# BMI The Beardwood 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 |

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

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

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

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

# Summary of findings

## Overall summary

The Beardwood Hospital is operated by BMI Healthcare. We carried out a comprehensive inspection of BMI The Beardwood Hospital on the 5 and 6 October 2016 and an unannounced visit on the 10 October 2016 as part of our national programme to inspect and rate all independent hospitals. We inspected the core services of surgical services and outpatients and diagnostic services as these incorporated the main activities undertaken by the provider, BMI Healthcare Limited, at this location.

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.

Throughout the inspection, we took account of what people told us and how the provider understood and complied with the Mental Capacity Act 2005.

The main services provided by this hospital were surgery and outpatients and diagnostics. The hospital also offered a dedicated oncology service for patients undergoing chemotherapy which we have incorporated in the review of the outpatient core service. We did not inspect a private service that operated at this location as this was a service from another provider, Alliance Medical. 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 surgical core service.

We rated this hospital as good overall because:

- There was a strong incident reporting culture within the hospital, however, incidents that occurred were of no or low harm. There was a safety focused culture within the hospital and when incidents did occur they were fully investigated, lessons were cascaded to staff through a variety of means and action plans were implemented to prevent reoccurrence.
- The hospital provided care and treatment that was in line with national guidelines and recommendations. There was a programme of audit in place to assess hospital compliance with policies and care pathways. Compliance with hospital policies and care pathways was good.
- Staff at the hospital provided care that was compassionate and caring. We observed staff treating patients with respect and dignity at all times. Patients reported that staff were very caring. The hospital participated in the NHS friends and family questionnaire and 98% of patients responded that they would recommend the hospital to others.
- The hospital was responsive to the needs of the local population and services were planned with patient needs in mind. Patients had flexibility about when they could attend for appointments and treatment. The hospital provided services to patients in a timely manner.
- The hospital leadership was effective in disseminating the organisational vision. There were systems in place which articulated a clear vision for services based on the needs of the patient and the provision of clinically effective services. There were robust governance structures in place which ensured that services provided were clinically effective and patient centred. Staff morale at the hospital was high, with staff reporting that they felt well supported to deliver good care to patients.

We found areas of practice that require improvement in surgery.

- The different incident reporting systems did not always correspond. Surgical site infections were not recorded as clinical incidents, even when they required a root cause analysis, and the number of falls on the quality dashboard did not match those on the incident log. An incident involving a serious injury to a patient did not appear on the incident log.
- We reviewed five world health organisation (WHO) safety checklists and observed a further two. We found that most steps were undertaken appropriately, but it was not consistently undertaken or embedded.
- Surgical site infection rates were higher than other independent hospitals.

# Summary of findings

Following this inspection, we told the provider that it should make other improvements, even though a regulation had not been breached, to help the service improve.

Details are at the end of the report.

Ellen Armistead

**Deputy Chief Inspector of Hospitals**

# 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.<br>We rated this service as good overall. The service was good in effective, caring, responsive and well-led, although it required improvement for being safe. |
| **Outpatients and diagnostic imaging** | Good | Overall, we rated out-patients and diagnostics services as good. Out patients and diagnostics comprised of a significant amount of hospital activity. In addition we inspected oncology services, including a four bed day care unit and included our findings in this section. Where our findings on out-patients and diagnostics also apply to other services, we do not repeat the information but cross-refer to the surgery section.<br>We rated this service as good because it was safe, caring, responsive and well-led. We did not rate the service for being effective. |

# Summary of findings

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Good

# The Beardwood Hospital

**Services we looked at**
Surgery; Outpatients and diagnostic imaging.

# Summary of this inspection

## Background to BMI The Beardwood Hospital

The Beardwood Hospital was acquired by BMI in 1995 and provides a range of medical and surgical services. The premises have operated as a hospital since 1957 when it became a private nursing home run by a Christian religious order providing surgical, medical and midwifery services to the local community.

BMI Beardwood hospital primarily serves the communities of Lancashire; however patient referrals from outside this area are accepted. The hospital has two key partnerships with the following providers:

- The North West Cancer Clinic, delivering outpatient, day case and inpatient cancer care.
- Computerised tomography (CT) and magnetic resonance imaging (MRI) in partnership with Alliance Medical.

The registered manager, Samantha Sheehan is the executive director and has been in post at Beardwood hospital since 5th August 2011.

The controlled drug Accountable Officer is Samantha Sheehan.

## Our inspection team

The team that inspected the service comprised a CQC lead inspector,two other CQC inspectors, and three specialist advisors with expertise in surgery, oncology and another with expertise in governance. The inspection team were overseen by Lorraine Bolam, Inspection manager.

## Information about BMI The Beardwood Hospital

The hospital comprises of a main block which houses one in-patient ward, two theatres and one minor operations room, diagnostic facilities and management accommodation. There are 18 beds on the in-patient surgical ward, seven day case beds in the day case unit and four day-case beds on the oncology unit. There is a physiotherapy and sports injury clinic housed in a separate building across the road from the main site. There were also more complex diagnostic services on site which included computed tomography (CT) scan and magnetic resonance imaging (MRI) on site. However these were provided by another provider and we did not inspect this service.

The hospital provides surgery including cosmetic surgery, an oncology service, and outpatients and diagnostic imaging. We inspected surgery, oncology and outpatient and diagnostic services.

The oncology department provided treatment for cancer patients by means of diagnostics, intravenous and oral chemotherapy and Monoclonal antibody therapy. The service is provided by oncology specialist nurses and consultants.

We inspected this service using our comprehensive inspection methodology. We carried out the announced part of the inspection on 5 and 6 October 2016, along with an unannounced visit to the hospital on 10 October 2016.

The hospital is registered to provide the following regulated activities:

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

We spoke with 21 staff including; registered nurses, health care assistants, reception staff, medical staff, operating department practitioners, and senior managers. During our inspection, we reviewed 30 sets of patient records.

# Summary of this inspection

There were no special reviews or investigations of the hospital ongoing by the CQC at any time during the 12 months before this inspection. This was the hospital first inspection since registration with CQC, which found that the hospital was meeting all standards of quality and safety it was inspected against.

Activity (Reporting period July 2015 to June 2016)

- In the reporting period July 2015 to June 2016 there were 8,380 inpatient and day case episodes of care recorded at the hospital; of these 82% were NHS-funded and 18% other funded.
- 8% of all NHS-funded patients and 28% of all other funded patients stayed overnight at the hospital during the same reporting period.
- There were 32,712 outpatient total attendances in the reporting period; of these 66% were NHS funded and 34% were other funded.
  - Eighty-six medical staff worked at the hospital under practising privileges. Two regular resident medical officer (RMO) worked for two weeks at a time 24/7. BMI The Beardwood employed 24 registered nurses, 26 care assistants and 51 other members of staff. The hospital ran its own bank staff.

**Track record on safety**

- 1 Never Event
- 246 Clinical incidents; 160 no harm, 84 low harm, 2 moderate harm, 0 severe harm, 0 deaths
- 1 self-reported serious injury
- 0 incidences of hospital acquired Methicillin-resistant Staphylococcus aureus (MRSA),
- 0 incidences of hospital acquired Methicillin-sensitive staphylococcus aureus (MSSA)
- 0 incidences of hospital acquired Clostridium difficile (c.diff)
- 0 incidences of hospital acquired E-Coli
- CQC received two complaints between July 2015 and June 2016

**Services accredited by a national body:**

- BUPA accredited Breast Services
- Bupa Accredited MR CT Scanning
- Macmillan Quality Environment Mark for the Oncology Department.
- The service does not have joint advisory group (JAG) accreditation

**Services provided at the hospital under service level agreement:**

- Catering
- Histopathology
- Histopathology reporting
- Pathology

## What people who use the service say

During the inspection, we visited areas where patients receive care and treatment. We observed care being delivered with respect and regard to patients' dignity at all times.

We were told by patients and their relatives that staff were kind and compassionate. This was supported by the hospital's excellent performance in the NHS friends and family test.

We observed staff involving patients in their care during treatment sessions and consultations.

The hospital participated in the NHS friends and family test, where 98% of patients said that they would recommend the hospital to others.

We spoke with 22 patients and relatives. We also received 15 'tell us about your care' comment cards which patients had completed prior to our inspection.

# 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?

**Requires improvement**

We rated safe as Requires improvement because:

- The different incident reporting systems did not always correspond. Surgical site infections were not recorded as clinical incidents, even when they required a root cause analysis, and the number of falls on the quality dashboard did not match those on the incident log. An incident involving a serious injury to a patient did not appear on the incident log.
- We reviewed five world health organisation (WHO) safety checklists and observed a further two. We found that most steps were undertaken appropriately, but it was not consistently undertaken or embedded.
- Surgical site infection rates were higher than other independent hospitals.

However,

- There was a robust system in place to report incidents and staff knew how to report an incident. Incidents were recorded and lessons learnt were disseminated across the hospital. Where repeat incidents had occurred, for example holes in surgical equipment packaging, staff had been pro-active and innovative in trying to resolve this. Openness and transparency about safety was encouraged. Any lessons learnt from incidents were cascaded across the hospital through a number of routes and there was a system in place to ensure all staff saw the lessons learnt.
- Nursing staffing was regularly reviewed and calculated based on patient acuity and dependency. Staffing in theatre was in line with national guidance. There were sufficient staff across outpatients and diagnostics and oncology to provide safe care and treatment.
- There were clear processes in place to access resident medical officers and consultants 24 hours a day. Systems were in place to manage the care of deteriorating patients.
- There was a system in place to ensure all equipment was in clean, in working order and adhering to all relevant safety standards.
- Record keeping was good in patient records and prescription charts.

# Summary of this inspection

- Staff were compliant with the safeguarding training targets and there was information in all clinical areas about how to raise a safeguarding concern.
- There were systems in place to monitor compliance with the hospital prevention and control of infection policy and reporting arrangements on compliance rates were robust. All areas were visibly clean and tidy and a cleaning schedule was in place and regularly monitored.
- The diagnostics and imaging department carried out treatment in line with the Ionising Radiation (Medical Exposure) Regulations (IR(ME)R.

## Are services effective?

Good

We rated effective as Good because:

- People were receiving care and treatment in line with current evidence based guidance and standards.
- Outcomes data indicated that the hospital was performing at a comparable level with other independent hospitals in terms of unplanned returns to theatre, unplanned transfers and unplanned readmissions.
- We saw evidence of pain being assessed and treated accordingly.
- Assessments for nutrition and hydration were completed and documented.
- There were opportunities for staff to undertake courses and work in different roles which allowed them to develop professionally.
- There was participation in relevant local and national audits, and actions from these were discussed and monitored at monthly governance meetings.

However;

Compliance with annual appraisals was variable in surgical services. However, an action plan was in place to address this.

## Are services caring?

Good

We rated caring as Good because:

- Staff were caring and compassionate to patient's needs, and treated patients with dignity and respect. Patients were supported, and were involved in planning their treatment and care.
- Patients were allocated a named nurse which meant they knew who was caring for them and who to approach if they needed assistance.

- Feedback from patients was positive about the way staff treated and cared for them.
- The hospital sought feedback from patients about the service using a BMI questionnaire and the NHS friends and family test. The results were consistently positive as 98% of patients said they would recommend the hospital as a good place to go for treatment.

## Are services responsive?

Good

We rated responsive as Good because:

- The booking system for patients to be treated was flexible and allowed patient choice. There were no waiting lists for surgery.
- An interpreting service was available for patients who did not speak English as their first language and quiet rooms were available on request, for people who required space for prayer or meditation.
- Patients completed a comprehensive pre-assessment process prior to admission.
- Visiting was permitted throughout the day.
- There was a policy for complaints and response times were monitored by senior management. Senior managers had received training in dealing with complaints. We were told about one complaint relating to outpatient/diagnostic charging. In response to this the hospital now provided clearer information about charging. Actions and learning were discussed at monthly governance meetings and disseminated to staff. We saw evidence of this dissemination when a staff nurse reported the actions of the complaint that had been previously mentioned by executive director of the hospital.

However,

- There had been occasions when family members had been used to translate during pre-operative assessment appointments. This is not in line with best practice.
- The outpatients department was signposted. During the inspection we observed numerous patients and relatives making their way to the main reception which was in a separate building, requiring them to be redirected, however all correspondence indicates where patients should report to prior to them attending the hospital. The signposting did not meet the needs of patients with a visual impairment.

## Are services well-led?

Good

We rated well-led as Good because:

# Summary of this inspection

- The hospital had a clear vision for providing services to patients. This vision was disseminated to staff and staff shared the vision.
- There was a robust governance framework in place, which oversaw the strategic and operational direction for the hospital.
- The medical advisory committee (MAC) was highly engaged and a central part of the governance structure. We saw evidence that the MAC was involved in making key decisions about clinical services.
- Staff morale was very positive and all staff reported that they could raise issues of concern with departmental managers and senior managers.

However,

- Although we saw evidence of a hospital risk plan which included a risk register, the register did not have dates when risks were put onto the register or timescales for when identified risks were to be removed.

# 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 | N/A | Good | Good | Good | Good |
| Overall | Requires improvement | Good | Good | Good | Good | Good |

Good

# Surgery

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

## Are surgery services safe?

Requires improvement

We rated safe as requires improvement.

**Incidents**

- There was an incident reporting policy in place. Staff told us there was no 'trigger list' in place, however those we spoke with understood their responsibilities to raise concerns, record and report safety incidents, concerns and near misses. Staff recorded the incident details on a paper form with support from senior staff as appropriate. These were submitted to the management team for signing, and were then returned to the originating department for inputting on to the system by senior staff.
- There had been one never event, (never events are serious, wholly preventable incidents that should not occur if the preventative measures had been implemented) in the reporting period from 1 July 2015 to 30 June 2016. This related to a wrong site anaesthetic block which occurred in February 2016. A root cause analysis (RCA) was completed, which identified a number of actions including a monthly audit of the 'stop before you block' process. We saw evidence that these monthly audit checklists had been completed. We also saw evidence that the event, including learning, had been discussed by the theatre team at their quarterly team meeting.
- There was one serious injury in the same reporting period, which related to an injury following a fall. The action for this was to develop a standard operating procedure (SOP) for care of the confused patient. This had been completed and the SOP had been implemented. However, the incident number recorded on the RCA for this incident related to the above never event and this fall did not appear to be included in the incident log provided by the hospital. Similarly, surgical site infections were also not included on the log of clinical incidents provided to us by the hospital. This meant that when the hospital were monitoring their level of incidents, and any connected themes, they did not have all the information recorded in one place which could provide an incomplete picture.
- There were 246 clinical incidents between 1 July 2015 to 30 June 2016, of which 71% (174 incidents) occurred in surgery or inpatients. The rate of clinical incidents in surgery, inpatients and other services was varied when compared to the rate of other independent acute providers.
- A total of 48 non-clinical incidents were reported during this period, of which 15% (seven incidents) occurred in surgery or inpatients. The rate of non-clinical incidents was similar to the rate of other independent acute providers.
- There was a 'safety cross' displayed on the wall where the daily communication cell meetings took place, recording safety incidents for discussion at the morning meetings.
- Incidents, including learning, were discussed at the bi-monthly theatre team meetings. Ward meeting minutes directed staff to the clinical governance reports for information about incidents. Incidents that required discussion at the time were raised in the team catch-up before the morning theatre list. Staff we spoke with confirmed that they received follow-up from incidents and provided examples of learning that had changed their practice.

- There was a monthly clinical governance and quality and risk bulletin, including lessons learned. This included details of key incidents and the actions that staff needed to take to prevent a recurrence. Staff received this bulletin by email, and had to click on a link within the document to send a ‘read receipt’ to the governance department, indicating that they had read it. In theatres staff kept a ‘league table’ on display in the staff room, showing who had complied with the requirement to read the bulletin. This encouraged a pro-active approach for staff to keep up to date with incidents and learning and staff were proud of their high level of engagement with this process.
- Theatre staff said they were “very transparent” and always told patients what had happened when a problem arose, for example when holes were discovered in the packaging that kept instruments sterile. The patients affected in the ‘never event’ and the serious incident had both been kept fully informed by clinical staff at the time.
- The duty of candour is a regulatory duty that requires the organisation to notify the relevant person that an incident has occurred, provide reasonable support to the relevant person in relation to the incident and offer an apology. The hospital had a duty of candour policy and senior staff were aware of this. We found evidence that the principle of duty of candour was adhered to and that the hospital met with the patient following an incident. In one instance a letter was not sent to the patient explaining what had happened, as required by the policy however, there was good evidence that the patient was satisfied with the outcome and had thanked staff for all they had done.

**Clinical Quality Dashboard**

- There was a quality dashboard in place, where performance indicators, targets and avoidable harms were recorded, however these did not always correspond with other reported figures. For example, there had been three falls reported as incidents between 1 July 2015 and 30 June 2016 (27 March, 11 April and 21 June 2016). The dashboard also recorded three falls, but in April, May and June 2016. There were no falls recorded as incidents on the incident log in May 2016. Therefore we were not confident that all falls were recorded accurately.
- The hospital monitored incidences of avoidable harm. Between 1 July 2015 and 30 June 2016 they reported that 100% of patients had been screened for venous thromboembolism (VTE) where appropriate. There were no reported incidents of hospital acquired VTE or pulmonary embolism (PE) during this time.
- The NHS Safety Thermometer allows teams to measure harm and the proportion of NHS patients that are 'harm free' from pressure ulcers, falls, urine infections (in patients with a catheter) and venous thromboembolism (VTE). The data is collected on one day per month. At BMI The Beardwood, safety thermometer data for NHS patients was collected by the ward manager who submitted it to the governance department. It was not displayed on the wards. Data was not collected for non NHS patients. The ward manager said there had never been any incidences of harm recorded on the data collection day.

**Cleanliness, infection control and hygiene**

- The two operating theatres used a laminar flow system, intended to provide a uniform directional flow of air in the operating room with very little turbulence to minimise contamination of the surgical field with airborne microbes. This system is used widely in orthopaedic procedures to try and reduce the opportunity for surgical site infections (SSIs) to occur.
- Theatres were visibly clean and tidy and up to date cleaning schedules were in place. However, doors to both theatres were scuffed and damaged. This meant there was a risk they could not be cleaned as effectively as required for a theatre environment.
- There were nine SSIs reported between 1 July 2015 and 30 June 2016. These were recorded onto a database, however, there were no reported incidents of surgical site infections included in the hospital incident log for that period.
- Of the nine SSIs, one had been reported in error, one had actions identified and discussed at subsequent clinical governance meetings, and six had no issues identified. There was no trend between the SSIs reported. A root cause analysis (RCA) had been completed for the ninth SSI, in line with BMI policy to undertake RCA investigations on deep and joint/organ space infections.
- The rate of infections during primary hip arthroplasty, other orthopaedic and trauma, breast, upper GI and colorectal and urological procedures was higher than

the rate for other independent acute hospitals. There were no SSIs resulting from primary or revision knee arthroplasty, spinal, gynaecological, cranial or vascular procedures.

- The hospital told us that notes of all patients who developed an SSI were reviewed by the infection prevention and control (IPC) lead. These were reported monthly to the corporate IPC lead. Locally they were discussed at the clinical governance and infection control committee meeting where any trends and actions were tabled. We saw documented evidence of these processes in meeting minutes.
- We requested the investigations from the SSIs and received one root cause analysis (RCA), dated August 2015, which included a timeline and an action plan. The actions were mainly around feedback to, and discussion with, the consultant involved. The November 2015 minutes of the local infection prevention and control meeting indicated that issues around the identified sub-optimal antibiotic prescribing had been discussed and were to be shared with teams.
- All clinical ward areas had appropriate hard flooring to enable cleaning in line with infection prevention and control protocols.
- Hand gel was available in each room on the ward, and basins for patient use were in each en-suite bathroom.
- There were regular audits for bare below the elbow and hand hygiene with ten hand hygiene observations per month recorded in line with the world health organisation (WHO) 5 moments of hand hygiene. Compliance with hand hygiene was mostly good and where non-compliance was found, the member of staff was spoken with at the time and the situation corrected. Notes were documented on the audit forms and we saw evidence of this. In July 2016 one of the ten observations was non-compliant, however for August and September 2016 there was 100% compliance.
- An annual theatre audit provided by the hospital from July 2016 recorded that the service was compliant with hand hygiene, it was performed appropriately, audits were in place and were accessible.
- There was a quarterly infection, prevention and control committee meeting, chaired by the director of nursing and deputised by the lead infection prevention and control nurse. This committee had oversight of the infection, prevention and control programme, including audits, incidents, outbreaks and good practice.
- There were no reported incidents of MRSA, MSSA, E.coli or C.diff infections between 1 July 2015 and 30 June 2016.
- There was a health and safety representative for the hospital who conducted quarterly work place assessments in each department. These included checking the provision of hand gel and personal protective equipment (PPE). They liaised closely with the regional BMI infection prevention and control lead who delivered IPC training to staff.
- Adequate hand hygiene facilities were not available (dedicated hand hygiene sinks available and clearly marked) in all clinical areas. Action plans with timelines were in place to address this.
- The endoscopy service did not meet the standards required for Joint Advisory Group (JAG) accreditation however the in-house decontamination process in use was acceptable practice. Decontamination services were due to be transferred to an external provider.

**Environment and equipment**

- There were appropriately stocked emergency resuscitation trolleys on the ward and in the theatre corridor. Equipment they contained was in date. There was a list of contents which was checked and signed daily by night staff on the ward. In theatre the trolley was checked weekly.
- In theatre one the laminar flow system was reaching time for replacement. However, the system was being monitored to ensure it continued to be safe to use, and it was due to be replaced at the end of 2016.
- Theatre two was equipped with new anaesthetic and ventilation equipment. All equipment was labelled with current service and maintenance dates.
- There was a documented schedule in place in theatres which listed all the equipment in use and included the name of the equipment, serial, reference and asset numbers, the service date and the name of the company responsible for servicing. In addition cleaning dates were logged on the schedule which enabled senior theatre staff to ensure equipment was maintained appropriately.
- Patient-led assessments of the care environment (PLACE) are undertaken by people who go into hospitals as part of teams to assess how the environment supports patients' privacy and dignity, food, cleanliness and general building maintenance. Between February

and June 2016 the hospital's PLACE scores were the same or higher (better) than the England average for all areas except for condition, appearance and maintenance where it scored lower (worse).

- Staff monitored fridge temperatures on Billinge ward which had a completed log where daily fridge and room temperatures were recorded.
- There was a fridge where bloods were stored should they be required for emergency transfusion. This was maintained by an external company which was responsible for re-stocking and delivery.

**Medicines**

- The pharmacy team were available between 8am and 5pm Monday to Friday. The responsible medical officer (RMO) was able to get medication if required at the week-end, and there was also a pharmacist on call.
- We reviewed the controlled drugs books in both theatres and found them to be appropriately completed.
- We reviewed 10 patient records, and nine prescription charts. Nine of the patient records had evidence of antibiotics review where applicable, but one patient did not have a completed medical alert sheet. In this case, as the doctor could not be sure it was safe to use penicillin, an alternative had been used.
- All nine prescription charts were signed, dated and legible.
- There were quarterly medicines management audits completed by pharmacy. We reviewed these from February and May 2016 and there was 100% compliance with the required standards in theatres and the ward.
- There were also quarterly controlled drugs audits. We reviewed these from March and June 2016 and there was 100% compliance with the required standards in theatres and the ward.
- There were other audits undertaken such as a 'medication omissions one day snapshot' and a medication reconciliation report. These highlighted some areas of non-compliance. There were no action plans with these audits, however there was documented evidence that medicines related audits were discussed and actions minuted at the quarterly regional medicines management governance meetings.
- All medications given on discharge were communicated to the general practitioner on the discharge letter.

**Records**

- We reviewed 10 patient records. All had the name and grade of staff documented clearly, all included a diagnosis and management plan and a VTE risk assessment where appropriate.
- All inpatient records had evidence of a daily ward round and of recorded observations and national early warning scores (NEWS).
- All records had consent documented, although sometimes this had been taken prior to admission, and for others, on the day of admission.
- There were falls assessments and pressure area assessments (Waterlow scores) where applicable in all of the patient records. Care plans were included in all 10 records, and all notes were signed and dated.
- Patient records were stored in the ward clerk's office, behind the reception desk, thus promoting patient confidentiality.

**Safeguarding**

- There were no safeguarding concerns reported to CQC between 1 July 2015 and 30 June 2016.
- Safeguarding was included as part of mandatory training and was above the 90% target for all staff. Staff completed the level of training appropriate to their role which was safeguarding children level one, and safeguarding vulnerable adults level one for all staff, and safeguarding vulnerable adults level two for clinicians and non-clinicians in a management or supervisory role.
- The director of nursing completed safeguarding vulnerable adults level three training and was the safeguarding lead for the site. There was a local standard operating procedure (SOP) available in all clinical areas for reporting safeguarding concerns. The SOP detailed a process flowchart with clear instructions about what to do if staff had concerns or were worried about a patient's welfare. All staff received safeguarding training as part of BMI Learn.
- The director of clinical services attended the pan-Lancashire safeguarding assurance meeting where all providers of care meet to assess their safeguarding practices and share lessons learned.
- The hospital completed the NHS annual safeguarding tool which was reviewed on a quarterly basis at the clinical commissioning group (CCG) quality meetings. There was also a BMI annual safeguarding audit tool.
- In each department there was a safeguarding resource folder with a copy of both the local and corporate safeguarding policies and other information including

assessment of capacity and best interest forms. We looked at one of these and found a comprehensive range of information, including material related to female genital mutilation (FGM).

- Theatre staff had never had to raise a safeguarding concern. Ward staff did have previous experience of safeguarding concerns and were able to provide examples of the steps taken. There had been no recent safeguarding referrals on the ward.

**Mandatory training**

- There was a comprehensive BMI mandatory training programme in place which included generic training such as equality and diversity, and more specialised training specific to particular roles, for example acute illness management (AIM).
- Information provided by the hospital showed the 90% compliance target was mostly met by staff, with some exceptions. Fire safety in a hospital environment had only 83% compliance and adult basic life support (clinical) had only 87%, with four people (of 30) not being up to date with this. All three infection and prevention courses were below the compliance target, with the lowest rate of 79% being for the infection prevention and control in healthcare.
- The above figures provided by the hospital were not broken down into individual areas, however theatre staff showed us locally held records showing that mandatory training in surgery was at 100% compliance.
- Managers told us the reason some of the mandatory figures were not compliant with the target was that the policy had recently changed to include bank staff in the training numbers. This meant there was a period of transition while bank staff completed their training.
- Mandatory training was a standing agenda item on the heads of departments and supervisors monthly meeting. We saw minuted evidence that compliance was being actively managed.
- Renewal and update of the mandatory training for the resident medical officers (RMOs) was organised and managed by the external agency who employed them and provided their services to the hospital.

**Assessing and responding to patient risk (theatres, ward care and post-operative care)**

- We reviewed five world health organisation (WHO) safety checklists and observed a further two. Most steps were undertaken appropriately, although one consent form was incomplete which was addressed at the time as detailed later in this report.
- There were exclusion criteria for receiving treatment at BMI The Beardwood. These included no cardiac events within the previous six months and a body mass index (BMI) of 40 or under for NHS patients (50 or under for private patients). Patients with dementia were assessed on a case by case basis but those scoring below the cut-off point on a dementia diagnostic assessment tool would not be accepted.
- In the recovery area in theatres there were three bays where patients were monitored on electronic observation equipment that stayed with the patient as they moved through the different areas. This meant that recovery staff could track patients' observations from pre-operation through to post-surgery.
- Monitoring included a non-invasive blood pressure monitor, electrocardiograph, oxygen saturation (pulse oximeter) and end-tidal carbon dioxide monitoring (capnography) which met AAGBI recommendations.
- The national early warning score (NEWS) was in place as part of patient observations.
- There was a policy in place for management of the deteriorating patient which included actions to be taken when transferring a patient out to the local NHS hospital.
- The major haemorrhage policy was next to every telephone so that staff had immediate access to actions they needed to take should the need arise. A 'scenario' was undertaken every 12 months, which allowed staff to practice what they should do in that situation.
- There was a sepsis policy and a neutropenic pathway in place.
- Two units of O negative blood were stored in Billinge suite in case an emergency transfusion was required, in line with accepted practice. We saw guidance was available for staff in the safe management of medicines policy.
- On one occasion the team members did not introduce themselves. For two checklists there were no patient specific concerns or equipment issues discussed by any of the team, and the time out sections were not signed.

These omissions indicated that the WHO checklists were not fully completed at all times, despite the audit checklist provided by the hospital showing 100% compliance between January 2016 and July 2016.

**Nursing and support staffing**

- There was a nursing dependency and skill mix tool in use as a guide to planning, five days in advance, for the right staffing numbers with appropriate skill mix to be on duty at the right time. This was updated and reviewed on a regular basis, dependent on bed occupancy and patient acuity. Actual hours worked were entered retrospectively to understand variances from the planned hours and the reasons for these.
- For inpatient departments at the hospital the establishment ratio of nurse to health care assistant was 2.1 to one. Establishment figures were based on qualified nurses looking after approximately five patients although this would increase to six for day patients only, or decrease if there were patients with hip or knee replacements.
- There was an appropriate skill mix in the theatre team which included staff trained in anaesthetics, a senior scrub nurse, operating department practitioners and recovery staff. There was one vacancy, for a theatre practitioner.
- The resuscitation lead was trained in advance life support (ALS). In addition an RMO was on site 24/7 and could be called upon as required, who was also ALS trained. This was in line with the recommendations of the Royal College of Anaesthetists guidance 2016.
- Both theatres were staffed in accordance with AAGBI guidelines including appropriate allocation of scrub practitioners where required.
- There were nurse champions on the ward for pain management and for bariatric patients and they would oversee all pre and post -operative care for these patients.
- The use of bank and agency nurses in inpatient departments was mainly lower than the average of other independent acute hospitals during this time, except for in October 2015, November 2015 and January 2016 to Mar 2016 when the rate was higher.
- There were no agency nurses working in inpatient departments in the last three months of the reporting period (1 July 2015 to 30 June 2016). There was no use of bank and agency health care assistants in inpatient departments in the same reporting period.
- Average use of bank nurses in theatre departments in the reporting period between 1 July 2015 and 30 June 2016 was 19% which was similar to the average of other independent acute hospitals that we hold this type of data for. Agency nurses were not used in theatres.
- During the same period, average use of bank operating department practitioners (ODPs) and health care assistants (HCAs) was 2%, which was lower than the average of other independent acute hospitals.
- There was one vacant full time theatre nurse post giving a vacancy rate of 13% at 1 June, 2016 which was above the average of other independent acute providers. There were no vacant posts for theatre ODPs or HCAs.
- There was a 0.8 whole time equivalent (WTE) inpatient nurse vacancy at 1 June 2016 which meant a vacancy rate of 6%. This was below the average of other independent acute providers. There were no vacant posts for inpatient health care assistants.

**Medical staffing**

- The hospital employed their resident medical officers (RMO) via an external agency on a two weekly 24/7 hour rotation. During 2015/16 there were two permanent RMOs who rotated with each other. There were also a number of RMOs who covered the hospital during periods of annual leave over the year.
- Prior to an RMO commencing work at the hospital their curriculum vitae (CV) was sent to the director of nursing and the ward manager for review and agreement. The CVs include evidence of employment history, references, occupational health, and training and general medical council (GMC) details. The CVs were filed in RMO electronic files. Further information about the practising privileges process is detailed later in the report under 'competent staff'.
- The employing agency reviewed the workload of the RMO by a telephone call every Tuesday. If any issues were raised the agency would contact the director of nursing and the ward manager when they were on site. No issues had been raised throughout the year.
- RMOs had open access to the director of nursing and the ward manager when they were on site, with further RMO support from their agency if necessary. The agency also provided the RMO with a 24/7 telephone clinical and non-clinical support service.
- It was a requirement of BMI Healthcare's practising privileges policy that consultants/doctors remained available (both by phone and, if required, in person)

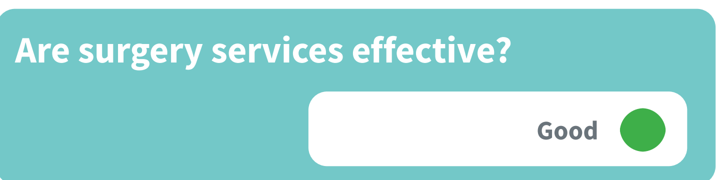
when they had inpatients in the hospital. It was also a requirement that consultants arranged appropriate, alternative, named cover if they were unavailable at any time when they had inpatients in the hospital. This included remaining in theatre to recover patients and attend the patient on the ward.

- There was a telephone book with all the contact details for all consultants listed. When consultants had arranged cover, the arrangements were detailed in the communication book.
- The RMO was only contacted overnight for emergencies and all routine work was completed before 10pm.
- We spoke with the RMO on duty who told us they felt well supported by the hospital. They said their workload got busier in the late afternoon and they were called out approximately once per night. They generally visited the ward at midnight and usually managed to get adequate sleep.
- BMI had recently changed the provider of the RMO contracts so the doctors had changed agencies in order to stay at the hospital. This meant there was good continuity of care.
- The RMO told us they had a good relationship with the consultants who were happy to come out as and when required, to see their patients.

**Emergency awareness and training**

- Staff were aware of business continuity and major incident considerations, for example outsourcing their patients to one of the other local hospitals within their organisational cluster. They had experience of this when another hospital had sent their patients to BMI The Beardwood theatres when their own were out of use due to an issue with the heating and air handling.
- Staff gave other examples regarding loss of essential utilities and told us that the backup generators were checked monthly. They had taken part in an 'earthquake scenario' table top exercise within the last 12 months.
- There was a nurse acting in the role of health and safety representative for the hospital. They had completed the national examination board in occupational safety and health (NEBOSH), a general certificate in occupational health and safety and some additional training provided by BMI.
- The health and safety representative's role included the carrying out of control of substances hazardous to health regulations (COSHH) assessments and bi-monthly fire risk assessments. They liaised with the fire officer for BMI and advised senior management regarding any breaches.

## Are surgery services effective?




We rated effective as Good.

**Evidence-based care and treatment**

- BMI corporate polices based on national institute for health and care excellence (NICE), national and royal college guidelines were available to staff on the intranet. A hard copy of all current policies was available if required.
- The hospital had a corporate audit programme in clinical areas that included a range of regular audit topics such as patient records, the world health organisation (WHO) surgical safety checklist, medicine management and falls. However, these were mostly snapshots or checklists against what was recorded in the notes, rather than complete clinical audits.
- Audit was a standing agenda item at the heads of department meetings and we saw minuted evidence that audit outcomes and actions were discussed.
- The BMI corporate monthly clinical governance bulletins set out relevant NICE Guidance, medical device alerts, drug alerts, patient safety alerts and facilities alerts. It also shared learning and best practice from other BMI hospitals.
- At monthly clinical governance committee meetings a clinical governance report was presented that included audit as a standing agenda item.
- New policies and guidelines were circulated to staff, who had to sign to say they had read them.

**Pain relief**

- Patients we spoke with said they had been regularly asked about their pain and received pain relief when necessary.
- Pain relief was discussed with patients at pre-assessment and pain advice booklets were given to patients for use post operatively.

- Pain scores were documented on the national early warning score (NEWS) chart and responded to accordingly. There were pictorial charts available for patients who were experiencing difficulty communicating.
- Following surgery, pain scores were recorded along with clinical observations. If patients had pain control issues the RMO or the patient's consultant was called to reassess them and amend their medication. The pharmacy team supported pain management at ward level providing advice and support to the clinical teams.
- We reviewed 10 patient records and all had evidence of pain assessment documented.

**Nutrition and hydration**

- Nutritional state was assessed for each patient on admission using the malnutrition universal screening tool (MUST). If a patient scored two due to low BMI, 10% weight loss in six months or had eaten little or no food in the last five days or more, they were referred back to the consultant whose care they were under.
- We reviewed 10 patient records and all included assessment of nutritional and hydration status where applicable.
- Food and fluid intake was monitored using food charts and fluid balance charts. Patients who were unable to feed themselves were assisted by the nursing team.
- In the 2015/16 patient surveys, catering was the area where the hospital scored achieved the lowest score, of 93% satisfaction, when compared with 98% for overall quality of care.
- Patients we spoke with had differing views on the quality of the food provided. Most were satisfied with it, but one patient said there were too many paninis, sandwiches and other stodgy food, and not enough vegetables. Breakfast was well received by all the patients we spoke with.

**Patient outcomes**

- The hospital participated in national audit programmes including patient reported outcome measures (PROMS), national joint registry and the surgical site infection surveillance programme conducted by public health England (PHE). The PROMS programme had recently been extended to include private patients undergoing hip, knee or hernia surgery.
- PROMS data published in May 2016 showed that NHS patients' outcomes were within the estimated range of the hospital's score for health improvements following primary knee replacement, primary hip replacement and groin hernia.
- Internally, a quality dashboard was produced and local data was reported in the monthly clinical governance report and reviewed on a monthly basis for a number of outcome indicators. These included transfers out, returns to theatres, surgical site infection rates, average length of patient stay, day case conversion rates, readmission rates and overall quality of care scores.
- Between 1 July 2015 and 30 June 2016 there were 70 incidents logged where a patient admitted for a day case stayed overnight. All of these were graded as no harm, or low harm. All had reasons and outcomes documented on the incident log.
- Results on patient outcomes were compared with other locations within the region and across other BMI Healthcare regions through the corporate clinical dashboard which used data from the hospital incident and risk reporting database.
- The hospital was engaged with the private healthcare information network (PHIN) in accordance with legal requirements regulated by the Competition Markets Authority (CMA) towards improved reporting of patient outcomes across the independent healthcare sector. The hospital had started to collect data from the consultants; this will enable effective comparison with data available from NHS providers to assist with information transparency and, in turn, patient choice.
- Between 1 July 2015 and 30 June 2016 there were eight cases of unplanned transfer of an inpatient to another hospital giving a rate of 0.96 per 100 patients. This is not high when compared to a group of independent acute hospitals which submitted performance data to CQC. All cases had been reviewed and followed up at the monthly clinical governance meetings. The assessed rate of unplanned transfers (per 100 inpatient attendances) is not high when compared to a group of independent acute hospitals which submitted performance data to CQC.
- In the last 12 months there were four unplanned returns to theatre giving a rate of 0.08 per 100 returns to the theatre. This is not high when compared to a group of independent acute hospitals which submitted performance data to CQC.

- In the last 12 months there w**as one** readmissions to surgery within 28 days giving a rate of 0.02 per 100 patients. This is not high when compared to a group of independent acute hospitals which submitted performance data to CQC.
- There was one unplanned readmission due to a surgical site infection. All were reviewed and investigations were carried out where appropriate.

**Competent staff**

- For a consultant to have been granted practicing privileges at the hospital the applicant must have been licensed and on the specialist GMC register. They must have held a substantive consultant post within the NHS or the defence medical services within the last five years. Applicants were asked to demonstrate relevant clinical experience relating to practice and attended for an interview with the executive director. Finally, applications were passed to the medical advisory committee (MAC) for review with respect to the applicants' qualifications, experience, competence and current fitness to practice.
- Practitioners who did not comply with the above but who could demonstrate relevant experience of independent practice over a sustained period would have their applications considered.
- When cosmetic surgeons applied for practising privileges the hospital considered whether they were bringing something new to the service. For plastic surgeons, consideration was given to their previous experience; however it was difficult for surgeons to get exposure to aesthetic cosmetic surgery in the NHS.
- Between 1 July 2015 and 30 June 2016 one consultant had their practising privileges removed due to retiring. Two had their practising privileges suspended; one while an investigation took place, and the other who took a sabbatical from work. Following investigation the suspension was lifted.
- The resident medical officers (RMOs) completed a BMI induction delivered by their employing agency and a local induction at the hospital of RMO to RMO.
- The hospital told us all staff were required to have an annual appraisal, including a mid-year review. However, compliance with annual staff appraisals was variable. The hospital year ran from 1 October to 30 September so this is how appraisal rates were recorded. In the appraisals year from October 2015 to September 2016 compliance for staff appraisals for nurses working in inpatient departments was above 75%. However, compliance was below 75% for health care assistants and other staff working in inpatient departments in the same appraisals year.
- Compliance was also below 75% for completion of staff appraisals for nurses, ODPs and health care assistants working in theatre departments, in the same appraisals year.
- Staff had taken action to address this and at the time of our inspection the theatre manager told us all contracted staff in theatres had completed an appraisal in the required timescale. Bank staff were in the process of completing their appraisals and 50% were compliant. There was an action plan in place to complete the other 50% by the end of November 2016 and we saw evidence of this. The process had changed to an online system which was described as more user friendly.
- Staff told us there were opportunities for development. The hospital worked with a local university to support health care assistants undertaking training to become operating department practitioners (ODPs). There was an agreement in place regarding student placements, and the hospital would pay the student's fees provided they stayed at the hospital for three years post-graduation.
- A list of internal courses was sent to staff each month, and where training was considered relevant to the person's role, permission was given for the training to be undertaken. Staff we spoke with had completed cannulation and venepuncture training and one nurse had been approved for electrocardiogram (ECG) training.
- A local doctor delivered teaching on topics such as anaphylaxis, and 'can't intubate, can't ventilate'. If a challenging situation had occurred in clinical practice, a course could be put on to educate staff and facilitate learning from what had happened.
- Monthly scenarios for cardiac arrest situations were facilitated by the RMO who was ALS trained. This provided staff with the opportunity to practice their skills for dealing with a patient in that situation, and to receive training and support in a safe environment.

**Multidisciplinary working**

- Staff reported good multidisciplinary working internally and with external organisations. Multi-disciplinary team

meetings took place at ward level and in pre-assessment clinics. Daily concerns and issues were dealt with through a communication (comm) cell structure.

- Comm cell meetings took place in the executive director's office every morning at 9.30am and were attended by the heads of department from each area. Standing agenda items included activity in the departments, staff levels, incidents or issues and moments to celebrate. Information was displayed on the comm cell board, such as dates available for mental capacity act (MCA) and syringe driver training.
- Heads of departments' whereabouts for the week was on display on the comm cell board, as were issues to escalate, alerts, mandatory training compliance rates and results from the quality of care patient satisfaction questionnaires.
- Information from the comm cell meetings was minuted in a communication book for each area and taken back to the departments. Staff were required to read the minutes, and sign to evidence this.

**Seven-day services**

- There were two theatres open Monday to Friday between 8.30am and 8.30pm, and available on Saturdays between 8.30am and 4.30pm. Weekday sessions typically ran from 8.30am until 1pm, 2pm until 5.30pm and 6pm until 8.30pm. On Saturdays there was usually only one session.
- An on-call theatre team was available 24 hours a day, seven days per week. There was a minor procedure room open Monday to Friday between 8.30am and 5pm.
- The radiology department was operational Monday to Friday, from 9am to 5.30pm. The department also provided an on-call service for the ward and theatre with a rota drawn up on
- a weekly basis by the clinical lead for the service. This was shared with main reception and the managers on call for the ward and theatre.
- Pharmacy services were not available at weekends, however the RMO was on site 24 hours a day, seven days a week, and able to obtain medication when necessary.
- The BMI practising privileges policy required that consultants who had any inpatients at the hospital were available by telephone and if required, were available to see their patient. Alternative, appropriate cover had to be made by the consultant if they were not going to be available. The RMO confirmed consultants were readily available for advice by phone and they attended the ward to see patients as necessary.

**Access to information**

- Information needed to deliver effective care and treatment was available to the relevant staff. We saw evidence of risk assessments, care plans and test results in the patient case notes which were accessible to staff.
- We saw evidence of timely letters to the patients' GPs on discharge.
- Staff confirmed they had access to policies and procedures via the hospital intranet.

**Consent, Mental Capacity Act and Deprivation of Liberty Safeguards**

- Qualified staff completed training in the mental capacity act (MCA) and deprivation of liberty safeguards (DoLS). This training was part of safeguarding adults training which was mandatory for all staff.
- There was a consent policy in place which stated that in all circumstances a consent form properly completed and signed by the responsible clinician and the patient must be available in the notes prior to the patient leaving their room for surgery or other invasive procedure for which written consent is required.
- Information provided by the hospital, both in the provider information return (PIR) and in the consent audit, referred to a two stage process, with stage one being the provision of information prior to admission, and stage two being a written consent form as above.
- The chair of the medical advisory committee said there was usually a four week cooling off period for cosmetic surgery, although this could be less for aesthetics such as skin cancer or breast reconstruction. The minimum requirement of a 14 day cooling off period was adhered to.
- Written consent was not obtained in advance for cosmetic surgery, but a letter was sent out to the patient with details about the proposed procedure including the likely benefits and the probabilities of success, any serious or frequently occurring risks and options for treatment or management of the condition. We saw examples of these letters in the patient records.
- We reviewed a checklist audit of 10 patient records undertaken in September 2016. All audited records had completed consent forms, however none had a record

of any information provided to the patient. The consent policy states that information must be provided to the patient and documented in the patient record. The audit did not include actions to address this.

- We also reviewed 10 sets of records, all of which included signed consent forms. There was evidence of discussion with patients prior to admission, with information provided to patients about the procedures being undertaken, and any risks and potential complications.
- One consent form in the notes was incomplete and had no patient ID, date of birth or age. The patient signature was not dated and the confirmation of consent by health professional was not completed.
- We observed one consent form in theatre not signed by the surgeon. We raised this with a manager and it was dealt with appropriately at the time. An incident form was submitted and the matter was discussed with the patient who felt fully informed and was happy to continue with the procedure.

## Are surgery services caring?

We rated caring as Good.

### Compassionate care

- We observed staff treating patients with care and compassion. We saw nursing staff introducing themselves and actively interacting with patients.
- We saw staff knocking on patients' doors before entering their room, and being respectful of patients' privacy and dignity.
- Patients were allocated a named nurse which meant they knew who was caring for them and who to approach if they needed assistance.
- The hospital carried out patient satisfaction surveys using inpatient postcard questionnaires as well as a more detailed long-form questionnaire. These were analysed by an independent provider and the results were published and shared monthly. For the 2015/16 patient surveys 98% of responses for overall quality of care provided a very good or excellent response.
- The hospital participated in the friends and family test (FFT) for NHS patients. The hospitals FFT scores were similar to the England average of NHS patients across the period January 2016 to June 2016. Response rates were above the England average of NHS patients apart from in May 2016.
- Comments from patients, both positive and negative, were acted upon and shared at the daily communication cell, at monthly heads of department meetings and recorded within the clinical governance reports.
- We spoke with seven patients and all were happy with their care and treatment. One patient described the staff as "absolutely wonderful – all of them" and said they could not do enough for them. Another described the staff as brilliant, and said it was a nice friendly hospital, with nothing to complain about.

### Understanding and involvement of patients and those close to them

- All the patients we spoke with said they had discussed their surgery with the doctors who had explained the risks involved, and gone through the consent procedure.
- We saw evidence in the patients' notes that risks and complications of surgery had been discussed with the patients.

### Emotional support

- Nursing staff discussed the support a patient had at home when they came for their pre-operative assessment. If the patient appeared unduly anxious they recommended that they see their GP.
- Patients we spoke with said staff had asked them if they felt anxious when they arrived. Staff checked on them regularly and they said they had not needed to ring the call bell.

## Are surgery services responsive?

We rated responsive as Good.

### Service planning and delivery to meet the needs of local people

- There were two theatres where types of surgery undertaken included orthopaedics, general surgery, gynaecology, urology, endoscopy, ear, nose and throat (ENT), spinal, cosmetic/plastic and dental.

- There was a minor procedure room for procedures such as cystoscopies under local anaesthetic, pain management and orthopaedic injections administered under local anaesthetic using imaging guidance. Patients were accommodated in the nearby ambulatory care area.
- Billinge ward had 18 single sex individual en-suite rooms and was used by inpatients and day-case patients. Inpatient occupancy was described by staff as low, with the majority of patients treated as day cases. There were usually between one and nine inpatients overnight. Occasionally there would be ten if a planned day case resulted in an unplanned overnight stay.
- The Pleasington suite could accommodate seven day case patients and provided single sex accommodation for ambulatory care and pain management between 8am and 5pm, Monday to Friday.

**Access and flow**

- BMI The Beardwood hospital did not have waiting lists for surgery. Patients were offered surgery according to their own availability, taking into account the need for a 'cooling off' period following consultation and the clinical need and urgency for the surgery. The nature of the private work at the hospital enabled choice for patients in respect of when to access the care they needed.
- Above 90% of patients were admitted for treatment within the 18 week NHS referral to treatment pathway in the reporting period between 1July 2015 and 30 June 2016. There was a hospital NHS team which monitored patient wait times and helped facilitate admissions to ensure no breaches occurred.
- Theatre utilisation was reported as 39% in July 2016 and 41% in August 2016, however these figures were not reflective of actual usage as they were calculated using the assumption that theatres were in use for 10 hours per day, seven days per week.
- In August 2016 the hospital had started to use a new electronic tool which will enable more accurate calculations of theatre capacity and utilisation including available versus planned and actual, staff activity, involvement in operations, average timing. It will also enable staff to collect information about bookings and cancellations.
- Pre-operative assessments took place on the ward and there were two full time registered nurses, one health care assistant and two part time registered nurses carrying these out. The assessments included taking blood samples when required, an electrocardiogram (ECG), haemoglobin A1c (HbA1c) testing for diabetic patients and MRSA screening. The MRSA tests were sent away and if they were returned as positive, the patient was treated ready to come back on day six for surgery.
- Payment for NHS patients included up to three nights admission for hip and knee operations so a mobility assessment formed part of the pre-operative assessment. If it was likely to take longer than this for the patient to be up and mobile this would be discussed with the ward staff and the surgeon to accommodate the potential extended length of stay.
- There was a separate pre-operative review with the anaesthetist. If either of these appointments identified a problem, for example the cardiac tests results were not as expected or a medication review was required, a cancellation form was completed and the reasons were discussed with the patient.
- When a patient's surgery was cancelled on the day of surgery for non-clinical reasons, the patient was offered an alternative date within 28 days of the original date where possible. In the Provider Information Return (PIR) BMI The Beardwood Hospital reported they had cancelled 18 procedures for a non-clinical reason in the last 12 months; of these 61% (11 patients) were offered another appointment within 28 days of the cancelled appointment.
- The most common reason for cancelling patients was when holes were found in the wrapping around the sterile instruments. This meant there was a risk of infection. The hospital was pro-active in minimising the chance of this happening and had introduced their own systems to keep the equipment trays secure.
- Consultant surgeons were encouraged to submit details of their annual leave as far in advance as possible, to enable their sessions to be offered ad hoc to other consultants in their absence. This reduced the chance of theatres being out of use.
- Patients were timetabled in to make the best use of theatre and of available beds. Admission times were staggered. If a surgeon requested a change to the order of the list, this could be made up to a week in advance but changes on the day were avoided where possible, to reduce the risk of errors being made. If a list was changed on the day it was reprinted on orange paper. If

further changes were made, the list was reprinted on red paper, for example if blood tests were not back in time. If any more changes were required, the list was cancelled as it was considered too risky to go ahead.

- Certain factors were considered when determining the order of the list, for example patients with a latex allergy would be scheduled first so as to minimise the opportunity of them coming into contact with latex particles in the air. More major operations were usually scheduled later, as these patients would need inpatient beds.

**Meeting people's individual needs**

- Provision of signing services was available if required for patients with hearing difficulties and hearing loops were installed at the main reception.
- In response to the cultural needs of patients, access could be provided to a quiet room for prayer or meditation, upon request at the hospital reception. The hospital did not have a dedicated multi-faith room, however this had been identified as an area for improvement and plans were in place to develop an area for this purpose.
- There were three pre-op assessment rooms and a quiet room which could be used if a family needed to stay over with a very unwell oncology patient or if a consultant needed to speak with a family privately.
- Interpreters could be arranged through the NHS office if they were required for a surgical patient; however there had been occasions when family members had been used to translate during pre-operative assessment appointments. This is not in line with best practice and nursing staff could not be sure that the patient was being given the correct information. Staff said that as the pre-operative appointments were made by the reservations team, they would not always know in the department, that an interpreter was required.
- A screening process was in place pre admission for patients with complex needs to minimise the risk of these patients being treated at the hospital. Staff gave us examples of how they may support patients with additional needs, for example those living with dementia or learning difficulties although this was rare.
- Visiting hours were between 11am and 9pm which meant visitors could spend most of the day with their relatives or loved ones.

**Learning from complaints and concerns**

- There were 32 complaints received by the hospital between July 2015 and June 2016. None of the complaints were referred to the ombudsman. The rate of complaints was similar to the rate of other independent acute hospitals. The hospital had a compliments and a comprehensive complaints policy which clearly outlined the management process to be followed when a complaint was received, including the monitoring process. There were electronic records in place for verbal and written complaints. These included a brief summary of the complaint and the status, for example whether or not it was upheld, and what the outcome was.
- The complaint investigation file was reviewed, along with the response to the patient by the hospital manager, who then approved the complaint response letters. Complaints were a standing agenda item at the monthly clinical governance meeting. We saw documented evidence in the minutes of discussion around complaints, as well as details of complaints, outcomes and actions in the monthly clinical governance report.
- Corporate protocols require that complaints should be acknowledged in writing to the complainant within 2 working days.
- Patient complaints then follow a three stage process, with each stage having a set timeframe. Stage 1 involves an investigation and response by the hospital within 20 days; stage 2 will result in regional or corporate investigation and response within 20 days and stage 3 provides for an independent, external adjudication.
- Whilst the hospital has been compliant with these timeframes in the majority of cases, there have been a small number of cases over the last 12 months when they have failed to meet them due to the complexity of the investigations. The patients were however kept up to date regarding the delays.
- Staff were aware of the complaints process and were able to discuss changes of practice with us that had occurred following complaints investigations. Learning was disseminated to staff via the communication book, following the communication (comm) cell meetings held by heads of department, and via a monthly lessons learned bulletin.
- The director of nursing /clinical services and the hospital manager were responsible for co-ordinating and managing the complaints procedure. The director of clinical services was directly responsible for ensuring

Good

# Surgery

comprehensive investigations were undertaken on clinical aspects of complaints and for ensuring any recommendations made from complaints were shared and acted upon clinically.

- The manager was working towards improving their responses to complaints. An annual audit of compliance with their complaints policy was conducted from October 2015-September 2016, which highlighted areas for improvement, for example the sending out of a holding letter.

## Are surgery services well-led?

Good

We rated well-led as Good.

### Leadership / culture of service

- Staff we spoke with in surgery described feeling valued and felt part of an inclusive, supportive team. They felt involved in the decision making processes within the hospital.
- Staff could be nominated for awards when colleagues felt they had gone 'above and beyond' their usual role. There was formal recognition for the winners from the senior management team. Staff reported there was a positive culture for raising any concerns.
- Ward staff said senior management were visible and came into the departments two or three times daily. They felt able to approach senior management if necessary, and said they regularly did so.

### Vision and strategy

- The BMI corporate vision focusses on delivering the best patient experience, best outcomes and being cost effective. BMI The Beardwood has been proud of its sustained top 10 ranking in the BMI Healthcare's independent patient satisfaction surveys.
- There was a 'mission statement' displayed on the wall in theatres and the theatre manager was clear that the team strove to achieve high standards both in their clinical practice, and in fulfilling their personal responsibilities, for example keeping up to date with reading policies, attending training and reading minutes from meetings.
- The theatre team had undertaken relevant training and the improvements to the environment had improved compliance with standards.
- Staff reported the manager shared plans for the hospital at the monthly staff meetings, examples included development of a multi-faith room for prayer or meditation.

### Governance, risk management and quality measurement

- The hospital has a robust structure of nine sub-committees feeding the monthly Clinical Governance meetings.
- There are also weekly senior management team meetings and daily hospital communications meeting.
- MAC meetings were held quarterly and the MAC chair met with the executive director at least fortnightly. MAC minutes showed evidence that incidents were discussed and actions were followed through resulting in lessons learned.
- The medical advisory committee (MAC) chair tenure was three years. Most specialties were represented on the MAC. The chair told us meetings were well attended, and doctors could nominate a deputy to attend on their behalf if they were unavailable.
- The hospital cascaded regular corporate updates including a monthly clinical governance bulletin, with associated action plans developed following their publication.
- There were monthly meetings for the heads of departments and supervisors. The standing agenda included staff related matters including training and status of appraisals. Operational, governance and business matters were also discussed at these meetings.
- Both the hospital manager and the clinical manager had a number of years' experience with the BMI group and were fully aware of the corporate vision.
- We reviewed the risk register dated October 2016, where we identified that there were no timescales regarding when risks were entered onto the register or for when risks can exit the register. The service had had concerns regarding the robustness of the risk register and there were imminent plans for the introduction of a new 'risk man system'. We were assured these issues would be rectified by the introduction of the system. However, a delay in its implementation had occurred following the pilot phase.

**Public and staff engagement**

- Patients were encouraged to complete feedback through three questionnaires. Either in paper format or on-line, in short or lengthier surveys. Comments were acted upon and shared at the daily communication cell.
- Patient-led assessments of the care environment (PLACE) were undertaken by people who go into hospitals as part of teams to assess how the environment supports patient's privacy and dignity, food, cleanliness and general building maintenance. Between February and June 2016 the hospital's PLACE scores were the same or higher (better) than the England average for all areas except for condition, appearance and maintenance where it scored lower (worse).
- Engagement with the staff is through bulletins, team meetings and each year a staff survey is conducted by BMI Healthcare. The Beardwood Hospital received excellent feedback ranking 2nd overall in staff satisfaction. Staff reported they felt valued and were happy to work there.

**Innovation, improvement and sustainability**

- The hospital manager told us continuous learning and improvement was engendered through access to training and development opportunities. Learning and auditing the service to see how the service is for patients was ongoing. Staff confirmed that improvement was acknowledged and celebrated, for example the oncology unit's Macmillan quality environment award and the ambulatory care service.

# Outpatients and diagnostic imaging

Good

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

## Are outpatients and diagnostic imaging services safe?

Good

We rated safe as good.

**Incidents**

- There was a system in place for staff to report incidents. Staff received training on how to complete an incident form. Staff reported incidents on a paper reporting system and this was then transferred onto an electronic system by managers once they had been reviewed. All managers, clinical and support staff we spoke with were able to tell us how they would report an incident and were confident describing issues that they recognised as incidents. Staff reported that they received timely feedback on the outcome of incidents they had reported, which enabled lessons to be learnt from them.
- Findings from all incidents were shared across all departments at team weekly meetings, handovers and through emailed bulletins. We saw from BMI healthcare bulletins that lessons from incidents were shared between providers. We saw a proactive system of cascading outcomes from incidents across all staff groups which encouraged reflection and learning from incidents. At the time of our inspection there was no analysis of trends arising from the incidents occurring, however, because the department was small and there were of very few incidents, learning from them was able to be cascaded to departments, teams and individuals rapidly.
- We were provided with evidence of the lessons learned from incidents changing practice to prevent reoccurrence. A recent incident was discussed with inspectors where the laboratory did not return the test results from a swab taken for analysis to the outpatient department in a timely manner. This had resulted in the standard operating procedure for laboratory requests being changed to allow the laboratory to easily identify priority requests. There had been no repeat of the initial incident since the changes were implemented.
- For the period July 2015 to June 2016, from the information sent to us pre inspection, 22 clinical incidents were reported across outpatients and diagnostics services, which were all low harm. The rate of clinical incidents in outpatient departments is similar to the rate of other independent acute providers. Following our inspection it was reported that there were only 7 non clinical incidents.

**Cleanliness, infection control and hygiene**

- A BMI infection prevention and control lead visited the hospital weekly. Staff told us that infection control had a high priority within the hospital.
- Staff had access to infection prevention and control guidance.
- All areas of outpatients, diagnostics, and oncology and physiotherapy departments were visibly clean and tidy. We were informed that a deep clean took place on a weekly basis in outpatients. We saw evidence that there was a regular cleaning schedule in place, which was monitored.
- Between July 2015 to June 2016 there had been no incidences of healthcare associated infections. Infection prevention and control training was provided for all members of staff as part of their annual mandatory training. If staff were involved in patient contact they received an annual face to face teaching session and hand hygiene competency check. Clinical staff received

more detailed training involving aseptic non- touch technique, a standardised approach to performing procedures in order to reduce the risk of a healthcare acquired infection and a competency check.

- We observed that staff adhered to hospital hand hygiene policy. We found that all clinical areas undertook ten hand hygiene observations per month based on the world health organisation (WHO) 5 moments of hand hygiene. For the period April to June 2016, the hand hygiene audits revealed 100% level of compliance with hospital policy. We observed one consultant who did not adhere to bare below the elbow policy during the inspection, other than that instance we observed 100% compliance with hospital policy We raised this one instance with the senior nurse who assured us this would be addressed. We saw evidence that the results of the hand hygiene audits were reported into the clinical governance and the infection control committees of the hospital and any trends were discussed. Results of the hand hygiene audits were shared with all departments.
- Staff were seen to be compliant with the hospitals infection and prevention policies, wearing personal protective equipment including gloves and aprons when appropriate. Staff had access to gloves for extra protection when administering chemotherapy. We found there was an adequate supply of hand sanitiser gel in appropriate places throughout outpatients and diagnostics and on the oncology suite.
- Some areas of outpatients and diagnostics did not have handwashing sinks which complied with national infection prevention and control guidelines. This was discussed with the IPC lead nurse. We saw evidence that the hospital had a refurbishment plan in place which included replacing handwashing facilities in the x-ray treatment room and in all the consulting/treatment rooms of outpatients. It also included the replacement of outpatient chairs and flooring with suitable products which complied with national guidelines. There were timescales included in the refurbishment plan and we saw that it was a hospital priority. We saw work had commenced as two of the consulting rooms had been refurbished including the replacement of sinks and flooring with products that complied with infection prevention and control guidelines.
- All equipment in the diagnostics and ultrasound department was visibly clean with cleaning schedules in place

**Environment and equipment**

- The outpatient department was housed in a separate single storey building on the main hospital site. There was an open plan waiting area with a sufficient seating to accommodate patients and relatives whilst waiting for their appointment. There were eight consulting and treatment rooms which were all of the appropriate size.
- The dedicated four single roomed oncology day case unit was visibly clean, well equipped and compliant with infection control policy. Patients spoke favourably about their rooms, telling us they were spacious, clean and had a great view. The unit provided a safe environment for treating patients. There was vinyl flooring throughout and chairs were easily wiped down. Staff told us they had the necessary equipment to provide safe and effective treatment.
- Resuscitation equipment was available in outpatient areas and on the oncology suite, however there was no resuscitation trolley in the radiology department. Due to the location and restricted access of the radiology department we raised our concerns with the management team as access to resuscitation equipment in the event of an emergency would not be immediate. Management were aware of the risk and had undertaken a full risk assessment of it, via an external company who carried out a simulation exercise. The simulation exercise involved an ‘emergency grab bag’ being taken from the outpatient suite down the stairs to the radiology and the resuscitation trolley following in the lift. The hospital had responded to this identified risk immediately and placed a defibrillator in the radiology department. When we returned for our unannounced visit we were informed that an additional portable defibrillator had been purchased. for the radiology department and we were shown the purchase order.
- Systems were in place to monitor resuscitation equipment. There was a daily checking system in place for a staff member to sign that these trolleys were fully and appropriately stocked and equipment they contained was in date. During the inspection we found there was 100% compliance with the system of monitoring the equipment. Information to support the resuscitation procedure was visible at the trolleys, including the hospital policy and the resuscitation team information.

- Patient-led assessments of the care environment (PLACE) were undertaken by external assessors. The purpose of PLACE assessments is to assess if the environment is clean, standard of food is appropriate, building fabric and maintenance is sound and whether the environment supports patients' privacy and dignity. For the period February to June 2016 the hospital's PLACE scores were better than the England average, except for condition, appearance and maintenance where it performed worse than the England average.
- We found that the physiotherapy department was well-maintained and in good order. However, we found the fabric of the outpatient and diagnostic department to be variable in quality. Some areas were newly refurbished including the consulting rooms in outpatients and the mammography and ultrasound room in radiology.
- We found that there were areas of outpatients and radiology which required refurbishment. In particular we found that there were fabric covered chairs and carpeting in the outpatient area and in most consulting rooms. These coverings did not comply with the most recent national requirements for infection prevention and control as they are not easily cleaned. There was a refurbishment plan in place which included replacing outpatient chairs with plastic covering and replacing carpeting with vinyl flooring throughout the department. During the inspection we found the light in the toilet for the disabled toilet did not work and the emergency pull cord was broken. We raised these issues and they had been addressed when we attended for the unannounced inspection. Plans were in place for the refurbishment of the main x-ray treatment room and the situation of staff toilet and handwashing facilities. This had been identified by hospital management and an action plan was in place with timescales.
- Equipment we checked was found to be maintained and in working order. We observed that all equipment had up to date labels indicating portable appliance testing (PAT) had been carried out within the required time frame and showed the due date for the next test.
- There was an asset register in place and a schedule for equipment replacement. The diagnostics and imaging department had recently purchased two new pieces of imaging equipment, a mammogram and an ultrasound. The hospital's mobile intensifiers had been replaced within the past five years. The hospital had a service level agreement with a company to service all diagnostic and imaging equipment. A decision had recently been made by the hospital to decommission the fluoroscopy imaging service because the machine was old and not fit for purpose.
- The oncology unit had been awarded the Macmillan quality environment mark; a quality framework for assessing whether cancer care environments meet the standards required by people living with cancer.

**Medicines**

- Staff confirmed they had access via the computer to BMI's current medicines management policies and procedures so they could be guided to manage medicines safely. Staff confirmed they were made aware of any changes by alerts.
- We found all medicines fridges were in good working order and there was a system in place to monitor fridge temperatures. We found that this system was adhered to at all times.
- All drugs held in outpatients were in date and appropriately stored. Medicines that required refrigeration were stored in a locked fridge and the senior outpatient nurse on duty held the key.
- The oncology unit had secure storage for medication in a temperature controlled room, including a dedicated fridge for chemotherapy drugs storage. Ambient temperatures were recorded and maintained to ensure the medicines potency. Records showed nursing staff checked the temperature on a daily basis to ensure the safe storage of medicines. Appropriate monitoring and audits were in place for the safe management of medicines. Controlled drugs were managed well and in line with national guidance and legislation.
- Chemotherapy drugs were stored in a dedicated fridge in the pharmacy department until released for individual patient usage when they were safely transferred to the unit.
- All chemotherapy drugs were bought in, dose and patient specific to minimise the risks to patients. The on-site pharmacy used an e-prescribing system for chemotherapy drugs. This system had many safety features built into it, for example a consultant was unable to produce a prescription unless a patient's blood results, height and weight were provided. We looked at three chemotherapy prescriptions that included the protocols for staff to follow, including any regular investigations and guidance for side effects.

- Chemotherapy spillage kits were available on the oncology unit and the management of clinical and cytotoxic waste was managed appropriately.
- Sufficient competent staff were available to administer medicines via intravenous lines. Ward staff were not trained in oncology, so unit staff provided the support to any oncology patients who were in-patients who required care with intravenous lines.

**Records**

- A system was in place for the management of patient records in outpatients, which included an identifiable trail for the handling of medical records. This system was designed to ensure that when patients attended outpatients, their medical records were always present for the consultant to view. The hospital did not undertake audits of compliance with hospital policy for record management in outpatients. However, staff reported there had not been any occurrences of missing notes for clinic appointments. If this had occurred an incident form would have been completed in line with hospital policy.
- Patient records were securely stored in a locked clinical audit department, within outpatients which members of the public were unable to gain access. Administration staff in the outpatient department handled notes in both the main outpatient department and consulting rooms. This meant there were always administrative staff present who understood each point of the process of handling patient records when patients attended for clinic appointments.
- We were told that medical records were identified prior to clinic. If it was identified that a record was not present there was a system in place to identify the last location of it. The day before clinic a member of staff reviewed the patient records to check if all required diagnostic tests and laboratory results had been completed and the relevant reports were present in patient notes.
- On the day of clinic, notes were stored in the nursing office, in order for consultants to review records during a consultation, or with nursing staff as they undertook treatment. Patients medical records remained on site at all times.
- We reviewed five sets of medical records in outpatients. All records had the name and grade of staff that had carried out assessments and treatments clearly documented. All records were signed and legible and in good order, with results of diagnostic tests secured into the records.
- In addition, we reviewed five sets of patient records in the day case unit. There was a yellow alert sheet within all the notes detailing communication difficulties such as hearing difficulties, patients' methicillin resistant staphylococcus aureus (MRSA) status and any allergies. We noted that in one record there was no allergy to penicillin recorded on the alert sheet even though the consultant had recorded this allergy in the patient's medical notes. We also noted that there was a misspelling of a drug that a patient was allergic to in one set of records. We had concern that misspelling of a drug a patient was allergic to had the potential to create a risk. We raised these issues at the time of inspection. These concerns were rectified immediately.
- The diagnostic and imaging department used a computerised system of record keeping where all information regarding the patient was stored, including all images, consent and referrals.
- On the oncology unit, systems were in place to manage patients' records securely. Staff accessed patient information from the NHS hospital where the patient was from, which included their treatment/management plan. We reviewed 10 patient's care records. Records were completed to a good standard including risks which were identified on an individual patient basis and appropriate action was taken by staff in response to these risks. Risks relating to cytotoxic (chemotherapy) medications were included. We saw one set of notes where the consultant's handwriting was unclear around the patient's risks. This was raised with the nurse in charge who told us this would be raised.
- Multidisciplinary team (MDT) meeting for oncology patients were discussed at their NHS hospital, relevant to their speciality. Copies of outcome forms from the MDT meetings and letters sent from the consultant to the GP, surgeon, palliative care team and patient were seen held in a sample of patients' notes. This meant the staff had up to date patient information.

**Safeguarding**

- We reviewed the hospitals policy for the safeguarding of vulnerable adults which included types of abuse and

action staff were required to take to report abuse. Safeguarding policies and standard operating procedures were in place for both vulnerable adults and children.

- Safeguarding training was a part of the annual mandatory training programme for all staff. Outpatients and diagnostics and oncology staff were all trained to level 1 and 2 safeguarding for adults.
- The director of nursing was the safeguarding lead for the hospital and attended a regional safeguarding meeting where discussions took place about local policies, procedures and incidents of safeguarding concerns. The director of nursing was trained to level 3 safeguarding for children..
- A safeguarding folder was kept in each department which contained the BMI corporate policy and the local hospital policy. This contained a wide range of information including information regarding female genital mutilation (FGM). Staff were aware of the policies and knew how to raise a safeguarding concern. However, no staff had raised a safeguarding alert. No safeguarding concerns had been raised in the hospital in the previous year.

**Mandatory training**

- There was an annual mandatory training programme in place for all staff. The generic programme was supplemented with modules of specific relevance to particular groups of staff. An example of this is that porters were trained in the transport of medical gases. The programme was a mixture of e-learning and face to face training. Examples of modules that were completed face to face were moving and handling, hand hygiene, basic life support and fire safety training.
- There was a hospital target of 90% compliance with the mandatory training programme. Compliance summary reports were provided to each department on a monthly basis. Up to 3 October 2016, there was 100% compliance with the mandatory training programme across outpatients and diagnostics and oncology.
- There was a commitment to staff development and training. Examples of courses staff on the oncology unit had undertaken since 2015 included: Nature of Cancer Course, Communication Skills Courses, Chemotherapy Administration and Care Level 6, Palliative and End of Life Care and Symptom Control in Palliative Care.

**Assessing and responding to patient risk**

- Staff in both outpatients and oncology were aware of how to respond if a patient became unwell. They would initially contact the resident medical officer who was available 24 hours a day.
- The diagnostics and imaging department carried out treatment in line with the Ionising Radiation (Medical Exposure) Regulations (IR(ME)R. Local radiation protection rules were visible and were easily accessible to diagnostic and imaging staff.
- Staff wore radiation detection badges that were monitored to ensure they were not exposed to unsafe levels of ionising radiation. We were told that feedback about levels of radiation exposure was included in the annual staff appraisal process. We observed that protective gowns were readily available, clean and free from damage. We saw that safety guidance for staff such as ‘stop and check posters’ were displayed in the department with the aim of maintaining staff safety awareness.
- All diagnostic and imaging staff had received training in acute illness management (AIM), which enabled them to swiftly identify and respond to a patient who had become acutely unwell. This was particularly important in diagnostics as, there was the potential for a patient to have an allergic reaction to the intravenous contrast media used, even though it was only used in small amounts.
- Staff told us that if a patient’s condition deteriorated or they were required to stay overnight they were transferred to the inpatient ward. An oncology nurse would monitor their patient, deal with their intravenous lines and support them if they were receiving chemotherapy.
- Nurses on the oncology unit used the United Kingdom Oncology Nursing Society (UKONS) triage tool. This is a risk assessment tool that standardises and supports excellent practice and provides evidence of service provision. The tool provides a robust framework for triage assessment, action and audit, and as a result leads to improved quality and safety in patient care. We looked at six completed triage log sheets for patients who call the unit by phone.
- These were clearly recorded and included completed indicators to assess if a patient may have sepsis and required assessment.
- Patients in diagnostic and imaging confirmed they were asked if they are or might be pregnant to minimise any risks presented by radiation.

Good

# Outpatients and diagnostic imaging

### Nurse and radiographer staffing

- The diagnostics and imaging department and oncology had adequate staffing.
- Prior to inspection we were given information to indicate that there were 3.9 whole time equivalent (WTE) registered nurses in the outpatient department. During inspection this figure was slightly different as one member of staff had transferred temporarily to a neighbouring BMI hospital. The number of registered nurses at the time of inspection was one full-time and two part-time positions. There were 3.8 WTE health care assistants for the outpatient department. The staffing levels were flexed according to the number of clinics running and the number of patients attending.
- The outpatient department had a low usage of bank and agency staff for both registered nurses and health care assistants compared to other independent acute hospitals in England. From June 2015 to July 2016 the percentage of bank and agency usage varied throughout the year for registered nurses from 0% to 5% in January 2016. For health care assistants the percentage usage was still low although more variable than registered nurses. It ranged from 1% in February 2016 to 13% in August 2015, reaching 15% for one month only in September 2015. There had been no use of bank or agency staff used in outpatients in the last three months of the reporting period June 2015 to July 2016.
- Nursing staff on the oncology told us they had sufficient staff on duty to provide safe and effective care to patients. There was one registered nurse and one healthcare assistant to four patients. Patients told us they felt ‘extremely well looked after’ and staff were always patient, thorough and kind when explaining and providing treatment for them.

### Medical staffing

- There were 86 consultants operating under practicing privileges and only consultants with approved practising privileges worked at the hospital. There was a rota for consultant radiologists which provided on call cover 24/7.
- Any Oncology patients who are in-patients on the ward are seen by their Consultant daily and he/she liaises with the RMO and nurses as to the care plan. If the patient is in for their regular chemotherapy the RMO would admit the patient and if there were any issues the nurses or the RMO would contact the Consultant for advice.

### Emergency awareness and training

- There were business continuity plans in place in the event of a major incident, of which all staff we spoke with were aware. Staff were able to tell us these plans were available on the intranet and a paper copy was accessible to them.
- Staff gave us a practical example of backup generators being available in the event of a power cut and these were regularly checked. We were told that the hospital had taken part in an emergency simulation exercise in the past year and records confirmed this.

## Are outpatients and diagnostic imaging services effective?

We inspected but did not rate effective.

### Evidence-based care and treatment

- Care and treatment in outpatients and diagnostics was delivered according to national clinical guidelines and in line with evidence based practice. The hospital had policies and procedures in place which followed national guidelines such National Institute for Health and Care Excellence (NICE). We saw examples of care pathways in outpatients and diagnostics. Examples of this included care pathways for x-ray imaging.
- We found that the hospital had an audit programme in place to monitor compliance with key policies and procedures. For outpatients and diagnostics the hospital undertook three monthly audits of compliance with the requirement to ask patients if they are or could be pregnant. This policy was based upon the IRMER regulations. We saw that in August 2016, 16 patient records from imaging had been reviewed and all of them complied with the hospital policy of asking patients if they could be pregnant prior to an x-ray being taken. Another example of the hospital’s compliance with policies and procedures in diagnostics is that we saw that an audit of the checking of patient identification and justification of x-ray. For the July 2016 audit 17 records were reviewed and we saw that there was 100% compliance with hospital policy.

- There were care pathways in place based on the National Institute of Health and Care Excellence (NICE) for oncology patients.

**Pain relief**

- The pain clinic, which was situated in a day case unit called the Pleasington suite, used nationally recognised clinical protocols to provide evidence based pain management treatment to patients. Patients told us that there pain was well managed.

**Nutrition and hydration**

- We saw that all patients at the pain clinic had nutrition and hydration risk assessments each time they arrived for treatment. The risk assessments used were the malnutrition universal screen tool (MUST) and the Waterlow assessment, which gives patients a score for their risk of pressure ulcer. After patients had received their treatment at the pain clinic they were given refreshments.
- We saw that there was a self-service machine that provided outpatients with tea and coffee in the outpatients department. We also saw that water was available.

**Patient outcomes**

- The diagnostic and imaging department carried out regular audits of the images that were taken in the department. We were told that a selection of the images were sent to Christie's cancer hospital to quality assure the standard of images. This process was underpinned by a service level agreement (SLA) with Christie's hospital. We were told that the results of the audits have not identified any difficulties with the quality of the hospital's images.

**Competent staff**

- We saw that there were competent staff across outpatients and diagnostics. Staff were supported in their development using the annual appraisal process. We were told that there was an induction and competence assessment for health care assistants when they joined the service. These competencies are taken from BMI corporate competencies and specifically address the skills required in outpatients. These competencies included clinical skills, venepuncture, wound care, removal of sutures, dressings and the proper cleaning of ear nose and throat scopes.
- At the time of inspection all staff in attendance, had received an annual appraisal. Staff that we spoke with felt supported by the hospital in achieving their professional development goals.
- All qualified staff within the diagnostic imaging department were registered with the health and care professions council (HCPC). The staff in the diagnostic and imaging department were experienced and three members of staff had a post-graduate qualification in mammography.
- We saw that the pain clinic was staffed by two healthcare assistants (HCA), who were undertaking risk assessments, which included identifying whether the patient had any allergies. This HCA position did not have identified competencies. We raised this issue with the nursing lead at the hospital. The hospital responded by identifying level 5 competency training for the staff involved, which included acute illness management (AIM) training. We were assured these staff have access to the registered nurses on the ward if they have any queries or concerns.
- The oncology staff completed annual chemotherapy competencies on 'BMI learn for administration of chemotherapy, care of central lines and cannulation'.

**Multidisciplinary working**

- We observed good multidisciplinary working in outpatients and diagnostics. We watched nursing staff liaising with diagnostic and medical staff to provide patients with treatment and care.
- We saw that there were SLAs governing clinical pathways to provide imaging to a local NHS trust and a private provider. There were also SLAs governing referral to an on-site provider of more complex imaging services such as MRIs and CTs.

**Access to information**

- We were told that there were no difficulties accessing information in outpatients or diagnostic and imaging services. There was a robust internal system for ensuring notes were available for clinics and procedures. Different staff were able to describe this process in detail and we were assured that patient information was always available for staff across outpatients and diagnostics when required.
- The hospital had an electronic system for the management, storage and retrieval of imaging called picture archiving and communication system (PACS).

Good

# Outpatients and diagnostic imaging

There was an outpatient pathway in place for receiving imaging requests and there was no waiting time for images. We were told that once the image is taken it goes straight into PACS and is ready to be reported upon immediately.

- Patients' observation charts were readily accessible and were kept in their rooms during treatment or at the nurse's station on the oncology unit.

**Consent, Mental Capacity Act and Deprivation of Liberty Safeguards**

- Qualified staff completed training in the mental capacity act (MCA) and deprivation of liberty safeguards (DoLS). This training was part of safeguarding adults training which was mandatory for all staff.
- The hospital had a consent policy in place and assured themselves that patients were given informed consent. Training was provided for all staff in how to obtain consent for patients. In every set of patient notes that we reviewed, consent was taken in compliance with hospital policy.
- We observed staff obtaining detailed consent from patients. In addition patients reported to us that staff explained treatment procedures in detail and discussed treatment decisions and options with them.
- Staff demonstrated an understanding of the issues of consent and capacity when they discussed the case of a patient with learning difficulties who did not consent to treatment.
- Patients on the oncology unit told us their consent had been obtained prior to them receiving treatment. Patients' cognitive ability to sign a consent form was assessed by staff in the oncology unit. We reviewed 10 consent forms for oncology patients, all of which had been signed and completed satisfactorily. This meant they were signed on or prior to the first day of treatment in all cases.

## Are outpatients and diagnostic imaging services caring?

Good

We rated caring as Good.

**Compassionate care**

- Patients told us the staff were caring, kind and compassionate. We observed all staff treating patients with compassion, dignity and respect across oncology, outpatients and diagnostics. We saw that staff were mindful of patient dignity when they were in treatment rooms, during consultations with medical staff and when preparing for imaging procedures.
- We spoke with 12 patients and their relatives in oncology, outpatients and diagnostics who all told us that staff were extremely kind and caring. Patients were particularly complimentary about staff in the day case suite and oncology, where they stated that nursing staff could not do enough to make them any more comfortable. Patients who were undergoing chemotherapy treatment spoke favourably about the way they were treated by all staff, the peaceful environment their treatment was provided in and how compassionate staff were towards them. Examples of positive comments included: 'Nothing is too much trouble for these exceptionally caring staff' and 'my care has been co-ordinated seamlessly between the NHS and BMI and between surgery and oncology. I feel at the centre of my care, listened to and involved.'
- The hospital participated in the NHS friends and family test. The results of this questionnaire were very positive on a consistent basis with 98% of patients stating that they would recommend the hospital as a place to go for treatment.
- We observed staff ensuring that the dignity of patients was maintained at all points of their journey through outpatients and diagnostics. Examples of this include doors were closed when patients were changing, confidential interviews were conducted in private rooms and during treatment only those areas involved in the treatment were exposed.

**Understanding and involvement of patients and those close to them**

- The patients that we spoke with reported that treatments and procedures were fully explained to them. They also reported that they felt that they were not rushed and staff gave them the time to ask any questions and that these questions were answered fully. One patient said that he got instructions prior to the procedure about everything to do with it, such as how long he would be there and what would happen when he was there. He also said that staff provided detailed

care about what to do and look out for after the procedure. Another patient said that all treatment options had been discussed fully with him and remained under review while he considered them
- When we first attended outpatients, each consulting room contained a sign informing patients that they could ask for a chaperone if they required one. Inspectors suggested that placing this sign inside the consulting room didn't provide patients with sufficient time to consider the matter. Staff responded immediately to this observation and during the inspection the sign was moved to a very prominent area at the reception desk.

**Emotional support**

- Patients told us that they felt supported by staff and that they were given reassurance when they required it. One patient told us that remained with him throughout the procedure, and providing him with comfort.
- We observed staff providing emotional support to patients before, during and after treatment procedures. We observed staff on the oncology unit sitting listening with patients and responding to any questions. They were seen to be unhurried and relaxed in their approach.

## Are outpatients and diagnostic imaging services responsive?

Good

We rated responsive as Good.

**Service planning and delivery to meet the needs of local people**

- Outpatient clinics ran Monday to Friday 8am to 8.30pm. These extended hours were provided to ensure that clinics ran at times convenient for all patients.
- Saturday Outpatient clinics ran as required. There was free car parking at the hospital for patients but it was limited.

**Access and flow**

- The national standard for referral to treatment (RTT) time stated that 95% of patients should start consultant led treatment within 18 weeks of referral. In the reporting period July 2015 to June 2016 the outpatients and diagnostics department data showed that between 96% and 99% (monthly) of patients were seen within 18 weeks of referral. There was no waiting list at the hospital for diagnostic assessment or treatment.
- We observed that patient flow was well managed in the outpatient department and patients were seen promptly.
- Access to care was managed in response to patients' individual needs on the oncology unit.

**Meeting people's individual needs**

- The outpatient's reception desk had a loop system for patients who wore a hearing aid. If patients did not speak English there was an interpreting service available for staff to request.
- There was a variety of information leaflets available to patients in the outpatient area. These were available in English only.
- The pain clinic organised its service with consideration of gender. For example there was a morning session for men and an afternoon session for women. This enabled patients to be cared for in gender segregated sessions which maintained the privacy and dignity of patients.
- It was very rare that patients with complex needs such as dementia or a learning disability were seen in the outpatients department. However, staff were able to say how they would adapt treatment and services to such patients.
- The oncology services were responsive to patient's needs. Information leaflets and signposting to other services was available for patients undergoing chemotherapy treatment. The outpatients department was signposted. During the inspection we observed numerous patients and relatives making their way to the main reception which was in a separate building, requiring them to be redirected, however all correspondence indicates where patients should report to prior to them attending the hospital.
- The signposting did not meet the needs of patients with a visual impairment.
- Access to a quiet room for prayer or meditation was available upon request at the hospital reception.

**Learning from complaints and concerns**

- Patients we spoke with aware of how to make a complaint and all the patients told us they would be happy to raise any complaints or concerns with the staff if necessary.

Good

# Outpatients and diagnostic imaging

- In the last few years there has only been one formal complaint in outpatient and diagnostic services. This related to confusion over charging structures when transferring hospitals. In response to this the department had made attempts to provide clearer information about the charging structure for self-funded patients.

## Are outpatients and diagnostic imaging services well-led?

Good

We rated well-led as Good.

### Leadership and culture of service

- We observed strong leadership from a cohesive hospital senior management team with an open culture. Departmental leaders articulated the hospital vision and cascaded this to staff through regular team meetings. There was strong leadership at departmental level with formal and informal communication in place to support teams. Regular team meetings were held in all departments that we visited.
- We observed that staff morale was very positive in all the departments we visited. All of the staff we spoke with reported a very supportive culture throughout the organisation and that all the senior management team were accessible and visible. They also reported that they would feel comfortable raising difficult issues with all members of senior management.

### Vision and strategy for this this core service

- The hospital had a clear vision for providing services to patients, which was a local application of BMI Healthcare corporate vision. This was conveyed in a mission statement which was displayed on the walls in different departments of the hospital.
- Staff within the oncology unit were aware of the future plans and how the service may develop.

### Governance, risk management and quality measurement

- There was a robust governance framework in place which oversaw the strategic and operational direction for the hospital. This comprised of structures and systems of governance in place, which placed patient safety and the patient experience at its heart. The MAC was engaged within the governance structure and we saw evidence in the minutes of MAC meetings that full discussions were undertaken about clinical governance issues and all clinical and operational developments.
- We saw a hospital risk plan which included a risk register. This was maintained and updated electronically. We saw evidence that issues on the risk register were reported quarterly to the board and fully discussed in senior management and clinical governance meetings. We saw that outpatient and diagnostic risks were identified on the risk register and there was a plan in place to deal with these risks. An example of this is the refurbishment of hand basins in both departments to meet IPC requirements. The risks were known and discussed by most staff we met in the departments.

### Public and staff engagement

- Patients were encouraged to complete satisfaction surveys when they attended services in both departments. If issues arose in the staff survey they were dealt with immediately.
- Staff reported that they had positive relationships with management and that their views about services were sought on a team and one to one basis.

### Innovation, improvement and sustainability

- The diagnostic department had recently made significant investments in two new pieces of equipment, a new mammogram and ultrasound machine. These investments were part of a plan to develop the diagnostic services offered at the hospital.

# Outstanding practice and areas for improvement

## Outstanding practice

The oncology unit had been awarded the Macmillan quality environment mark; a quality framework for assessing whether cancer care environments meet the standards required by people living with cancer.

## Areas for improvement

### Action the provider SHOULD take to improve

- The provider should ensure that systems and processes are in place to always enable them to identify and assess risks to the health, safety and welfare of people who use the service. With particular reference to incident reporting systems, surgical site infections, information on the quality dashboard and the embedded and consistent use of the world health organisation (WHO) safety checklists.
- The provider should improve the collation of data to ensure they had a clear picture of the risk when monitoring incidents.
- The provider should ensure the guidance on the safe management of medicines policy, includes detail on the safeguards required on the safe administration of blood products.
- The consent audit action plan should include actions to improve this process, for example providing information for leaflets for patients.
- The provider should ensure that patients who do not speak English are supported to have private conversations about their treatment in line with hospital policy.
- The provider should ensure the healthcare assistants in the pain clinic undertake appropriate training, including the level 5 competency training which included acute illness management (AIM) training.
- The provider should ensure that suitable emergency equipment is provided in the diagnostic department.
- The provider should consider the needs of the patients with sensory impairments attending outpatient clinics and review signage to all departments.