure and what to do in an emergency.
- There was an emergency button in the out-patients department which was connected to a call centre.

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- Staff told us there was an emergency generator back-up system for the hospital; however, the lifts could not operate with the limited generated power.
- Diagnostic imaging staff were aware of what to do in a major incident and had informal reciprocal arrangements with the neighbouring NHS acute trust.
- In diagnostic imaging, the local rules on radiation protection included contingency plans for equipment and fire. Staff were clear on what to do if a radiation incident occurred.

Are outpatients and diagnostic imaging services effective?

Not sufficient evidence to rate 

Effective was inspected but not rated.

Evidence-based care and treatment

- Patient care and treatment reflected relevant research and guidance, including the Royal Colleges and National Institute for Health and Care Excellence (NICE) guidance.
- BMI The Sandringham Hospital completed the standard range of BMI audits. The diagnostic service also completed audits for IR(ME)R registration and to improve its own safety systems, for example reinforcing the patient pregnancy checks after auditing understanding of this.
- BMI The Sandringham Hospital participated in the BMI hospitals corporate audit programme. This included audits of patient health records, infection prevention and control, resuscitation, controlled drugs, consent, safeguarding, hand hygiene, medicines management and consent.
- The imaging service used diagnostic reference levels (the dose set at the average of a group of patient doses) to ensure exposures were safe. This included gathering the data and establishing the average dose level for patients within a weight tolerance. Most commonly they did this for hip and knee x-rays where there were sufficient patients for the exercise to be statistically valid, and they compared against national norms. Staff made a note when patients were very heavy or light so this was taken into account. Staff also monitored diagnostic reference levels for fluoroscopy (barium meals and swallows) and dental scans. Diagnostic reference levels were displayed in graph form on the office wall. This helped the service expose the patient to the minimum dose of radiation necessary for an effective x-ray (Optimisation).
- The imaging service had a range of local policies and procedures to ensure that it met the Ionising Radiation (Medical Exposure) Regulations 2000 (IR(ME)R). It had an Ionising Radiation Safety Policy which outlined governance arrangements, roles and responsibilities, training arrangements and the terms of reference of the radiation protection committee. They had a procedure to correctly identify the individual to be exposed to ionising radiation.
- Diagnostic imaging had an audit schedule which included radiologists reporting time, pregnancy checks, patient ID checking, and clinical evaluation of theatre medical exposures. These audits resulted in action plans for improvement. To meet its IR(ME)R obligations the hospital also had an annual radiation protection audit. The most recent audit was in July 2016 and resulted in improvements to the referral letter, routinely covering quality assurance as part of induction, and requesting a copy of the neighbouring NHS acute trust's radiation protection audit.
- An audit of pregnancy status undertaken by the radiology department showed that in November 2016, 88% of patients had their pregnancy status checked before x-ray. The imaging lead reminded the radiographers about checking patient's pregnancy status, discuss it in the departmental meeting and planned to re-audit compliance a year later.

Pain relief

- BMI The Sandringham Hospital carried out a pain management audit of surgical day case and inpatients in August 2016. It did not audit outpatients or imaging patients for pain.
- Staff assessed patients for pain relief during appointments and supported them in managing pain through prescriptions and appropriate medications.
- Pre-assessment staff provided patients with pre-operative information including pain relief and information on managing their pain. BMI The Sandringham Hospital also provided a chronic pain clinic.

Nutrition and hydration

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- Patients and visitors had access to both hot and cold drinks within the outpatient area. Due to the transient nature of stay in the outpatient department, food was not provided. However, there were onsite catering facilities should there be a need for a patient to stay for a prolonged period of time.

Patient outcomes

- There was no evidence of outpatients and diagnostic imaging taking part in national audits. The hospital did not participate in the Imaging Services Accreditation Scheme.
- Most of the indicators in the hospital's quality accounts applied to inpatient activity. There was a lack of indicators concerning outpatients or imaging. However the provider did have a site level quality dashboard which included outpatient and diagnostic services. With relevant performance measures such as waiting list times until first treatment, and waiting times from referral to diagnostic test.
- Physiotherapy staff performed audits of their group sessions to monitor patient improvement and satisfaction. Feedback from patients was collated and actions made against the recommendations. For example, providing a model of a knee replacement to use in preoperative consultations.

Competent staff

- All outpatient nurses received appraisals between October 2015 and September 2016.
- The learning needs of staff were identified during regular appraisals. Staff told us they were encouraged to develop and to undertake continuous professional development. For example, one of the health care assistants who had a special interest in palliative care, was encouraged to undertake further training in the subject. They told us how they were able to comfort a patient who had suffered a recent bereavement in one of the outpatient clinics last year.
- Data provided by the hospital showed that 100% of nursing and medical staff were appropriately registered with their professional body.
- For practising privileges, see information under this sub-heading in the surgery services section.
- The medical advisory committee (MAC) was responsible for the granting and renewal of practising privileges which were reviewed on an annual basis.

- Staff employed in diagnostic imaging received induction training. This included reading and understanding IR(ME)R procedures and understanding the local radiation safety policy and quality assurance manual.
- All staff we spoke with said they had undergone induction training before commencing work at BMI The Sandringham hospital. The training of all radiographers and radiology consultants working in diagnostic imaging and ultrasound scanning at the hospital met the standard of their professional body, the Health and Care Professions Council (HCPC). Diagnostic imaging staff used webinars, online learning and shadowing of NHS acute trust staff to keep their skills up to date, for example on quality assuring equipment.
- The Resident Medical Officer (RMO) had appropriate advanced life support training and skills.

Multidisciplinary working

- There was a strong multi-disciplinary team (MDT) approach across all of the areas we visited. We observed good collaborative working and communication amongst all members of the MDT. Staff and managers reported they worked well as a team. Due to the small size of the hospital everyone knew each other well. This was evident on the day of our inspection. Effective staff communication was also seen between departments.
- Managers described a good working relationship with the local NHS acute trust with regards to the transfer of patients and the request for medical records if required.

Seven Day services

- Diagnostic imaging services were available on a 24/7 basis. There was an on call service available out of hours and would attend the site if imaging services were required.
- The imaging service had a service level agreement with the neighbouring NHS trust for magnetic resonance imaging (MRI) and computerised tomography (CT) scans. The trust provided MRI scans from 5pm to 7pm Monday to Friday and CT scans from Tuesday to Thursday from 5pm to 5.30pm. The agreement was flexible and the trust could provide CT scans from Monday to Friday if necessary. They also provided nuclear medicine treatment although this was relatively rare at one case a month.

Access to information

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- There was no electronic access to diagnostic scanning results. This was done by paper record. The service planned to work with commissioners to provide electronic access but there was no clear target date at the time of our inspection.
- Medical records were requested before patient appointments. Appointment lists were printed off daily, which enabled staff to know which patients were attending.
- All of BMI The Sandringham Hospital's own records were kept on site. The consultants' secretaries, whether internal or external, provided the consultant's own letters prior to any outpatient appointment.
- BMI The Sandringham 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.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- The hospital audited the use of consent procedures in March 2016 and formulated an action plan. The action plan listed key actions such as outpatient consultants needing to record any information they gave to the patient, carrying the consent process in a timely way to give the patient sufficient time to decide, and ensuring that the patient received a signed copy of their consent form.
- We reviewed five sets of outpatient medical records which all contained documented patient consent.
- Staff had not had experience of undertaking mental capacity assessments, but were able to describe the practice thereby demonstrating an understanding of the legislation and the process
- We did not see any examples where patients lacked capacity and due to the nature of the patients accessing the service.

Are outpatients and diagnostic imaging services caring?

Good



Compassionate care

- The hospital asked patients to complete a Friends and Family Test postcard (a survey which asked how likely a patient was to recommend the service to their friends and family). In July 2016, 97.5% of NHS patients and 95.9% of insured or self-pay patients said they were likely or extremely like to recommend the service. This was for the out-patients department only.
- Results for the hospital overall were slightly better. In the reporting period October 2015 to September 2016 the provider collected data for the friends and family test. The hospital had a response rate of 69% for NHS and other funded patients and achieved a score of 99 % for NHS funded patients in the last month of the reporting period.
- We looked at 42 Care Quality Commission 'Tell us about your care' cards in the outpatients department and eight cards in the physiotherapy department. All, without exception were very positive about the care they received at BMI The Sandringham Hospital.
- The diagnostic imaging service had positive feedback from patients. In November 2016, 14 patients were asked for their feedback and all of them said that they were extremely likely to recommend the service to friends and family. Patients described the service as fast, friendly and efficient.
- During the inspection, we saw staff taking time to interact with people who used the service and those close to them in a respectful and considerate manner.
- Patients told us they felt they were treated with dignity and respect, and described staff as friendly and polite, always introducing themselves. Patients who had attended the hospital for follow up appointments commented that it was nice to see the same staff each time. All patients described staff as 'caring' and having their 'interests at heart'.
- Conversations at the reception desk were not within the clinic waiting area, although others waiting to speak to the receptionist may overhear conversations, so privacy was not always assured. Rooms were available within the reception area for more private conversations.
- The service offered chaperones of either gender for patients. This person acted as a safeguard and a witness for patients or healthcare professionals during intimate medical examinations or procedures.

We have rated caring as good.

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- Patient confidentiality was maintained in consultation rooms. All doors were closed when consultations were taking place on the day of our inspection. We saw a member of staff knocking, prior to entry to a room therefore maintaining patient dignity and privacy.

Understanding and involvement of patients and those close to them

- Staff involved patients in their treatment and care. Staff talked to patients and informed them about what was going to happen and what their procedures involved. Where possible staff provided patients with options regarding procedures and ongoing treatment. One patient said they were involved in their treatment and care, and they were offered a choice about the type of hearing aid they could receive.
- Patients received copies of letters sent to their GP. We saw a patient letter that informed the patient about the next appointment, and observed staff telling patients when they would receive their results.

Emotional support

- Information leaflets were available to explain conditions and treatments to patients. We saw during our inspection nursing staff explaining to patients what their treatment would include by referring to the information leaflets.
- Patients told us that treatment options were discussed with them and they felt included in the decision process.
- Staff were keen to tailor care and services to best support the patient's physical and emotional wellbeing. We heard staff offering reassurance and encouraging patients to call back if they have any concerns before their next appointment.

Are outpatients and diagnostic imaging services responsive?

Good 

We rated responsive as good.

Service planning and delivery to meet the needs of local people

- The services provided reflected the needs of the local population. Services were planned with local

commissioners. At monthly contract monitoring meetings, local commissioners were able to influence new areas of hospital activity such as podiatry and diabetic clinics.

- There were a number of different clinics provided throughout the outpatients and diagnostic imaging department (OPD) which met most of the needs specified by the commissioner.
- The outpatient and diagnostic imaging waiting areas were appropriate and suitable for patients. There was suitable seating and an accessible toilet in the outpatients and reception area with a door which had been adapted for ease of access. The outpatient area had coffee making facilities and reading materials. The imaging service had a pleasant and modern patient waiting area.
- Consulting and treatment rooms were clinically appropriate to treat adults. The hospital had a programme of refurbishment and patients did not receive clinical treatments in carpeted rooms.
- Car parking was limited but free of charge. Staff made it as easy as possible by helping patients to park. They proactively managed the parking by asking patients to double park in front of other patients or consultants who were not likely to want to move their cars because they were in the hospital for several hours. This allowed patients to park even if the car park was full.
- There were out of hour's clinics available to patients who needed to be seen outside of normal working times. Outpatient clinics took place in the evenings on weekdays from 5 pm to 8 pm and could be arranged for Saturday morning, depending on the consultant. Diagnostic imaging services were on call 24 hours a day, seven days a week.
- The outpatient's service offered an alternative to face to face appointments where appropriate. Consultants of any speciality could hold telephone follow up clinics with low risk patients. This avoided travel and inconvenience for the patients but gave both the patient and consultant the opportunity for monitoring, reassurance and discussion.
- Patients told us that information the hospital provided them with before appointments was clear and easy to understand.

Access and flow

- BMI The Sandringham Hospital met national standards for diagnostic imaging. Data showed that for February

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2017 no patients waited longer than six weeks from referral to x-ray, for magnetic resonance imaging (MRI), computerised tomography (CT) or non-obstetric ultrasound tests.

- The neighbouring NHS trust carried out magnetic resonance imaging (MRI) or computerised tomography (CT) scans under a service level agreement. There were allocated times for these scans so patients did not have to wait more than a few days and would often have their scan within two days.
- Patients had timely access to diagnostic appointments. The imaging service could offer same day appointments for x-ray, providing a radiographer was available. The wait time was longer for ultrasound but could be booked for the next day if needed. In general for private patients, the wait was up to three days. It was longer for NHS patients but still well within the NHS target time of six weeks.
- Same day/next day outpatients appointments were available in urgent circumstances. There were no 'hot clinics' but consultants would arrange to see someone quickly if needed.
- Referral to treatment time (RRT) is the term used to describe the period from when an appropriate referral for treatment was made and the date of the initial consultation or treatment occurred. The Department of Health stated for NHS patients that 95% of non-admitted patients should start consultant led treatment within 18 weeks of referral.
- Between October 2015 and August 2016 the hospital met the commissioner's overall waiting list target of 95% of NHS outpatients treated within 18 weeks (Referral to Treatment for non-admitted patients). However, in September 2016 the performance declined to 57% of patients treated within 18 weeks. The service achieved 100% in October but then performance declined again to 88.3% in December 2016. Data showed the reason for the decline in performance was that a number of patients had already waited in excess of 18 weeks before they were transferred to BMI The Sandringham Hospital from NHS hospitals (47 urology cases in September and 25 urology cases in December 2016). In other specialities, delays were due to patient choice, medical fitness for the procedure, watchful wait and treatment through less invasive methods such as physiotherapy. The patients affected were mainly in orthopaedics, urology, oral surgery, general surgery and podiatric surgery.
- The process lead reviewed patients who were waiting 18 weeks or longer because of transfer from another hospital or a delay for medical or other reasons on a daily basis. This information was shared with commissioners. As a result of the regular review, all of these patients were treated within six weeks.
- BMI The Sandringham Hospital monitored and managed Did Not Attend (DNA) rates. In December 2016 the DNA rate was 3.1%, but had been 7.1% in July 2016. If patients did not attend, they were allocated another appointment time. The hospital had taken action to minimise DNAs by reminding patients about their appointment by phone and text.
- Patients told us that appointments mostly ran on time. However, we heard that a small minority of consultants had a tendency to arrive late or exceed appointment times so their clinics ran late. Staff tried to contact patients if they knew that a consultant was running late, giving patients the chance to re-arrange the appointment if it was excessively delayed.
- BMI The Sandringham Hospital took action to avoid disruption to patients because of cancellations. If a consultant could not attend, the hospital contacted another consultant in the same speciality to run the clinic. If this was not possible, they re-scheduled patient appointment times. From October 2016 to December 2016, between one and two percent of follow up appointments were cancelled by the hospital.
- BMI The Sandringham Hospital did not measure some aspects of the patient experience. They did not routinely record or audit how long people were kept waiting once they arrived in the outpatients waiting area. They did not measure how long people would be kept waiting if they needed a diagnostic imaging appointment after their outpatients appointment.
- During our inspection, we saw a patient had complained about the length of time to wait between a private referral and seeing a consultant. The hospital arranged for the patient to have an appointment with a consultant three days later.
- Staff tried to ensure that consultants clinic times was used effectively. With each consultant, they planned a 30 minute slot for a new patient appointment, and 10-15 minutes for a follow up. This was the same for all specialities. However, some consultants needed 20 minutes for a new appointment so administrative staff

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ensured their time was well utilised by planning extra follow ups where needed and time for activities around appointments such as eye drops for ophthalmic appointments.

Meeting people's individual needs

- The service ensured new service users had sufficient time to discuss their treatment with consultants. Patients told us they had enough time to talk about their condition and treatment and to ask questions.
- BMI The Sandringham Hospital's contractual agreement with commissioners excluded some NHS patients. These were NHS patients: under the age of 18 years; grossly obese with a body mass index (BMI) greater than 40; with incapacitating disease which is a constant threat to life; with an unstable mental condition and receiving psychiatric treatment or if there was evidence that previous anaesthetics led to serious adverse events.
- BMI The Sandringham Hospital could not obtain bariatric equipment for heavier private patients if needed, such as bariatric chairs or mattresses. However, some equipment such as the x-ray table was not suitable for very heavy people.
- Outpatients (OPD) and diagnostic services adapted services to vulnerable patients, although the hospital saw very few patients of this type. Where this was the case, they allowed patients living with dementia to be seen first. Staff received training on how to treat people with complex needs, learning difficulties or living with dementia.
- BMI The Sandringham Hospital provided an interpreting service for local ethnic groups. In the local area, the ethnic groups were mainly Eastern European or Portuguese. In 2015 – 2016, the hospital used interpreters for five patients; four patients were of other European nationalities, and another patient needed a sign language interpreter.
- Staff explained that a language line was available for communication with patients for whom English was not their first language.
- BMI The Sandringham Hospital partly supported NHS patients who had mobility difficulties. It arranged return transport after a procedure. Before the procedure, patients had to arrange their own transport to the hospital via their GP.

- Patient information was available. However, this was in regular print. Staff told us they could obtain information in large print/other formats, braille and different languages if needed.
- In between clinic appointments, patients were provided with emergency contact details to make contact with hospital should the need arise.
- There were private changing rooms and lockers for patients.

Learning from complaints and concerns

- BMI The Sandringham Hospital did not always explain to patients how to complain or give them relevant information to help them do this. We observed an interaction with a patient who was disappointed by a consultant cancellation and although staff did their best to resolve the issue, they did not give the patient a complaint leaflet or explain the process.
- In the reporting period (October 2015 to September 2016) the provider received 29 complaints 16 of which referred to outpatient and diagnostic services. The majority of complaints were not clinical. The majority of outpatients complaints related to financial costs and the cost of consultations. The service responded by reminding new consultants to fully explain costs to patients.
- We reviewed the handling of two outpatient complaints. We found timely responses were provided and apologies extended to patients where required.
- Complaints about outpatient services in 2015 – 2016 included issues related to privacy and dignity (lack of modesty blankets in outpatients), charging, staff behaviour, and lack of communication about appointments/lacked of booked appointment in outpatients. BMI The Sandringham Hospital responded by ensuring that modesty blankets were available in outpatients
- BMI The Sandringham Hospital received two complaints about diagnostic imaging in the year October 2015 to September 2016. In these cases patients were complaining about being invoiced for diagnostic costs which BMI The Sandringham Hospital had not explained to them beforehand. The diagnostic lead told us the service started to advise patients about the price by telephone in advance and confirmed this to them in an email to minimise misunderstandings.
- BMI The Sandringham Hospital had a process for managing complaints. The Executive Director oversaw

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the process which aimed to respond to complainants within 20 days, this was being achieved. Staff were encouraged to resolve verbal complaints as soon as possible.

Are outpatients and diagnostic imaging services well-led?

Good 

We rated well-led as good.

Leadership and culture of service

- The outpatient service had strong operational leadership in the outpatients sister. However, the service was not specifically represented at senior key meetings such as clinical governance or leadership. Instead, the outpatients sister attended the daily communication (CommCell) meeting. Staff in outpatients had a daily 'catch up' (handover) meeting to discuss any incidents or new guidance and plan the work for the day.
- Leaders were visible and approachable and had the capability to lead effectively. Staff told us senior managers were present and supported them in day to day problems solving. They told us they were treated as equals and staff and managers of any level sat together at lunch.
- Leaders of the outpatient and diagnostic services understood the challenges to good quality care and identified the actions needed to address them. For example, the level of complaints concerning payments and invoicing.
- The culture was centred on patients. We observed booking staff giving patients options. We also saw staff being honest with a patient whose appointment was cancelled, at the same time offering appointments later in the same day, and during the same week. There was also reimbursement of the patient's travel expenses.
- Staff told us that morale was good. Sickness rates for nurses in outpatients departments were equal to the average for independent hospitals in October 2015 but reduced to less than the average or zero for the months up until September 2016. Sickness rates for healthcare assistants were lower than the average for independent hospitals from October 2015 to September 2016.
- In October 2016 there were no vacancies for outpatient nurses or healthcare assistants.

- Outpatient nurse staff turnover was 33% from October 2015 to September 2016, a decrease of 17% from the previous reporting period. There was no staff turnover for outpatient healthcare assistants over the same period.
- BMI The Sandringham Hospital launched an Employee of the Month scheme in July 2016, with afternoon tea for two for the winning employee.

Vision and strategy for this core service

- BMI The Sandringham Hospital had clear corporate and local organisational values and its vision was: 'By delivering a consistent level of high patient care and optimum clinical outcomes, we will be the local hospital of choice.'
- The BMI group's brand promise was to be "serious about health, passionate about care". Its four core themes were safety, clinical effectiveness, patient experience and quality assurance, showing that safety and quality were high priorities. Staff we spoke to demonstrated these values.
- Plans for outpatients services and diagnostic imaging were less clear. Staff told us that plans were broadly about expansion or replacing equipment. There was no specific outpatient or diagnostics strategy or costed action plan. This meant their objectives were unclear and there was no progress monitoring to ensure that objectives were achieved.

Governance, risk management and quality measurement

- There were effective governance arrangements to support the delivery of the hospital's business plan. These arrangements were reviewed. The hospital implemented a quality improvement plan which was part of its business plan. This contained actions to put in place a robust decision making structure which mirrored national arrangements, and ensured business continuity plans were in place.
- BMI The Sandringham Hospital held effective meetings to address patient quality. The meetings included the Medical Advisory Committee (MAC) meeting, bimonthly integrated clinical governance meetings and a monthly clinical lead group which focused on problem solving. We looked at a number of clinical governance and MAC meeting minutes and saw that incidents and learning from incidents and near misses were discussed. The clinical lead group monitored audits, quality, incidents

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and risk. Although the diagnostic lead radiographer attended clinical governance and leaders group meetings, the outpatients sister was not on the attendance list.

- Other specialty service meetings took place in their areas and the team leads were responsible for the feedback to staff and escalate concerns to the senior management team. As a result, there was a two-way flow of information about quality and safety.
- Staff were clear about their roles and what they were accountable for. The staff survey showed 100% of employees were clear about their personal objectives and what was expected of them.
- The outpatients service held regular quality focused meetings every other month. These meetings discussed infection control, equipment, audits, training, risk register and Never Events and serious incidents. They included a summary of actions to be taken forward. The outpatients sister attended the hospitals 'CommCell' (huddle) communication meeting every morning. Staff in outpatients had a daily 'catch up' (handover) meeting to discuss any issues from 'CommCell', any incidents or new guidance and the work plan for the day.
- Governance arrangements around diagnostic imaging were clear. There was a radiation protection committee meeting annually in February, with terms of reference, and the radiation protection advisor attended. The clinical governance meeting covered complaints, learning from incidents, and risks and reviewed radiation protection quarterly.
- The diagnostic imaging service had an appropriate governance framework around radiation protection. This included safety policies, risk management arrangements, a set of local rules, an annual radiation protection audit and annual radiation protection committee attended by the independent radiation protection advisor. The diagnostic imaging lead attended leadership, clinical governance, leadership and heads of department meetings regularly. These measures ensured that the hospital continued to improve its radiation safety arrangements.
- BMI The Sandringham Hospital had measures in place to ensure information used to monitor performance was reliable. It had a monthly, hospital wide quality dashboard which included data quality measures in

addition to national wait time indicators, patient satisfaction, did not attend (DNA) and cancellation rates. The process lead checked patient pathways daily to ensure accurate reporting.

- Performance and quality measurement for outpatients was not comprehensive. BMI The Sandringham Hospital's quality dashboard did not include in clinic wait times, frequency of hospital cancellations or satisfaction with booking arrangements. The hospital's outpatient performance was not reported publicly, for example on its website.
- Service risk registers identified key risks. For example, the main x-ray unit was 14 years old and carpets were identified as an infection control risk in outpatients. The hospital mitigated the risk posed by older equipment by making sure it was frequently checked and had a plan in place to remove the carpets. However, despite the static x-ray table being on the risk register for 5 years, this was not addressed by senior managers who sought funding from the corporate group.
- Working arrangements with partners and third party providers supported quality improvement. For example, monitoring arrangements for diagnostic services provided by the NHS acute trust included receiving information about incidents involving BMI The Hospital Sandringham patients. In 2015 – 2016 there was an incident of a mistaken location lumbar spine magnetic resonance scan (MRI) on a BMI The Sandringham Hospital patient. The NHS trust shared its learning with BMI The Sandringham Hospital. Both organisations took action to inform the patient under the duty of candour and rectify the situation. The trust also shared details of relevant diagnostic imaging audits with BMI The Sandringham Hospital, for example an audit of use of contrast medium in CT scans.

Public and staff engagement

- In mandatory staff survey questions to meet NHS obligations, BMI The Sandringham Hospital scored highly compared to other hospitals for job satisfaction and purpose and raising concerns. Results were less positive for management of change and for communication between different parts of the hospital, career development and recognition. Over half of the workforce did not feel they were paid fairly.
- Outpatients had installed a wide access two way opening door to the disabled toilet in the reception in response to patient comments.

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- In outpatients staff contributed to service improvements. They put reminders in key places to ensure consultants complied with the consent process, because audits showed they did not always comply, and gave patients relevant information about their conditions and treatment.
- Staff understood the value of raising concerns. We heard that staff reported anything of concern and staff survey results also showed this.
- The diagnostic imaging service focused on continuous improvement. The service lead developed a set of local rules for radiation protection. This included a post training assessment to check understanding of the rules. This was shared with other diagnostic services in the rest of the BMI hospitals group.
- The outpatient sister attended the BMI outpatient steering group. This group facilitated an exchange of ideas within the BMI group and jointly the group set up arrangements to build competencies on subjects such as plaster casts and minor procedures.

Innovation, improvement and sustainability

- BMI The Sandringham Hospital aimed to expand its services. The hospital sought to improve and in the last year introduced ambulatory cystoscopies (bladder endoscopies). In 2015 it introduced eye laser procedures and GP and optometrist events.

Outstanding practice and areas for improvement

Outstanding practice

- Physiotherapists offered treatment to patients both before and after joint surgery. They ran an enhanced recovery programme which was a dedicated programme of rehabilitation offered to all inpatients following hip and knee surgery. This programme provided a personalised rehabilitation and individual goal setting.
- The BMI group aimed for patient's average length of stay for hip and knee replacement surgery to be no longer than 3.5 days. Total average length of stay for hip and knee surgery for the BMI The Sandringham Hospital for July 2016 was 2.3 days respectively.
- The pharmacists attended all weekday ward rounds to give advice on medications. If patients required advice support with medications during outpatients or physiotherapy appointments pharmacists had also provided advice.

Areas for improvement

Action the provider **MUST** take to improve

- The provider must take action to ensure all staff are compliant with the acute care competencies for clinical care.

Action the provider **SHOULD** take to improve

- The provider should ensure all incident investigations have a clear completion date stated on the action plans.
- The provider should ensure the clinical environment is compliant with HBN 00-09 infection control in the built environment.
- The hospital should take action to ensure the theatre departments' access is safe for patients whilst in the department.
- The provider should ensure all staff comply with the Five steps to Surgery process.
- The provider should consider a written policy or treatment criteria for patients living with dementia or patients with a learning disability is available, evidenced based, ratified and up-to-date as a reference point for staff.
- The provider should ensure staff are aware of the business continuity policy in the event of lift breakdown when on generator power backup.
- The provider should ensure that the consent and whistleblowing policies are up-to-date.
- The provider should ensure the two stage consent process is followed, as a recommended following a never event.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Surgical procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment 12(2)a Assessing the risk to the health and safety of service users. Not all staff had completed the acute care competencies for clinical care as recommended following a serious untoward incident for delay in the response to assessing and responding to a deteriorating patient.