BMI Three Shires 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?	Good
Are services effective?	Good
Are services caring?	Good
Are services responsive?	Good
Are services well-led?	Good

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

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

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

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

Summary of findings

Overall summary

BMI Three Shires Hospital is operated by BMI Healthcare. The hospital opened in 1982 as a private elective surgery hospital. The hospital is registered for 53 beds. Facilities include five operating theatres, an ambulatory care unit, and outpatient facilities.

The hospital provides surgery, medical care, services for children and young people, and outpatients. We inspected surgery, medicine, outpatients and services for children and young people.

We inspected this service using our comprehensive inspection methodology. We carried out the announced part of the inspection on 27 and 28 June 2018 along with an unannounced visit to the hospital on 3 July 2018 and 10 July 2018.

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

Services we rate

This is the first time BMI Three Shires has been inspected since it registered in June 2015. We rated it as good overall.

Summary of main findings:

- There were systems in place to keep patients protected from avoidable harm, including the reporting and investigation of incidents. Learning from incidents was cascaded to staff.
- Staffing levels were sufficient to meet the needs of patients and there was an effective multidisciplinary approach to care and treatment. Staff worked well together to benefit patients.
- Staff were proud of the hospital and were committed to providing the best possible care for their patients. We observed positive interactions between staff and patients. All patients spoke highly of the care they had received.
- The hospital was focused on providing quality care and had a defined strategy, which was aligned to its vision. Staff were committed to providing a positive patient experience.
- Services had a vision and strategy for what it wanted to achieve and workable plans to turn it into action developed with involvement from staff, patients, and key groups representing the local community.
- Staff told us they felt appreciated and supported by service leaders and said they were visible and approachable, this included the executive director.
- There were governance structures in place to ensure that risk and quality were regularly reviewed and actions were taken to address performance issues, where indicated.
- There was a complaints management process with a culture of being open and honest with patients. There was a complaints policy and complaints were taken seriously and investigated.
- When things went wrong, staff apologised and gave patients honest information and suitable support.
- Patients' views and experiences were gathered and acted on to shape and improve the services and culture.
- Staff ensured that patients' privacy and dignity was maintained at all times.

However:

Summary of findings

- Arrangements were in place for the management of medicines, however we saw incidences where patients were not always given their medication as prescribed.
- Not all staff within surgery services received relevant resuscitation training at the level appropriate to their role, including in the use of emergency equipment.
- The records maintained by the cancer breast nurse were not assessed or audited which meant that we could not be assured the hospital had oversight to validate the information contained was legible, accurate and up to date.
- Although the service managed patient safety incidents well, staff within the oncology unit did not always recognise incidents and report them appropriately.
- Although the hospital had an audit and risk management structure there were no specific audits regarding breast cancer patients. Compliance to risk assessments, including the use of NEWS2 and sepsis guidance were not audited either.
- Consultants provided the interaction between their patients and the NHS multi-disciplinary team (MDT) meetings. However, the minutes from these meetings were not provided to the hospital.
- Not all entries in patient records had been signed and dated by the consultant.
- The hospital had effective systems for identifying risks, planning to eliminate or reduce them, and coping with both the expected and unexpected. However, we found some risks had not been escalated to the risk register where relevant and some risks were not monitored or acted upon.
- The service and the hospital had identified risks to children and young people but were not recorded on risk registers.

We found areas of practice that **require improvement** in **surgery**:

- Not all staff received relevant resuscitation training at the level appropriate to their role, including in the use of emergency equipment.
- Not all patients were given all medication as prescribed.
- Action plans were not routinely completed where audit results had fallen below required rates.
- Some risk assessments were carried out on patients. However, the service did not audit its compliance to risk assessments, including use of NEWS2 or compliance to sepsis guidance.

Following this inspection, we told the provider that it must take some actions to comply with the regulations and that it should make other improvements, even though a regulation had not been breached, to help the service improve. We also issued the provider with one requirement notice that affected surgery services. Details are at the end of the report.

Heidi Smoult

Deputy Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Medical care	Good 	Medical care services were a small proportion of hospital activity. The main service was surgery. Where arrangements were the same, we have reported findings in the surgery section. We rated this service as good because it was safe, effective, caring, responsive and well led.
Surgery	Requires improvement 	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. Staffing was managed jointly with medical care. We rated this service as requires improvement overall, and for being safe and well-led. However, we rated is as good for effective, caring and responsive.
Services for children and young people	Good 	Children and young people's services were a small proportion of hospital activity. The main service was surgery. Where arrangements were the same, we have reported findings in the surgery section. We rated this service as good because it was safe, effective, caring, responsive and well led.
Outpatients and diagnostic imaging	Good 	Outpatients was a small proportion of hospital activity. The main service was surgery. Where arrangements were the same, we have reported findings in the outpatient's section. 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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Services we looked at:
Medical care; Surgery; Services for children and young people; Outpatients.

Summary of this inspection

Background to BMI Three Shires Hospital

BMI Three Shires Hospital is operated by BMI Healthcare. The hospital opened in 1982 as a private elective surgery hospital. It is situated in Northampton, Northamptonshire and is built in the grounds of another healthcare provider. The hospital has had several major additions and refurbishments including two extensions, outpatient refurbishment and a kitchen extension.

Three Shires Hospital Limited is a joint venture between St Andrews Healthcare and BMI Healthcare and owns and operates BMI Three Shires Hospital. The hospital is managed by BMI Healthcare and is part of a network of 59 hospitals and treatment centres across England, Scotland and Wales.

The hospital primarily serves the communities of Northampton. It also accepts patient referrals from outside this area.

The hospital has a registered manager who has been in post since April 2016.

The registered manager is the accountable officer for controlled drugs.

The hospital is registered for 53 inpatient beds most with private en-suite facilities, WiFi, television and telephone, (47 beds are currently in use, four of which are allocated to paediatrics). There are also four chemotherapy pods. Facilities are undergoing a programme of refurbishment. The facilities are laid out over two floors. Situated on the ground floor are the operating theatres, two with laminar flow, the outpatients department with 14 consulting rooms, three treatment rooms, a plaster room and minor operations room. Inpatient beds and the oncology suite are situated upstairs. There is a physiotherapy gym situated in the Cliftonville Unit.

The hospital provides surgery, outpatient and diagnostic imaging, oncology, endoscopy services and services for children and young people (CYP).

The hospital also offers some cosmetic procedures which was included within surgery services, however some cosmetic procedures such as dermal fillers and laser hair removal, ophthalmic treatments and cosmetic dentistry are not regulated, therefore we did not inspect these services.

The imaging department is owned and operated by a separate provider and therefore was not included in this inspection.

The hospital offers services to NHS patients, self-funding patients and privately funded patients.

BMI Three Shires was previously inspected by the Care Quality Commission (CQC) in June 2015, however the hospital has since de-registered and re-registered under a different legal entity (Three Shires LLP). At the last comprehensive inspection, we rated the hospital requires improvement overall. We also issued the hospital with two requirement notices in relation to regulations that were not being met and where they needed to make significant improvements to the health care provided.

We inspected the services using our comprehensive inspection methodology. We carried out the announced (staff knew we were coming) part of our inspection on 27 and 28 June 2018, along with an unannounced (staff did not know we were coming) on 3 July 2018 and 10 July 2018.

The hospital has one ward and is registered to provide the following regulated activities:

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

Our inspection team

The team that inspected the service comprised a CQC lead inspector, inspection manager, six other CQC

Summary of this inspection

inspectors, an assistant inspector and six specialist advisors with expertise in surgery, oncology, outpatients, children and young people and governance. The inspection team was overseen by Bernadette Hanney, Head of Hospital Inspection.

Information about BMI Three Shires Hospital

BMI Three Shires Hospital provides an inpatient and outpatient service for various specialities to both private and NHS patients. This includes, but is not limited to, orthopaedics, gynaecology, general surgery, urology, ear nose and throat (ENT) and ophthalmology. Children aged zero to three are only seen in out-patients, children aged three to 15 are seen as day cases and 16-17 year olds are seen as inpatients.

BMI Three Shires Hospital is one of few independent hospitals now providing care to children and young people (CYP). CYP services were a small proportion of the hospital activity and the main service was surgery.

BMI Three Shires Hospital does not undertake acute or emergency surgery admissions.

During the inspection, we visited the surgical ward, operating theatres, oncology unit and outpatient department. We spoke with 66 staff including; registered nurses, health care assistants, reception staff, medical staff, operating department practitioners, senior managers, catering, support staff and physiotherapy staff. We spoke with 32 patients and 15 relatives. We also received nine 'tell us about your care' comment cards which patients had completed before our inspection. During our inspection, we reviewed 37 sets of patient records six incidents and ten staff files.

There were no special reviews or investigations of the hospital ongoing by the CQC at any time during the 12 months before this inspection.

Activity (February 2017 to January 2018)

- In the reporting period February 2017 to January 2018, there were 7,531 inpatient and day case episodes of care recorded at BMI Three Shires Hospital; of these 47% were NHS-funded and 53% other funded.
- 21% of all NHS-funded patients and 27% of all other funded patients stayed overnight at the hospital during the same reporting period.
- There were 42,679 outpatient total attendances in the reporting period; of these 53% were other funded and 45% were NHS-funded.
- In the 12 month period from January to December 2017 there were 7,949 visits to theatre.
- There were seven total inpatient cases and 140 day cases for children and young people aged between three years and 17 years; and 1,336 outpatient attendances from birth to 17 years in the reporting period 1 February 2017 to 31 January 2018.

142 doctors had practising privileges and their individual activity was monitored.

94 surgeons, 34 anaesthetists, 3 physicians and 11 radiologists worked at the hospital under practising privileges. An agency provided two regular resident medical officer (RMO) who worked on a weekly rota. BMI Three Shires Hospital employed 41 registered nurses, 23 operating department practitioners (ODP) and health care assistants and 63 other staff, as well as having its own bank staff.

Track record on safety

- Zero Never events
- 795 Clinical incidents (586 no harm, 190 low harm, 15 moderate harm, 0 severe harm, 3 death)
- Two serious injuries
- Zero incidences of hospital acquired Meticillin-resistant Staphylococcus aureus (MRSA),
- Zero incidences of hospital acquired Meticillin-sensitive staphylococcus aureus (MSSA)

Summary of this inspection

- Zero incidences of hospital acquired Clostridium difficile (C.difficile)
- Zero incidences of hospital acquired E-Coli
- Sixty five complaints

Services accredited by a national body:

- Joint Advisory Group on Gastrointestinal endoscopy (JAG) accreditation
- BUPA Accredited Breast and Eye Care
- MQEM – MacMillan Quality Environment Mark for the environment for the oncology service

Services provided at the hospital under service level agreement:

- Clinical and or non-clinical waste removal
- Cytotoxic drugs service
- Interpreting services
- Grounds Maintenance
- Laser protection service
- Laundry
- Maintenance of medical equipment
- Pathology and histology
- RMO provision
- Catering

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

Good

We rated safe as good because:

- The service provided mandatory training in key skills to all staff.
- Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had completed safeguarding adult and children's training which was above the hospital target of 90%.
- The service controlled infection risk well. Staff kept themselves, equipment and the premises clean. Control measures were in place to prevent the spread of infection. Most staff complied with the infection prevention and control policy.
- The service had processes in place to assess the risk to patients using the service and developed risk management plans in line with national guidance.
- Pre-operative risk assessments for surgical patients were carried out in line with national guidance.
- The service had enough staff with the right qualifications, skills, training and experience to keep people safe from avoidable harm and abuse and to provide the right care and treatment.
- The resident medical officer (RMO) had the appropriate training and experience to meet the needs of CYP.
- There was an embedded culture of incident reporting and staff said they received feedback and learning from incidents.
- There was access to appropriate equipment for children and young people (CYP) to ensure the provision of safe care and treatment. Resuscitation equipment was age appropriate, checked daily and stored safely.
- Records were up to date, legible and had clear plans in place for each patient and were stored securely.
- The risks associated with anticipated events and emergency situations were recognised and systems were in place to deal with these.

However:

- The records maintained by the cancer breast nurse were not assessed or audited which meant that we could not be assured the hospital had oversight to validate the information contained was legible, accurate and up to date.

Summary of this inspection

- Although the service managed patient safety incidents well, staff within the oncology unit did not always recognise incidents and report them appropriately. This meant that we could not be assured of the hospital's oversight of risk regarding the service.
- Not all staff within the surgery service had the required level of life support training. Some staff had not received training in the use of a new defibrillator and some staff were unable to identify items used for life support stored on the emergency trolley.
- Some patient rooms used post operatively did not have piped oxygen and the service relied on portable oxygen supplies only.
- Items required for resuscitation in an emergency were not immediately available in the resuscitation trolley.
- Commode chairs were used to transport patient's short distances.
- Medicines within the surgery service were not always administered as prescribed. Medicines were not always managed according to the hospitals medicines management policy. Some medical guidelines were out of date.
- Some risk assessments were carried out on patients. However, the service did not audit its compliance to risk assessments, including use of NEWS2 or compliance to sepsis guidance.
- There were limited facilities available for CYP in outpatients although the hospital had mitigated the risks to CYP through regular safety checks and the provision of a limited supply of toys.

Are services effective?

Good

We rated effective as good because:

- The service provided care and treatment based on national guidance and evidence of this effectiveness. They assessed staff compliance with guidance and identified areas for improvement.
- Staff gave patients enough food and drink to meet their needs and improve their health. They used special feeding and hydration techniques when necessary. The service made dietary adjustments for patients for religious, cultural, personal choice or medical reasons when required.
- The service monitored the effectiveness of care and treatment and consistently used the findings to improve them.
- Policies and procedures reflected current guidelines and adherence was monitored with a schedule of local audits which were CYP specific. Staff reviewed the outcomes of audits and there was evidence of action plans and changes to practice.

Summary of this inspection

- The service made sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them, when required, to provide support and monitor the effectiveness of the service.
- Staff worked together as a team to benefit patients. Doctors, nurses and other healthcare professionals supported each other to provide good care.
- Staff understood the guidance and legislation relevant to consent and informed decision making with regards to CYP.
- There was a hospital policy to ensure that staff were meeting their responsibilities under the MCA and Deprivation of Liberty Safeguards (DoLS).Staff said they had had training in MCA and DoLS as part of their mandatory training.

However:

- Although the hospital had a comprehensive audit and risk management structure there were no specific audits regarding breast cancer patients which meant that we could not be assured what oversight the MAC had of the service being provided by the breast care nurse.
- Consultants provided the interaction between their patients and the NHS multi-disciplinary team (MDT) meetings. However, the minutes from these meetings were not provided to the hospital which meant that we could not be assured that the information provided was accurate and up to date.
- Not all entries in patient records had been signed and dated by the consultant.
- There was a high number of patients transferred out to the local NHS hospital following their operation and there were no action plans to reduce the number of transfers. The transferring of patients out of hospital was not on the service risk register.
- Not all staff working in theatres had the necessary skills to assist in all operations. This was on the service risk register.

Are services caring?

Good

We rated caring as good because:

- Staff cared for patients with compassion. Feedback from patients confirmed that staff treated them well and with kindness.
- Staff provided emotional support to patients to minimise their distress.
- Staff involved patients and those close to them in decisions about their care and treatment.

Summary of this inspection

- We saw excellent interactions between staff, children and their parents. All interactions were kind and compassionate and very caring. Staff were skilled at communicating with CYP and we observed this in every area we visited.
- Children spoke about the 'kind nurses and doctors who looked after them' and 'the wonderful toys and games at the hospital'.
- Staff minimised emotional distress to children by encouraging parents to lie or sit beside their child to distract them whilst waiting for their procedure. For example, we saw a parent lying on their child's bed and holding them when they returned from theatre.

Are services responsive?

Good

We rated responsive as good because:

- The hospital planned and provided services in a way that met the needs of local people.
- Services were planned to consider the individual needs of patients. Adjustments were made for patients living with a physical disability and a new dementia friendly room had been set up for patients.
- Patients could access the service when they needed and there was minimal waiting time for patients to receive their procedure.
- The service provided reflected the needs of children and young people (CYP) and ensured flexibility, choice and continuity of care.
- Areas used were not dedicated solely for the use of CYP but were adapted where possible to make them more appropriate for any age of child. For example, beds for CYP had age appropriate bed linen and activities were provided to entertain and distract children of all ages.

However:

- There was a high number of cancelled operations which could have been avoided. This included cancellations for reasons which should have been identified at a pre-operative assessment, and operations cancelled due to the inappropriate skill levels of staff.
- The service's Patient-Led Assessment of the Care Environment (PLACE) audit for 2017, scored 73% for dementia and 77% for disability which was lower than the England average score.
- The service treated concerns and complaints seriously, investigated them and learned lessons from the results, which were shared with all staff. However, it was unclear if staff completed a complaints report which meant that we could not be assured that lessons were identified and learnt.

Summary of this inspection

- There was no information for CYP in age appropriate formats.

Are services well-led?

Good

We rated well-led as good because:

- The hospital was committed to the BMI Healthcare corporate vision, which was to offer "the best patient experience and best outcomes in the most cost-effective way".
- The service had managers at most levels with the right skills and abilities to run a service providing high-quality sustainable care.
- Children and young people's (CYP) services were overseen by a lead paediatric nurse (LPN) and a named consultant paediatrician. Staff told us the LPN and consultant paediatrician had raised the profile of children's services and were recognised as being clinical experts in the care of CYP. Staff told us they were approachable and could be contacted for advice and support.
- Services had a vision and strategy for what it wanted to achieve and workable plans to turn it into action developed with involvement from staff, patients, and key groups representing the local community.
- Services collected, analysed, managed and used most information well to support all its activities, using secure electronic systems with security safeguards.
- There was an internal audit programme in place which aimed at improving patient care, treatment and outcomes. Audit and data was used to inform practice and change within the service. However, we found in surgery services action plans were not always implemented as a result of the audit findings.
- Staff told us they felt appreciated and supported by service leaders and said they were visible and approachable.
- Information needed to deliver effective care and treatment was available to relevant staff in a timely and accessible way.

However**:**

- The hospital had systems for identifying risks, planning to eliminate or reduce them, and coping with both the expected and unexpected. However, we found some risks had not been escalated to the risk register where relevant and some risks were not monitored or acted upon.
- Some policies were out of date.

Detailed findings from this inspection

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Medical care	Good	Good	Good	Good	Good	Good
Surgery	Requires improvement	Good	Good	Good	Requires improvement	Requires improvement
Services for children and young people	Good	Good	☆ Outstanding	Good	Good	Good
Outpatients and diagnostic imaging	Good	Good	Good	Good	Good	Good
Overall	Good	Good	Good	Good	Good	Good

Good

Medical care

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

Are medical care services safe?

Good

Mandatory training

- The service provided mandatory training in key skills to all staff.
- For clinical staff there was a dedicated clinical education facilitator who oversaw mandatory training. Senior staff confirmed they were informed when staff training required updating. Examples of the training modules included health and safety, infection prevention and control, information governance, medicines management and manual handling.
- Mandatory training at the hospital was delivered through online learning and face to face training. The hospital's target for mandatory training completion was 90%. Records seen from January to June 2018 within the oncology and endoscopy units showed training was 100% and 87% respectively. Senior staff within endoscopy confirmed they were currently waiting for face to face training dates to ensure all staff would be up to date with their training. We saw a training plan for 2018 within the endoscopy unit to manage outstanding training. These included; the washing of scopes, conscious sedation, decontamination processes, and the insertion of a cannula.
- Senior staff confirmed that endoscopic training was based on the British Society of Gastroenterology guidance.
- The training records showed that staff had undertaken Immediate Life Support (ILS) as part of their mandatory training. Also, senior staff had completed their Paediatric Immediate Life Support (PILS) training. We saw ILS and PILS refresher course dates on display within the oncology unit for July and September 2018.
- BMI infection prevention and control (IPC) education at Three Shires Hospital comprised of two mandatory training modules for staff. The first module was for staff who had direct physical contact with patients while the second module was linked to high impact interventions and the use of the aseptic non-touch technique. Aseptic technique means using practices and procedures to prevent contamination from a bacterium, virus, or other micro-organism that can cause disease. We saw that both endoscopy and oncology services had achieved 100% for their IPC and aseptic non-touch technique training.

Safeguarding

- Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had completed safeguarding adult and children's training and had achieved 100% which was above the hospital target of 90%.
- The hospital had policies and procedures in place to safeguard children and vulnerable adults at risk of abuse. Nursing staff showed how they would locate them on the hospital's intranet system. We saw information displayed within the endoscopy unit showing contact details of the hospital's safeguarding leads and external organisations.
- Staff were required to complete safeguarding level one and two for adults and children as part of their mandatory training. At the time of our inspection 100% of staff in oncology and endoscopy had completed level

two safeguarding for both adults and children. In theatres, where the endoscopy procedures were performed, all senior staff and consultants had received children's safeguarding level three training. We saw that senior staff within endoscopy had a training schedule in place which showed they were arranging dates for all staff to complete their children safeguarding level three training in 2018.

- There were no patients treated at the oncology unit who were aged under 18 and the nursing staff had received adult safeguarding training level two as part of their mandatory training.
- Staff who were caring for young people aged between 16 to 18 years were trained to level three in safeguarding which meant that we were assured that staff who had contact with young people had received the appropriate level of safeguarding training. The endoscopy lead informed us they rarely treated children but ensured that when they saw a child or a young adult, a registered nurse (child branch) was in attendance.
- The 2018 quality report reported two safeguarding reportable concerns, one of which was deemed to be unfounded and the other was supported through social services. Staff we spoke with had a good understanding of their responsibilities in relation to safeguarding of vulnerable adults and children and explained how to respond to and escalate a concern or make a referral.
- PREVENT is one of the arms of the government's anti-terrorism strategy. It addresses the need for staff to raise their concerns about individuals being drawn towards radicalisation. Prevent training formed part of the wider safeguarding agenda and encouraged staff to view a patient's vulnerability as they would any other safeguarding issue. Training figures across oncology and endoscopy showed that most staff had completed their training.
- Staff spoken with had good awareness of female genital mutilation (FGM) and breast ironing. FGM comprises all procedures that involve partial or total removal of the external female genitalia, or other injury to the female genital organs for non-medical reasons. Breast ironing also known as breast flattening is the pounding and massaging of a pubescent girl's breasts, using hard or heated objects to try to make them stop developing or disappear. Staff confirmed FGM and breast ironing was included in their induction training.

Cleanliness, infection control and hygiene

- The service controlled infection risk well. Staff kept themselves, equipment and the premises clean. Control measures were in place to prevent the spread of infection. Staff complied with the infection prevention and control policy.
- Monthly infection control audits included adherence to hand hygiene protocols. We saw that there were posters relating to hand-washing techniques in the endoscopy and oncology units. All staff seen adhered to the arms bare below the elbow policy. Handwashing facilities and hand gel were widely available and easily accessible. All hand wash dispensers that we checked were full and in working order.
- There were reliable systems in place to prevent and protect people from a healthcare associated infection. BMI Healthcare was committed to reducing the risks of healthcare associated infection through a pro–active strategy, continual development and implementation of best practice initiatives. We saw this was in line with current legislation from the National Institute for Health and Care Excellence (NICE) Quality Standard 61: Infection Prevention and Control (2014).
- The endoscopy and oncology units were visibly clean and tidy. We saw cleaning schedules in place and housekeeping staff had signed throughout the day to indicate when the area had been cleaned. There were also 'I am clean' stickers on equipment marked with the date they were cleaned. We found no issues or concerns during the inspection.
- There was a robust process in place which ensured that the endoscopic equipment decontamination process was adhered to. The endoscopes were transported directly to a dedicated decontamination area adjacent to the theatre. Clean endoscopes were placed in sterile trays, transported to a drying unit and then placed in an ultraviolet cupboard and appropriately stored.
- We saw the Joint Advisory Group on Gastrointestinal Endoscopy (JAG) report for December 2017 regarding the decontamination room. The results were as follows:

- Operational management (93%)
- Decontamination pre-cleaning and manual cleaning (96%)
- Endoscope storage (100%)

- The Department of Health (DoH) Health Technical Memorandum (HTM) 01-06, provided best practice guidance on the decontamination of endoscopes. We saw that the processes adapted at BMI Three Shires Hospital were in line with Department of Health recommendations which meant there was a clear system in place regarding the tagging and numbering of endoscopes and their traceability.
- The infection prevention control annual report for 2016/17 showed that for 2017 the hospital had made steady progress with compliance by including IPC education within the induction programme and extending the monitoring of high impact interventions to include, oncology and endoscopy. In addition, the IPC lead had completed the infection prevention society competencies and designed a personal development plan based on the competencies.
- The IPC lead conducted audits within the endoscopy and oncology units. These included audits relating to aseptic techniques used when inserting catheter devices for delivering systemic anti-cancer therapy (SACT). We saw that in January and February 2018, staff in the oncology unit achieved 100% and 93% respectively.
- During the inspection we saw all staff complying with being arms bare below the elbow and all sharps containers had been assembled correctly.
- Waste management was handled appropriately with separate colour coded arrangements for general and clinical waste. Bins were foot operated and not overfilled. We found all sharps disposal bins were labelled correctly and not overfilled and did not appear to contain inappropriate waste.
- Staff working in endoscopy described the precautions taken when seeing patients with communicable diseases, this included arranging the theatre list to see the patient at the end of the list when possible and followed infection control procedures. Staff also told us that they would liaise with the infection control lead and consultant microbiologist for advice.
- Data provided showed there were no reported cases of MRSA, C.Difficile, Methicillin-susceptible Staphylococcus Aureus (MSSA), a type of bacteria (germ) which lives harmlessly on the skin and in the nose or E. Coli from January to December 2017. Staff informed us that all identified infections were reported using the hospital's electronic incident report and management system. All incidents relating to a blood stream infection were subject to a root cause analysis where generated reports were discussed at the IPC and clinical governance committee.
- Staff had access to appropriate personal protective equipment (PPE) such as disposable aprons and gloves. We saw staff using masks and eye protection in the endoscopy unit. Staff confirmed they had access to all relevant PPE equipment.
- BMI Healthcare had an infection prevention and control training programme for all staff which included e-learning and face to face training sessions.
- The IPC lead monitored infection risks through a process of surveillance, using data drawn from risk assessments, audits and clinical incident reports as well as microbiology test results. These findings and a review of current risk assessments were reported to the IPC committee for analysis and action. For example, we saw the March 2018 IPC audit for oncology which had achieved 100%. Areas reviewed included; staff "arms bare below the elbow" and whether hands were decontaminated before, during and after the point of care.
- The water safety committee ensured the safe delivery of portable (drinkable) and non-portable water supplies by overseeing the testing schedules of water systems and outlets. We saw the results of the June 2018 water sampling which showed the endoscopy unit had passed all criteria's which included the ED Flow AER (automated endoscope reprocessing) system. The JAG report results for December 2017 evidenced that the unit had scored 100% in the use of AER which included testing and maintenance.
- The hospital held an international infection prevention and control awareness week in October 2017. The focus was on hand hygiene, sepsis and sharps management. The IPC lead and link practitioners manned a table within the hospital and external companies

demonstrated the correct management of sharps containers and the use of cleaning equipment. Staff said the information provided was useful and they could adapt what they had learnt to their working environment.

- The hospital had a screening and immunisation programme which was in accordance with national guidance, specifically 'immunisation against infectious diseases'; including pre-employment screening and ongoing health screening.

Environment and equipment

- The service had suitable premises and systems in place to ensure equipment was well looked after.
- There were effective arrangements in place for the appropriate decontamination of instruments and other reusable medical equipment. This was in line with the Health Technical Memorandum (HTM) 01-01 (England).
- We saw the endoscopy equipment competency records from February to April 2018 which showed that the following; the gastroscope, cystoscope and dudodenoscopy, had been reviewed regarding their usage. There were no concerns or issues identified.
- Appropriate procedures were in place for the acquisition and maintenance of decontamination equipment. A monitoring system ensured decontamination processes were fit for purpose and met required standards with respect to:
  - risk assessments
  - weekly water testing and feedback of results
  - machine checks
  - maintenance of equipment
- We saw the environment report for May 2018 which showed the endoscopy unit had scored 94% overall with no issues or concerns identified.
- There were systems and arrangements in place to manage waste which included processes for managing cytotoxic (cytotoxic drugs are used for cancer treatments to help prevent growth of cancer cells) spillages. We saw that they had appropriate 'spillage packs' for cytotoxic drugs in the oncology unit. Staff in the oncology unit and pharmacy described the process in the event of a spillage and the hospital had a comprehensive policy on the safe management of cytotoxic substances.
- All equipment seen had been electronically tested. However, we did see a urine analyser within the oncology unit which was dated 2010 with instructions for a review in 2014. This was brought to the attention of the nurse in charge who informed us they would arrange for the analyser to be checked.
- We saw the endoscopy and oncology units had up to date control of substances hazardous to health (COSHH) risk assessments in place to support staff's exposure to hazardous substances.
- An external company reviewed the resuscitation provision at BMI Three Shires Hospital in March 2018 with no recommendation identified for the oncology unit. Areas covered included the emergency call bell system and piped oxygen and suction unit. The oncology unit is located immediate to Davidge ward and had access to the emergency equipment stored there. Staff demonstrated their response in the event of an emergency. The oncology unit also had access to separate anaphylaxis packs which were checked and found to be in date during the inspection.
- From March to June 2018 we saw that the resuscitation trolley within the endoscopy unit was clean, sealed and its contents matched the corporate list. The resuscitation trolley had been checked and maintained daily during business hours. Staff demonstrated, and the records showed they had received training in the use of resuscitation equipment.
- In the oncology unit we saw evidence that staff had received training by manufacturers to use specialist equipment such as syringe drivers. A syringe driver helps to reduce symptoms such as pain or sickness by delivering a steady flow of injected medication under the skin. The endoscopy and oncology leads told us they regularly arranged for medical device representatives to attend the unit and deliver bespoke training; we saw records that showed that staff had attended these training sessions.
- The oncology unit had access to two cold cap machines of which only one was currently in use due to the manufacturer having cancelled the appropriate training.

We did not see a timescale as to when this would be completed. A cold cap is a special hat that's worn during chemotherapy to prevent hair loss. Staff informed us that this had not impacted on patient's use as this service was utilised by very few of the patient's seen.

- Equipment seen was stored appropriately. The maintenance of equipment was completed by BMI Healthcare engineers and manufacturers of specialised equipment. The hospital had guidance which defined which equipment would need to be serviced and repaired in house or off site.

Assessing and responding to patient risk

- Staff assessed risks to patients and monitored their safety, so they were supported to stay safe. Assessments were in place to alert staff when a patient's condition deteriorated.
- The hospital had processes in place to assess the risk to patients using the service and developed risk management plans in line with national guidance. Risk assessments were carried out at pre-assessment, upon admission to hospital and throughout the patient pathway.
- Both the oncology and endoscopy units had a clear admissions policy which set out guidelines for the safe admission of patients. Every patient attending the endoscopy and oncology unit undertook a pre-admission risk assessment. The system consisted of a RAG (red, amber, green) rated triaged telephone call; if there were co-morbidities or symptoms that classified a patient as having an enhanced degree of risk, these patients would attend a face to face nurse led pre-assessment and if necessary a pre-admission assessment by a consultant anaesthetist.
- Patients had their bloods taken when attending the oncology unit for their pre-assessment which were taken by a porter to the local NHS hospital for analysis. Senior staff confirmed they had a service level agreement in place with the local hospital for this service. Staff confirmed they received the results usually within one hour which meant that they could support the patient appropriately when attending their appointment. Staff confirmed there had been no incidents regarding this service or delays with results.
- Admissions were not accepted unless the patient was under the care of an appropriate consultant who had practising privileges at the hospital. Practising privileges ensured that all health and social care professionals involved with patient or client care are qualified, competent and authorised to practice. The endoscopy and oncology units did not accept emergency or unplanned admissions.
- Oncology staff told us they had attended a sepsis workshop. The unit had access to a sepsis box which was developed by the IPC lead which included patient flow charts and weekly checklists. The sepsis box was stored on the adjacent surgical ward. Staff confirmed they knew the whereabout of the sepsis box but had not had to use the facility.
- The endoscopy and oncology units were day case procedures with no overnight facilities. Out of hours provision was through the inpatient ward area and patients undergoing chemotherapy who became acutely unwell were admitted to the main inpatient area for treatment.
- The oncology unit provided a 24-hour telephone advice service which was usually staffed by the hospital's oncology nurses. Staff used the United Kingdom Oncology Nursing Society (UKCON) triage tool when holding the mobile phone for the 24-hour telephone advice service. The triage tool enabled staff to:
  - Ensure assessments were of a high-quality standard
  - Provide advice on action required that was appropriate to the patient's "level of risk"
  - Identify and reassure those patients who were at a lower risk that they may be safely managed by the primary care team or a planned clinical review to avoid unnecessary attendance.
- Patients were advised to contact the 24-hour line for any queries and concerns. In addition, some staff on the wards had received training and guidance on how to use the triage tool. Staff told us that this meant that in an emergency if a patient was unable to get through to the 24-hour line they would still be able to receive an appropriate assessment. Staff could not provide us with any specific examples of when a patient had not been able to get through to the 24-hour line.

- The hospital used the National Early Warning Score (NEWS 2) for all patients in line with the National Institute for Health and Care Excellence (NICE) guidelines relating to recognising and responding to the deteriorating patient. This was used to record routine physiological observations such as blood pressure, temperature and heart rate, with clear procedures for escalation if a patient's condition deteriorated. Nursing staff that we spoke with could describe the process and explained who they would contact in an emergency. We found no issues or concerns in the records seen.
- The hospital had a clear critical transfer policy for patients who deteriorated and needed a higher level of care than that provided by the hospital. There was a service level agreement with a local acute NHS trust to transfer patients by ambulance if required. Staff spoken with in the endoscopy and oncology units described the process and their actions and confirmed they had received training in the recognition of a deteriorating patient. Staff told us that this was rare and if this happened it would be recorded as an incident.
- Patients receiving chemotherapy treatments were advised of the risk of neutropenic sepsis (patients receiving anti-cancer treatments are susceptible to neutropenic sepsis due to a temporary reduced white blood cell count during treatment) and given information to allow them to recognise any signs or symptoms of sepsis after treatment. Staff accessed an algorithm based on NICE guidelines regarding treatment of neutropenic sepsis, this included timeframes for antibiotic administration.
- We saw that the hospital had an extravasation policy. Extravasation is a term used when medicines that are being administered intravenously (such as chemotherapy) unintentionally leak into the surrounding tissue and cause damage. Staff confirmed they had never had to use the process and stated that they would have to utilise the guidance on the hospitals intranet system. However, staff described a good knowledge of the process and treatment and the importance of recognising the early symptoms. The service had an agreement with a local acute NHS trust to transfer patients who needed treatment as a result of extravasation.
- The service used a modified version of the World Health Organisation (WHO) five steps to safer surgery checklist. Staff conducting procedures were required to confirm the patient's name, age, procedure site and consent before starting treatment and record that this had been done on the checklist. We saw that in an audit conducted in April 2018 the theatre service which included endoscopy had achieved 100%. Areas covered included the completion of the briefing sheet. All "sign in", "time out" and "sign out" had been completed appropriately. We observed this practice in place during the inspection. We also noted that patients confirmed before their procedure; their identity, site of the procedure and consent.

Major incident awareness and training

- The service planned for emergencies and staff understood their roles if one should happen.
- We saw the fire safety audit for May 2018 with completed actions which included updated COSHH and risk assessments. These were incorporated into the health and safety folder which was available to staff within the staff room.
- The hospital had a business continuity plan which described what staff should do in the event of loss of facilities due to events such as severe weather or loss of power. Staff on the endoscopy unit described a recent event where they had implemented the plan when the power failed which included the cancellation of procedures.
- The oncology service had a separate business continuity plan due to the nature of the treatment being delivered. Staff directed us to the plan and explained the processes that they would follow.

Nurse staffing

- The service had enough nursing staff with the right qualifications, skills, training and experience to keep people safe from avoidable harm and abuse and to provide the right care and treatment.
- During the inspection we observed in the endoscopy and oncology units that there was a good skill mix and appropriate level of nursing staff to meet patients' needs.
- There were systems and processes in place to assess, plan and review staffing levels, including staff skill mix within the endoscopy service. BMI Healthcare provided

a staffing tool which staff used to calculate the number of nurses and health care assistants required for each shift based on the acuity (level of care a patient requires) and needs of the patients. The staffing tool was in line with NICE staffing guidance. This tool was used to plan staff skill mix seven days in advance, with continuous review daily. The actual hours worked were also entered retrospectively to understand variances from the planned hours and the reasons for these. We saw required and actual staffing levels on display within the endoscopy service. We did not observe any issues or concerns with staffing levels during the inspection.

- The hospital used a labour tool which outlined the clinical hours worked as well as the staffing mix on the units. This was linked to the hospital's key performance indicator tracker. For example, the data provided by the trust for August 2018 showed that the oncology unit worked a total of 318 hours against a requirement of 126 hours. We saw variance in the hours worked was reflected for example, additional training from an external drug representative. The oncology unit was staffed with an oncology sister and two chemotherapy nurses. The staffing rota was adjusted accordingly to ensure the unit was adequately staffed based on the demands of the service. Staff confirmed they had no concerns with the rota which they found worked alongside their individual needs.
- The breast nurse specialist worked across two hospital sites and provided 30 hours per week to BMI Three Shires Hospital.
- The hospital aimed to use minimal bank and agency staff. The figures specifically for endoscopy and oncology were not available. The data provided showed that the rate of bank and agency staff usage for nursing and midwifery registered staff averaged 18% from February 2017 to January 2018 in theatres. There had been no usage of agency health care assistant staff.
- There was an average of 17% sickness rate for nurses and 3% for health care assistant staff sickness from February 2017 to January 2018 across the hospital. These figures were on par with other independent acute hospitals. The figures specifically for endoscopy and oncology were not available.
- Bank or agency staff received a comprehensive induction to ensure they were familiar with the endoscopy or oncology units layout and processes. We saw completed checklists which included the following competencies; health and safety, consent for treatment, administration of intravenous bolus chemotherapy (the rapid administration of medicines), administration of oral chemotherapy and the disposal of cytotoxic (a medicine that has a toxic effect on cells) waste. Agency staff spoken with had worked on the units previously and confirmed they had received a comprehensive induction and felt they had sufficient support from nursing staff. They said staff answered questions and provided guidance when required.
- Most patients attending the endoscopy or oncology units were admitted as day cases. We observed appropriate handovers between theatre staff and nursing staff in the recovery area which included all vital information necessary for continuity of care.

Medical staffing

- The service had enough medical staff with the right qualification, skills, training and experience to keep people safe from avoidable harm and abuse and to provide the right care and treatment most of the time.
- If a consultant wished to engage with BMI Three Shires Hospital they had to comply with the practice privileges policy. Initially they would apply, complete the necessary documentation, meet with the key departmental leads before submitting their application to the executive director and latterly to the Medical Advisory Committee (MAC) for approval.
- The consultants were largely drawn from the local NHS hospital which enabled close working relationships and the sharing of services.
- Consultants with practising privileges at BMI Three Shires Hospital were required to be always contactable, when they had a medical patient at the hospital. They were also required to be able to arrive at the unit within a specified timeframe of 45 minutes if there was an emergency. Nursing staff told us that they could call and speak with the consultants at any time for advice.
- The hospital had two resident medical officers (RMOs) who provided emergency consultant cover and medical advice 24 hours a day, seven days a week. The RMOs worked a week on duty and a week off duty and stayed within the hospital during this time. Rotas were

arranged so that there was one RMO always available in line with national guidance. Should an RMO become ill or feel tired during that week they could request cover for their shift during that week. The RMOs curriculum vitae (CV) was reviewed before their appointment by the hospital and all mandatory training is evidenced within that CV. An external provider completes the RMOs annual appraisal and the hospital had input into that appraisal as a 360 degree review. The hospital raised concerns when applicable.

- Consultants with practising privileges were required to make their own arrangements for appropriate equivalent cover for annual leave. This was with another consultant with practising privileges at the hospital and cover arrangements were logged on an electronic register.
- The RMOs conducted handovers at the change of their shifts with the new RMO on duty detailing any areas of concern and highlighting any patients that may have higher acuity needs and require extra monitoring.

Records

- Staff kept appropriate records of patients' care and treatment. Records were kept in locked cupboards to maintain confidentiality.
- Records within medical services were paper based and patients' individual care records were managed and stored appropriately. The hospital had a comprehensive policy which described how records should be completed and stored. There was clear guidance on how information should be recorded and which areas of the records had to be filled in, for example, hospital numbers and discharge details. We found no issues with the storage of records during the inspection.
- There were systems in place to ensure that medical records generated by consultants holding practising privileges were safely integrated into the hospital's records for the patients. The process for this was clearly defined in the hospital's records management policy, which those with practising privileges were required to adhere to.
- During our inspection we reviewed seven sets of patient's records and found that the admission notes had been written in line with General Medical Council (GMC) guidance. The reasons for admission were clearly documented and decisions relating to care pathways documented. Records for patients receiving chemotherapy treatment were detailed and contained clear information about individual patient medication regimes and treatment plans.
- The cancer breast care nurse liaised with external organisations to provide support and advice for patients. The cancer breast care nurse was the initial point of contact before patients saw their consultant. The nurse informed us they updated their own medical records which they maintained until the patient was discharged. However, these records were not included in the hospital's audit system which meant that we could not be assured the hospital had oversight to validate the information contained was legible and up to date.
- Notes made by nursing staff within the endoscopy and oncology units were clear, legible and described the care and treatment given to patients in line with the Nursing and Midwifery Council (NMC) guidelines. We saw the results of the patient health records audit from January to April 2018 which ranged from 81% to 91%.

Medicines

- The service prescribed, gave, and recorded medicines well. Patients received the right medication at the right dose at the right time.
- Nursing staff were aware of the hospital's policies on medicines management and the administration of controlled drugs was in line with the hospital's local policy and NMC guidelines.
- Pharmacy services were available at the main hospital site Monday to Friday 9am to 5pm and ward services started from 8am. Out of hour pharmacy staff were available to the hospital staff for telephone advice. Staff could access emergency stock medicines through a service level agreement with the local NHS hospital pharmacy department. There was also an agreement with a local pharmacy to provide weekend dispensing services for outpatients.
- The pharmacy team dealt with inpatient medicines, managed high-risk medicines required for chemotherapy, and provided medicines needed for discharge. Pharmacy provided a medicines top-up

service to all clinical areas of the hospital ensuring consistent supplies of stock as needed. The pharmacy manager had completed specific training to dispense medications related to oncology.

- There were arrangements in place for safely managing medicines, including chemotherapy. This included systems for obtaining, prescribing, recording, handling, storage and security, dispensing, safe administration and disposal.
- Electronic prescribing for systemic anticancer treatment (SACT) associated with solid tumour treatment was introduced during 2016 using web-based software. Staff confirmed these changes had significantly enhanced the accessibility of medicines. The pharmacy team monitored wasted chemotherapy medicines which we saw in place during the inspection. This meant the hospital had oversight of all SACT medicine management.
- There was an interface with pathology results including automatic alerts when parameters were outside those stated in the protocol. However, this system was not compatible with the BMI Three Shires Hospital pathology system so required manual checks and input for prescriptions as necessary.
- Medicines were stored securely with access restricted to authorised staff. The procedure room, recovery room and medicine refrigerators were checked daily. We saw no issues or concerns in the records seen from March to June 2018. Any discrepancies were acted upon immediately and staff explained what action they would take if the temperatures were not safe for medicine storage.
- Controlled drugs were stored in a locked unit in line with the hospital guidelines. Controlled drugs are medicines such as morphine which are controlled under the misuse of drugs legislation. We saw that the controlled drug cupboard was tidy and did not hold any other equipment or medicines. Entries in the controlled drug register were made correctly regarding the administration of drugs to the patient and were signed appropriately. New stocks were checked and signed for. All intravenous fluids were stored safely behind locked doors and only accessible to appropriate staff.
- There were no controlled drugs kept at the chemotherapy unit. Chemotherapy treatments were prepared by an external provider and delivered to the dedicated oncology pharmacy at the main hospital site and transported to the oncology unit within 48 hours. We saw that the hospital had processes in place to track the transfer and receipt of all chemotherapy treatments.
- In theatre four where endoscopic procedures were carried out controlled drugs were kept in locked cupboards. The keys were stored in a locked cupboard when theatres were closed. There were processes in place to track and identify who had the keys and we saw that medicine management was discussed at team meetings.
- We saw the controlled drug audit dated December 2017 for endoscopy. This identified missed doctor signatures in relation to the completed recording of administered medicines. Staff confirmed there was an action plan to address concerns. The unit achieved 100% in May 2018 which was based on 24 records. During this inspection we found no issues or concerns with the management and signage of controlled drugs.
- We saw the endoscopy medicine management audit for April 2018 which achieved a target of 93%. Areas covered included the appropriate storage of medicine appropriately within correct temperature controlled locations, the safe and effective preparation and administration of medicines and the availability of emergency medicines when required. Staff described that should they be below the hospital target senior staff created an action plan which would be discussed at team meetings and displayed in the staff room.
- We reviewed seven sets of medical records and found these had been completed appropriately regarding medicine management and identified if a patient had any allergies. This was clearly indicated in the appropriate area of the records.
- Medicines reconciliation was completed by designated nurse practitioners and pharmacy staff. This was a process of identifying medicines that patients were prescribed before admission and reviewing any newly prescribed drugs to prevent any interactions.
- The hospital did not use unlicensed medications but did have access to medications that were not usually

available on the NHS, for example, specific anti-sickness medications used in the chemotherapy unit. This was overseen by the pharmacist and the director of clinical services.

- Patients who received medicines to take home were given clear instructions on how to take them and given the opportunity to discuss possible side effects.
- The hospital had a robust policy, process and guidelines for managing the administration of prophylactic and therapeutic antibiotics. This included regular monitoring and review as a part of the overall medicines audits to ensure that prescribers were following protocols.
- The hospital had a sedation policy based on the American Society of Anaesthesiologists (ASA) and British Society of Gastroenterology (BSG) guidelines; staff in theatres could articulate the process including emergency situations.

For our detailed findings on medicines please see the Safe section in the Surgery report

Incidents

- The service managed patient safety incidents well. However, staff did not always recognise incidents and report them appropriately.
- The hospital used an electronic incident reporting system that enabled issues with individual or hospital-wide accountability to be understood and acted upon in an open and transparent environment. Most staff understood their responsibilities to raise concerns and report incidents.
- Most staff recognised incidents and reported them appropriately. The director of clinical services investigated incidents. When things went wrong, staff apologised and gave patients honest information and suitable support. Staff told us they received feedback about incidents that had occurred within the hospital and other hospitals within the BMI Healthcare group. Information was cascaded in a variety of means including the daily communications cell, which was a meeting held every morning to review hospital activity and raise any concerns, staffing brief, emails, governance and team meetings, newsletters and noticeboards. We observed this during our inspection.
- From January 2017 to December 2017 there had been a total of 795 clinical incidents and 125 non-clinical incidents reported for BMI Three Shires Hospital.
- From January 2017 to July 2017 the oncology unit reported 18 incidents. However, no incidents had been reported from August 2017 to June 2018. This meant that we could not be assured of staff's understanding of incidents or the medical advisory committees' (MAC) oversight of the oncology service. This was brought to the attention of the director of clinical services who informed us they would review staff's knowledge of incidents and where required, additional training would be provided. During our unannounced visit on 3 July 2018 we noted that additional training had been provided to the oncology team.
- From January 2018 to June 2018 the endoscopy unit reported 30 incidents. Identified themes included abandoned procedures and endoscopes out of date. Senior staff explained how they would investigate the incident which was cascaded to the staff team for review. Staff confirmed that incidents were discussed at team meetings and on display within the staff room.
- Incidents were recorded as clinical or non-clinical and graded in severity from no or low harm to severe harm or death. Incidents were discussed at team meetings, governance meetings and the MAC meetings. The clinical review meeting minutes included reviews of incidents that had resulted in expected or unexpected death to identify trends. From January 2017 to October 2017, there was one unexpected death reported on the ward. We saw evidence that this had been investigated fully with no recommendations identified from the coroner's report. However, the hospital had undertaken its own review and had cascaded shared learning across the staff team which included the alerting of the manager on call and director of clinical services in the event of an emergency. Staff spoken with knew of the incident and could explain the procedures they would undertake.
- There had been no never events across the oncology or endoscopy service. Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.

Good

Medical care

- From November 2014, providers were required to comply with the Duty of Candour Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain notifiable safety incidents and provide reasonable support to the person. Nursing staff understood their responsibilities regarding the duty of candour legislation. They said they were open and honest with patients and applied this to all their interactions. Staff said they would discuss any identified concerns with the patient and provide a full apology. We saw evidence that the duty of candour regulations was followed in the incident reports we reviewed.
- There had been three incidents which had triggered the duty of candour during 2017/18 of which one referred to the unexpected death of an oncology patient. We reviewed the death relating to oncology and found the duty of candour was completed the same day as the incident and key contacts participated in follow up discussions.
- National patient safety alerts were discussed at clinical governance meetings and we saw evidence that alerts were dealt with appropriately; staff were informed through daily briefings and team meetings.

Safety Thermometer (or equivalent)

- BMI Healthcare is compliant with the reporting guidelines in relation to the NHS Safety Thermometer. This forms part of the BMI Healthcare's hospitals' engagement with the local clinical commissioning groups nationwide. The measures reported monthly related to the following:
  - Venous thromboembolism (VTE)
  - Falls
  - Catheter related urinary tract infection
  - Pressure ulcers by category
- The oncology and endoscopy units had systems in place to monitor the number of falls, pressure ulcers, catheter related infections and blood clots (venous thromboembolism, VTE) that occurred for inpatients in line with national guidelines. Senior staff confirmed that where applicable, the integrated monthly audit captured the monitoring process.
- We saw that there was venous thromboembolism (VTE) (a blood clot in the vein) screening processes in place and the hospital had carried out audits. Audits showed that from January 2017 to December 2017 there was 100% compliance with VTE screening.
- Monthly audits were conducted on the wards to check the effectiveness of controls put in place to minimise the risk of patients falling or acquiring pressure ulcers. This included comprehensive risk assessments and training to ensure compliance to organisational policies.

Are medical care services effective?

Good

Evidence-based care and treatment

- The service provided care and treatment based on national guidance and evidence of this effectiveness. They assessed staff compliance with guidance and identified areas for improvement.
- BMI Three Shires Hospital and BMI Healthcare followed nationally recognised guidance and standards relating to patient safety. We saw policies and procedures in place and these were cascaded through team meetings or e-mails to staff to ensure they were communicated, understood and followed nationally.
- We noted that most of the policies looked at were in date although a few which included; extravasation and sepsis were under review. However, the intrathecal (a route of administration for drugs through an injection into the spinal canal) policy was out of date with an issue date of 2010 and a review date of 2014. This was brought to the attention of the nurse in charge during the inspection.
- There was a systematic programme of clinical audit and local audit and processes in place. We saw evidence of the integrated audit in place and the results for May 2108. Areas covered included: standard precautions, theatre asepsis/surgical site infections and patient equipment.

- We saw that policies and processes relating to cancer care were based on the National Institute for Health Care Excellence (NICE) and UK Oncology Nursing Society (UKONS) guidelines.
- We saw evidence that patients' needs were assessed and treatment delivered in line with legislation, standards and evidence-based guidance. For example, the endoscopy service followed NICE professional guidance for endoscopic procedures and the Joint Advisory Group on Gastrointestinal Endoscopy (JAG) procedures.
- Endoscopy services used the American Society of Anaesthesiologists (ASA) grades as a guide regarding a patients' fitness to undergo an anaesthetic. This was in line with NICE guidance. The ASA physical status classification system is a simple scale describing fitness to undergo an anaesthetic. For example, ASA1 or ASA2 are relatively low risk patients. ASA3 patients have a higher risk of complications during anaesthesia due to other comorbidities they may have. Senior staff informed us there was a new electronic system based on ASA guidance which would recognise and calculate the ASA based on the data input. Staff said this made calculations much easier and both medical and nursing staff confirmed they liked the improved system.
- Staff told us they used a range of integrated care pathways and protocols to standardise practice and improve outcomes for patients. These included a urinary catheter pathway and the guidance on the prevention of venous thrombo-embolism (blood clots following surgery, often referred to as VTE).

Nutrition and hydration

- Staff gave patients enough food and drink to meet their needs and improve their health. They used special feeding and hydration techniques when necessary. The service made dietary adjustments for patients for religious, cultural, personal choice or medical reasons when required.
- Pre-admission information for patients gave them clear instructions on fasting times for food and drink before endoscopy procedures. Records showed checks were made to ensure patients had adhered to fasting times before procedures went ahead.
- The endoscopy unit, when required, adopted the Association of Anaesthetists of Great Britain and Ireland (AAGBI) 2010 Pre-Operative Assessment and Patient Preparation guidelines. This provided clear reference on how much patients should drink before their procedures. This included the:
  - Intake of water up to two hours before induction of anaesthesia.
  - A minimum pre-operative fasting time of six hours for food (solids, milk and milk-containing drinks)
- Intravenous fluids were prescribed, administered and recorded appropriately in all patient notes we reviewed.
- Patients with nausea or vomiting were formally assessed and prescribed antiemetic medicine (a drug effective against vomiting and nausea). We saw patients were given antiemetic medicine intravenously in the recovery area if they complained of nausea post operatively.
- The catering department, where required, provided food and drink for patients after and during procedures. Patients were encouraged to eat before leaving the endoscopy unit, for example, after undergoing a colonoscopy (an internal endoscopic investigation of the bowel).
- Patients who attended the oncology unit could request food and drink which was delivered to the unit for patients' appointment times. Staff also had an area where staff or relatives could prepare hot and cold drinks for patients.
- The oncology unit had recipe booklets on display for patients affected by cancer to help them with their dietary changes. The book looked at eating problems, low immunity and other health conditions.

Pain relief

- The service managed patients' pain effectively and provided or offered pain relief regularly.
- Pain was risk assessed and recorded using the National Early Warning Score (NEWS 2) scale and we saw these were completed. We observed staff asking patients if they were in any pain. Staff had access to tools to help assess the level of pain in patients who were non-verbal.

- The service met the core standards for pain management services (Faculty of Pain Medicine, 2015). We saw in medical records that patients with acute pain had an individualised analgesic plan appropriate to their condition. Pain was assessed during observations and recorded on NEWS 2 charts. The clinical services manager for pharmacy was also the hospital's pain lead. They encouraged successful pain management through meetings with their peers and training sessions with staff.
- We saw the pain management audit for February 2018 which showed the day case service achieving 90%. An area which scored the least was: Is there documented evidence that the patient was asked if they had pain on admission and what they took to help. During the inspection we observed both medical and nursing staff asking patients about their pain levels and how they managed their pain.
- Staff responded compassionately to pain, discomfort, and emotional distress in a timely and appropriate way. All patients spoken with told us that their pain had been well managed.
- Syringe drivers were used in the chemotherapy unit which delivered a slow steady flow of pain relief. We saw that all staff had received specific training in the use of these.

Patient outcomes

- The service monitored the effectiveness of care and treatment and consistently used the findings to improve them.
- The hospital had a comprehensive audit and risk management structure which ensured the service had a transparent approach to the management of risk and the assurance of safety. The integrated audit results for January and February 2018 ranged from 90% for pain management to 100% for hand hygiene and infection prevention control. However, there were no specific audits for breast care patients and we were informed they formed part of the ward and theatre audits. This meant that we could not be assured what oversight the MAC had of the service being provided by the breast care nurse.
- The hospital had a comprehensive clinical audit programme. For example, the oncology unit was participating in the national organisational neutropenic sepsis audit which looked at compliance to NICE guidelines for risk assessing, recognising and treating neutropenic sepsis. However, they were unable to submit their data due to not reaching the criteria regarding the number of patients with neutropenic sepsis. Senior staff confirmed they would continue to monitor and submit data as required by guidelines.
- The endoscopy service had maintained its Joint Advisory Group Gastroenterology Society (JAG) accreditation (June 2018). The accreditation is based on the results of audits which were based on JAG quality and safety in endoscopy global rating scale (GRS) (British Society of Gastroenterology Quality and safety indicators for endoscopy, 2009). The GRS audit is divided into four areas which are: clinical quality, patient experience, workforce and training.
- The oncology unit had been assessed by the Macmillan Cancer support charity and had been awarded the Macmillan Quality Environment Mark (MQEM) in March 2017. The MQEM award was an assessment of services provided for patients living with cancer, which is based on the environment ensuring it is welcoming and accessible. The MQEM also ensured that patients were treated with dignity and respect and given choices in their care and treatment. Accreditation standards are reassessed three yearly to ensure continued compliance.
- We saw evidence within the oncology service that BMI Three Shires Hospital had been adopted by the Macmillan service. This is where the Macmillan service enters into a partnership with other organisations and adopts a post or service. This allows the professional in post and their service to be branded as Macmillan. This also meant they could take advantage of opportunities and support offered. Areas included:
  - Learning and development events including a free coaching service
  - Networking events
  - Grants for learning and development (within our criterion) both as individuals or as a group
  - Access to free materials and branded merchandise to help them promote them self and their service

- The hospital participated in the Patient-Led Assessments of the Care Environment (PLACE) audit. The assessments involve patients and staff who assessed the hospital and how the environment supports patient's privacy and dignity, food, cleanliness and general building maintenance. We saw the results for 2017 which demonstrated the hospital achieved 100% for cleanliness, 99% for food, 96% for privacy, dignity and wellbeing, 100% for condition, appearance and maintenance and 88% for dementia.
- The hospital participated in the Commissioning for Quality and Innovation (CQUIN) framework. The aim of the CQUIN is to demonstrate improvements in quality and innovation in specified areas of patient care. The hospital participated in the Sign up to Safety campaign. The CQUIN had three principals which the hospital was committed to which included:
  - To reduce avoidable harm from failures or omissions in care
  - To ensure leadership from learning and safety improvement locally
  - To reduce avoidable harm by sharing and implementing learning
- BMI Three Shires Hospital was represented on the Northamptonshire countywide Sign up to Safety partnership group. We saw evidence dated 14 March 2018 provided by the Clinical Commissioning Group (CCG) joint executive management team which stated that the hospital had achieved this CQUIN.
- We saw the integrated audit for endoscopy dated May 2018. The results were RAG (red, amber, green) rated and was based on a hospital target of 90%. The endoscopy unit had achieved the following:
  - Standard precautions which included the use of personal protective equipment (100%)
  - Aseptic non-touch technique (ANTT) for intravenous therapy (82%)
  - Theatre guidance which included the WHO checklist (98%)
  - Patient equipment (94%)
- The endoscopy unit failed the hand hygiene audit (57%). This was based on 20 practitioners which included medical and nursing staff. Staff confirmed they did not have sufficient staff to complete the audit and had requested this element to be reviewed to enable them to be compliant.
- We saw the integrated audit for oncology which had achieved the following:
  - Standard precautions which included the use of personal protective equipment – 100%
  - Aseptic non- touch technique (ANTT) for intravenous therapy audit – 100%
  - Patient equipment – 94%
  - Hand hygiene – 90%

Competent staff

- The service made sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them, when required, to provide support and monitor the effectiveness of the service.
- The service had access to the clinical education team whose role focussed on the retention and upskilling of staff. This enabled the hospital to develop competent and proficient staff. There was a focus on developing and cross skilling health care assistants to deliver improved flexibility across theatres, wards and outpatients.
- Staff told us they received a comprehensive induction when they commenced work at the hospital. This included a hospital wide induction and local induction. The local induction included orientation to the area and local competencies. Staff told us they found the inductions useful. The hospital wide induction training included areas such as information governance, infection prevention and control and fire safety.
- Nursing and medical staff we observed and spoke with had the skills, knowledge and experience to deliver effective care and treatment to patients. Nursing staff and healthcare assistants (HCAs) could describe ways in which they managed and cared for patients living with dementia or a learning disability.

- Staff within oncology had undertaken additional training relevant to their role. These included for example, dealing with emotional stress and living well with cancer.
- An oncology lead for BMI Healthcare had completed BMI Three Shire Hospital's oncology staff competencies. We saw records that showed that these were up to date.
- Training for staff in endoscopy was based on the British Society of Gastroenterology (BSG) guidelines and we saw that this was reviewed annually to ensure that staff received on-going appropriate training.
- Staff said they rotated staff between the surgical ward and the endoscopy unit to ensure they had an overview of the various procedures within each area. Endoscopy staff said that this helped them in their role and provided them with an insight of the day to day workings on a ward.
- All registered nurses that worked in the wards and theatres had valid nursing and midwifery qualifications. This confirmed that nurses were trained and eligible to practise within the UK. There was an effective revalidation process in place to ensure these were updated.
- Revalidation is the process that all nurses and midwives in the UK need to follow to maintain their registration with the Nursing and Midwifery Council (NMC) and allow them to continue practising. We saw that the hospital had arranged workshops to assist staff with understanding revalidation requirements and training sessions in specific areas which could be used for revalidation purposes; for example, an oncology study day for all staff which included training about managing and screening for neutropenic sepsis.
- The executive director was responsible for ensuring that all medical staff with practising privileges had the correct skills, competencies, experience and qualifications to carry out the care and treatment provided. The MAC assisted with this process by providing professional advice.
- From November 2017 to May 2018 100% of staff had received their appraisal within the endoscopy and oncology units. Staff confirmed they had received their annual appraisal and said this was an opportunity for them to highlight their individual training needs and identify areas for improvement.
- Medical staff with practising privileges were required to provide evidence of appropriate appraisals in line with the General Medical Council (GMC) guidelines; this was checked by the MAC and the hospital had a comprehensive policy which described the consultants' responsibilities. Consultants who did not provide appropriate evidence had their practising privileges suspended until the evidence was produced.
- As part of the pharmacy chemotherapy competencies, neutropenic sepsis (a life-threatening complication of anticancer treatment) was covered and a member of the clinical pharmacist team had undertaken this course.

Multidisciplinary working

- Staff worked together as a team to benefit patients. Doctors, nurses and other healthcare professionals supported each other to provide good care.
- We saw that staff, teams and services worked effectively together to deliver patient care.
- Consultants provided the interaction between their patients and the NHS multi-disciplinary team (MDT) meetings to ensure that their patients benefit from the full range of clinical specialists involved in supporting their care. However, the minutes from these meetings were not provided to BMI Three Shires Hospital which meant that we could not be assured that the information provided regarding patients was accurate and up to date. We spoke with the director of clinical services who confirmed they were aware of the shortfall and were in discussion with external colleagues to arrange a mutually agreed conclusion.
- Endoscopy staff attended the endoscopy user group meeting which was across the BMI Healthcare service. Staff said they found this group was very helpful and they could e-mail each other for advice and support.
- Nursing staff told us they had developed good working relationships with consultants and that they felt confident to contact a consultant as required if they had any concerns regarding a patient's care and treatment.

- We saw that the service had good working relationships with local NHS acute trusts for transferring patients in line with agreed pathways.
- We saw that discharge plans included information sent to the patient's GP and referral to other community services such as local hospices for ongoing care.

Seven-day services

- The oncology and endoscopy units did not provide seven-day services.
- The chemotherapy unit and endoscopy facility provided services Monday to Friday 8am to 8pm. Staff told us that they sometimes adjusted the times to meet demands, for example, staff told us that on occasion they would deliver treatment on the weekends to ensure patients received their treatment in a timely manner.
- It was a requirement of the hospital's practice privileges policy that surgeons were available always to care for their admitted patients. If for any reason they are not immediately available then they were expected to provide named and appropriate cover. Key staff had access to all the contact details of consultants to ensure that support was available if required.
- The same process was expected of the consultant anaesthetists although there was arranged 24-hour cover seven days a week through the Northampton Anaesthetic Group.
- The hospital's resident medical officer (RMO) was available 24-hours a day, seven days a week to support patients, hospital staff and care for patients.
- The breast care nurse followed up patients with a telephone call 24 to 48 hours post diagnosis to assess their psychological state and to answer any further questions they may have.
- Patients could phone staff for advice at any time, and they could contact the consultant if required.

Health promotion

- Staff supported patients to manage their own health, care and well-being and to maximise their independence following surgery and as appropriate for individuals.
- Staff identified patients who may need extra support. We saw health promotion information and materials on display on the units. Examples included; eating a healthy diet, moderating your alcohol intake, increasing your physical activity and smoking cessation.
- The breast cancer nurse was involved with health promotion. Work was in progress with the Macmillan service to assist in delivering talks to local business on breast awareness.
- The Macmillan service in partnership with Coventry University had developed a HOPE programme which is a lifestyle coaching course to support patients to live well following cancer treatment while promoting self-management techniques based on cognitive behavioural therapy and positive psychology and self-efficiency theory. BMI Three Shires Hospital planned for the programme to be delivered within their premises which enabled their patients to enrol on the course.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- The hospital had a comprehensive consent policy which was up to date and regularly reviewed to ensure compliance with legislations.
- Consent to care and treatment was obtained in line with legislation and guidance, including the MCA. Staff understood their responsibilities and the procedures in place to obtain consent from patients before undertaking surgical procedures. This was in line with the consent for examination and treatment policy which gave clear guidance for staff. We saw completed and signed authorised forms for treatment and exploratory investigation during the inspection. We observed that consent had been obtained for all patients before their surgical procedure.
- Staff understood their roles and responsibilities under the Mental Health Act (MHA)1983, the Mental Capacity Act (MCA) 2005 and Deprivation of Liberty Safeguards (DoLS). They knew how to support patients experiencing mental ill health and those who lacked the capacity to make decisions about their care.
- MCA 2005 and DoLS training formed a part of mandatory training for staff. The records seen showed that all staff within the endoscopy and oncology services had completed their training.

Good

Medical care

- Nursing staff we spoke with explained the consent procedures and what to do if a person lacked capacity to consent for care and treatment. They outlined the principles of the MCA and the implications for their practice. They spoke about how they supported patients to make decisions whenever possible and were aware of the role of independent mental capacity advocates when patient did not have any family or informal cares who could be involved in the best interest decision making process.
- We saw the consent audit from August 2017 to January 2018 which showed the following results:
  - 54% done on the ward
  - 40% done in a procedure room
  - 6% done in the outpatient's department
- The quality review meeting minutes for June 2018 evidenced that the consent audit for quarter four (January to March 2018) showed 97% compliance. The medical records audit (based on 10 records) for March 2018 identified 24 out of 25 (96%) records as having "completed corporate consent form including benefits and risks which must be legible" and one out of 25 (4%) as having "not applicable" listed.
- Patients we spoke with told us they were given all the information they needed to decide about the treatment being provided. They said medical staff had fully explained the procedure at their initial appointment, they were given further information at their pre-operative assessment and when they were admitted to the unit it was explained again. This meant that when a patient was due to sign their consent form they had been provided with clear, concise information about the procedure and the associated risks.
- The deprivation of liberty safeguards (DoLS) protect people who are not able to make decisions and who are being cared for in hospital or in care homes. People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). None of the patient records seen required an assessment regarding their capacity.
- Nursing staff confirmed that patients with a learning disability or those living with dementia would be involved in a pre-operative meeting with the carer or family member to ensure there was a plan in place for their admission. Staff said that carers or family members were encouraged to stay with the patient and operating lists would be adjusted to suit patient needs.

Are medical care services caring?

Good

Compassionate care

- Staff cared for patients with compassion. Feedback from patients confirmed that staff treated them well and with kindness.
- We observed staff to be caring and compassionate with patients and their relatives without exception during the inspection. Patients universally praised staff for their kindness and their understanding of their needs.
- We observed staff treating everyone with kindness and respect. They welcomed people onto the units and put them at their ease. We saw staff explaining what they were proposing and responded well to people's questions and concerns. They quickly recognised when someone might need some extra reassurance or support and provided it tactfully.
- Feedback from patients confirmed that staff treated them very well and with kindness. Staff respected patients' privacy and dignity both on the endoscopy and oncology units. We observed staff maintaining patient's dignity before going into theatre and during surgery.
- Staff in the oncology unit had undergone specific training regarding compassionate care and providing support for patients with life changing conditions.
- The overall friends and family survey, which included both NHS and private patients scored between 98% and 100% for the number of patients who would recommend the hospital from August 2017 to January 2018. The overall response rates were 36% (99 responses) for the same time, which was in line with the England national average. For example, we saw 100% of patients saying that their privacy and dignity was maintained before, after and during their procedure.

- Breast patients said that they "couldn't have done this journey without constant support which was over and above the call of duty" and that the surgical team were "friendly and professional."
- One patient attending the oncology said the "care here is excellent" while another said that "staff were helpful and compassionate when they phoned."
- Both the oncology and endoscopy services displayed many thank you cards which they had received from patients and relatives. One person wrote, "thank you for everything you did, your help and support and advice was very much appreciated" and another said, "your unfailing support and concern has given us strength to cope with all the ups and downs."

Emotional support

- Staff provided emotional support to patients to minimise their distress.
- Patients and those close to them could receive support to help them cope emotionally with their care and treatment. Patients said staff quickly responded to their needs and they could talk openly with them and discuss any concerns. One patient said staff had a "positive attitude" and their "smiling faces and unending professionalism" was a "godsend." Other patients spoken with said that staff were "approachable and provided morale support when required."
- Nursing staff showed a holistic understanding of the personal, cultural, social, religious and physical needs of patients and those close to them. Patients' spiritual needs were considered irrespective of any religious affiliation or belief. Patients could access an external faith centre or church which was available within the grounds of the hospital. This was available for all patients and staff at the hospital where services and prayers were held regularly.
- Staff understood the emotional stress of patients having an anaesthetic before surgery. We observed staff being supportive and reassuring patients before their anaesthetic to minimise their anxiety and stress. Post-operative care within the recovery area was empathetic and staff did everything they could to ensure patients were comfortable and free from any pain.
- Nursing staff showed an awareness of the impact that a patient's care, treatment or condition could have on their well-being and those close to them.
- Patients were given information about relevant counselling services and peer support groups.
- Staff told us that if they had to deliver distressing news to a patient or their loved ones this would happen in a single use room or in a consulting room to allow privacy.

Understanding and involvement of patients and those close to them

- Staff involved patients and those close to them in decisions about their care and treatment.
- Patients said they felt involved in their care and had been asked for permission and agreement first which meant that the views and preferences of patients were considered.
- Patients and relatives had been given the opportunity to speak with the consultant looking after them. Patients said the doctors had explained their diagnosis and that they were fully aware of what was happening. Most patients were very complimentary about the way they had been treated by staff. We observed staff introduced themselves to patients and explaining to both patients and their relatives the care and treatment options.
- All the patients spoken with could explain their procedure and confirmed they had received all relevant information during their pre-assessment appointment. All patients were clear what was expected of them post operatively and the exercises, if applicable, they should continue.
- Staff recognised when patients and those close to them needed additional support to enable them to be involved in their care and treatment. Staff said that the pre-assessment clinic identified the communication needs of patients. This included access to language interpreters, specialist advice or advocates. This meant the service was compliant with the Accessible Information Standards (2015). These standards direct and define a specific and consistent approach to identifying, recording, flagging, sharing and meeting information and communication needs of patients, where those are related to a disability, impairment or sensory loss.

Good

Medical care

- We saw staff in the oncology unit greeting patients by their first name and patients calling nursing staff by their first names upon arrival.
- We saw staff taking the time to explain information to patients in an appropriate manner and making sure patients knew how to contact them if they needed more information.
- Nursing staff told us that conversations about the costs of treatment were handled in a sensitive manner and were discussed as a part of the pre-admission assessment and again on admission.
- We saw that patients and their loved ones had been involved in the decision-making process and this was reflected in patients' medical records.

Are medical care services responsive?

Good

Service delivery to meet the needs of local people

- The hospital planned and provided services in a way that met the needs of local people.
- The hospital saw both NHS funded (47%) and non-NHS funded (53%) patients. The service understood the different requirements of the local people it served by ensuring that it actioned the needs of local people through the planning, design and delivery of services. Services were planned in a way which ensured flexibility and choice. For example, pre-assessment clinics offered weekend appointments for patients who were unable to attend on a weekday.
- Planning for service delivery was made in conjunction with other external providers, commissioners and local authorities to meet the needs of local people. For example, we saw that GPs and community care providers were involved in planning care for patients receiving chemotherapy and the hospital liaised with local NHS trusts to establish appropriate pathways of care.
- We saw that the needs of the population were discussed at organisational level and shared through annual quality accounts defining the role of the organisation in delivering healthcare in all communities.
- Over the financial year 2018/19 the aim of the hospital was to redesign the functionality of theatre four, currently being utilised by the endoscopy unit, to include cataract and hernia surgery. Staff were aware of the impending changes and said they were looking forward to receiving the appropriate training. Senior staff confirmed they were currently looking at the staffing requirements before recruitment to ensure they met the needs of the local people.
- Staff were proud of the fact that they strived to deliver care in a manner that met the patients' medical and social needs; this included arrangements to have relatives or carers stay with patients at the hospital or nearby suitable accommodation.
- The breast care nurse provided each cancer patient with a diary to take away together with an explanation of its contents, how to complete and what to fill in when. The diary also contained useful information such as; contact numbers, details of both local and national support groups and a record of the patient's consultation.
- At the end of a breast cancer patient's treatment they were given information on "moving forward after breast cancer." This was in line with the national cancer recovery package and encouraged patients to attend the local course run by the Macmillan service to assist in self-management.
- The breast care nurse attended the monthly Northampton Breast Friends Support Group. They informed us this was a good way of reaching out to patients, seeking feedback and ensuring services within the hospital were caring.

Meeting people's individual needs

- Services were planned to take into account the individual needs of patients. Adjustments were made for patients living with a physical disability. The hospital had disabled access across all areas of the surgical services.
- There were arrangements in place for patients with complex social health and social care needs. Staff said patient's individual needs were identified during their pre-operative assessment and the theatre lists were arranged to accommodate the patient's individual needs.

- Staff carried out an initial screening of patients for dementia during their pre-operative assessment or on admission. There were specific admission checklists and discharge planning tools for patients living with a learning disability. Appropriate arrangements were put in place for older patients with complex needs.
- All staff were clear regarding their responsibility and accountability and knew their role in ensuring the hospital was safe while meeting the individual needs of the patient.
- On the day of surgery and for the continuity of care the breast care nurse admitted the patient onto the ward and reviewed them again before discharge. Any temporary prosthesis required could be fitted before the patient was discharged.
- Staff knew how to access the translation services including British Sign Language interpreters. They said they could offer face to face and telephone interpreting services for those patients whose first language wasn't English.
- Interpreters were pre-booked for the pre-operative assessment and before surgery. This was confirmed by staff spoken with who said that interpreters were usually booked by the medical secretaries but they could access the telephone translation service in an emergency. Staff also had access to communication aids when they were required.
- Nursing staff told us that specific patient communication needs would be assessed before admission and highlighted in the patient's medical records which complied with Accessible Information standards (NHS England 2015).
- Staff we spoke with were aware of the diverse population they served and were aware of the needs of people with varying cultural, ethnic and religious requirements. Staff were able to describe the principles of 'protected characteristics' as defined by the Equalities Act 2010.
- The oncology unit had linked with the Lewis Foundation. The Lewis Foundation is a charity which provides gift packs to patients in hospital. We saw these on display throughout the unit.

Access and flow

- Patients could access the service when they needed and there was minimal waiting time for patients to receive their procedure.
- Theatre four at the hospital had been allocated to the endoscopy unit. The theatre operated between 8:30am and 6pm and the occasional Saturday to support the consultant's waiting list. The theatre had a stand-alone recovery unit to promote good access and flow within the unit.
- The hospital had redesigned the pathway for inpatient and day case admissions. Staff informed us that patients attending as a day case would come to an admission lounge located within ambulatory care. We did not see this in use during the inspections as all patients had been admitted through the surgical wards.
- The pathway enabled:
  - The staggering of admission times
  - Closer adherence to NICE guidance on fasting times
  - Enhance the efficiency on the ward area
  - Better patient admission process and discharge.
- There had been a total of 5,754 day case attendances from January to December 2017. The endoscopy unit's data was linked with theatres and we saw the following results regarding returns to theatre, unplanned transfers and unplanned readmissions. Staff within the endoscopy unit said that this rarely happened within the unit.
  - Between January and December 2017, there was eight unplanned returns to theatre
  - Between January and December 2017, there had been three unplanned transfers
  - Between January and December 2017, there was six unplanned readmissions.

(Source: Evidence provided by the hospital – PIR2)

- The hospital had a robust admissions and discharge policy. It set out the time frame for admissions from referrers and the process for requests for emergency admissions. All admissions had to be agreed and accepted by a consultant and a booking form completed.

- Breast patients who were discharged with drains in situ were taught how to manage them at home during the pre-operative assessment. This would be revisited before discharge to ensure the patient was competent and confident to do so. Patients' drains would be monitored every 48 hours by a telephone call by the breast cancer nurse and drainage, where required, every 24 hours. When the drain was ready for removal the breast cancer nurse would arrange for the patient to attend the outpatient department.
- The scope of practice policy at the hospital set out the guidelines for procedures and treatments that could be carried out. Consultants who were referring patients were required to ensure that the procedure or treatment booked for their patients was within the scope of practice.
- Patients requiring breast care services could be referred using three routes:
  - GP referral
  - The NHS breast screening program from a local NHS hospital
  - Patients requiring a surgical procedure following neoadjuvant chemotherapy (a drug treatment that takes place before surgical extraction of a tumour).
- Patients could access care and treatment at a time to suit them in line with the hospitals terms and conditions of admission. All patients were offered flexibility of appointments.
- There was no waiting list for endoscopic procedures and staff told us that all endoscopic procedures were carried out within two weeks of referral unless the patient requested a time longer than two weeks. Patients spoken with confirmed they had waited less than two weeks for their procedure.
- The hospital had a system in place to manage cancellations of procedures or treatment for non-clinical reasons, for example lack of staff. For example, we saw that from April 2017 to March 2018 there had been nine cancellations within oncology for non-clinical reasons and all patients had been offered alternative appointments within 28 days. Cancellations were discussed at clinical governance meetings to identify trends and areas for improvement.
- Patients who attended the oncology unit had already received their initial consultation and staff told us that appointments for treatment were planned and discussed with patients.
- There were arrangements and processes in place for patients to receive emergency care and advice outside of the services' normal working hours.
- Discharge letters were sent to the patients' GPs immediately after discharge, with details of the treatment, including follow up care and medications provided.

Learning from complaints and concerns

- The service treated concerns and complaints seriously, investigated them and learned lessons from the results, which were shared with all staff.
- Patients we spoke with told us they hadn't had a reason to complain during their stay, but they would feel confident in raising a concern or complaint if necessary. Staff said that if a patient raised a concern or wanted to make a complaint they would listen to the issue, see if they could resolve the matter immediately and report it to the ward manager or nurse in charge. However, it was unclear if staff escalated complaints resolved on the ward for recording which meant that we were not be assured that lessons were identified and learnt.
- We observed literature on display advising patients and their relatives how they could raise a concern or complaint, either formally or informally.
- BMI Healthcare had a three-staged process for dealing with complaints with clear timeframes. The hospital maintains a complaints tracker to ensure all complaints are overseen to ensure a timely and appropriate response. The three stages were:
  - Stage 1 - the complaints process is within the hospital with complaints managed or escalated to the executive director.
  - Stage 2 – If the complaint remains unresolved the patient has the option of escalating their concerns to the senior regional management team

- Stage 3 – this is the signposting of any stage 2 complaints which remain unresolved to the Parliamentary and Health Service Ombudsman or the Independent Healthcare Sector Complaints Adjudication Service.

- From February 2017 to January 2018 the hospital received 65 complaints. We saw that complaints were discussed at clinical governance meetings and areas for improvement and learning were highlighted. Patients were offered apologies and compensation when billing errors occurred and staff had been reminded of the importance of information governance and maintaining patients' records when information between providers was not effectively communicated. The hospital informed us that there had been no complaints relating to oncology or endoscopy for 2018.
- The BMI complaints policy requires acknowledgement within two working days and a substantive response to the patient within 20 working days. A holding letter would be sent to the patient if there was a delay in the response time such as the gathering of information or the requirement of a statement from consultants or staff.
- Staff told us new complaints and learning from complaints were discussed at their team meetings. We reviewed the minutes from monthly clinical governance team meetings, medical advisory committee meetings and heads of department meetings that demonstrated complaints were a regular agenda item.
- The executive director had overall responsibility for the management of complaints. Complaints were logged on the electronic incident reporting system, which alerted staff when there was a new complaint, and investigations were carried out by the head of the department as appropriate. Complainants were offered a face to face meeting or a telephone call with the executive director and appropriate staff such as the director of clinical services.

Are medical care services well-led?

Good

Leadership

- The service had managers at most levels with the right skills and abilities to run a service providing high-quality sustainable care.
- The hospital had a clear management structure in place with defining lines of responsibility and accountability. The hospital's senior management team consisted of an executive director, who had overall responsibility for the hospital, the director of clinical services, the quality and patient safety lead and the operations manager. The MAC chair and heads of department supported the senior management team. All the heads of department reported to one of these four leaders.
- The executive director attended regular meetings with other executive directors within the region, and told us they were well supported by the corporate senior management team.
- Staff told us that the executive director was well respected, visible and supportive. All staff said the director of clinical services had an open-door policy and they could approach them if they had any concerns.
- Staff we met were welcoming, friendly and helpful. It was evident that staff cared about the services they provided and told us they were proud to work at the hospital. Staff were committed to providing the best possible care for their patients.
- The oncology lead had played an integral part in the implementation and further developments of the service which included being the patron for the Lewis Foundation and a link with the Macmillan service.
- The endoscopy lead was new in post but had the responsibility for leading and developing staff and services for patients receiving endoscopic procedures. For example, staff within the endoscopy unit said that they could approach the lead with any issues and they were always available to listen to any concerns.
- Nursing staff said that leaders were visible and approachable and felt that they could express any concerns to them and they would be listened to.
- There was a strong culture of openness and transparency and staff at all levels spoke of identifying areas to improve the patient experience.

- Staff at all levels and in clinical and non-clinical positions told us that they felt valued as part of the team and felt that their contribution mattered. Senior management team spoke with pride about the work and care their staff delivered daily.

Vision and strategy

- The service had a vision and strategy for what it wanted to achieve and workable plans to turn it into action developed with involvement from staff, patients, and key groups representing the local community.
- The hospital had a five-year vision (2015 to 2020) which was based on eight strategic priorities which we saw on display around the hospital. Examples of the strategy included;
  - Recognised as a leading provider of complex surgical procedures and medical services.
  - An employer of choice.
  - Consistently delivering quality services and care in a cost-effective way.
- The hospital's strategy was to provide the "best patient experience and outcomes, in the most effective way, from our comprehensive UK network of acute care hospitals." Staff we spoke to at all levels were aware of the hospital's strategy.
- The hospital had a nursing clinical strategy 2018. The aim of the strategy was to reflect the principles of what good future independent healthcare would look like by working with the Royal College of Nursing, partnership groups and staff forums. Examples of key priorities included:
  - The provision of safe and effective care.
  - A commitment to continued learning and improvement.
  - The delivery of integrated models of care with partners to improve the health of the patients served.
- The endoscopy unit had created their own mission statement which staff referred to. This was; "We aim to deliver a high-quality patient endoscopy service that meets the needs of each individual patient in a safe environment with a compassionate, caring manner."

Culture

- Managers across the hospital promoted a positive culture that supported and valued staff, creating a sense of common purpose based on shared values.
- Openness and honesty was encouraged at all levels and staff said they felt able to discuss and escalate concerns. Two staff members had completed the guardian's office training as freedom to speak up guardians. Staff knew who the hospital's freedom to speak up guardian were. The role of the freedom to speak up guardian is to ensure that staff have the capability to speak up effectively and are supported appropriately.
- Both oncology and endoscopy staff reported a good culture within the service. Staff felt supported by their colleagues in their individual areas. They told us they were proud to work within the hospital. Staff said their service lead looked after them well. We also observed positive and supportive interactions between staff and service leaders. Staff said the oncology and endoscopy lead as well as the director of clinical services had an open-door policy where any member of staff could see them privately.
- All the staff we spoke with talked about an open and transparent culture within the hospital and the hospital. Quotes from staff included, "I love coming to work," "Everyone is friendly and we support each other." Staff also confirmed they enjoyed caring for their patients and we observed good interaction during the inspection.
- Staff told us they were happy with their work and their immediate team. There was a culture of collective responsibility between teams and services. Staff felt listened to and said they worked well as a team.
- BMI Three Shires Hospital is part of a group of 59 hospitals. Performance was reviewed against peers and patient satisfaction levels. This gave an insight to overall performance and potential areas of improvement. The annual staff survey demonstrated a high level of engagement and the hospital was ranked 13th out of the 59 hospitals.
- Staff appointed the freedom to speak up guardian. The director of clinical services and the staff representative were then trained through the guardian's office. Staff across the endoscopy and oncology units knew who their freedom to speak up guardian contact was. Staff also referred us to literature on display across the units.

Good

Medical care

Governance

- The hospital used a systematic approach to continually improve the quality of its services and safeguarding high standards of care by creating an environment in which excellence in clinical care would flourish.
- There was a clear governance structure in place with a variety of committees, such as resuscitation, infection prevention and control, and health and safety, which fed into the hospital's governance meetings and ultimately reported to the BMI corporate board. All these committees had terms of reference, which reflected their role in the hospital, their structure and purpose. We reviewed three sets of governance meeting minutes and saw they were well attended by the senior management team, heads of department and clinical leads. Standard agenda items for discussion included clinical incidents, complaints, audits and risks.
- The hospital had a formal structure of governance meetings. These include senior management team meetings, clinical governance meeting, MAC meeting, heads of department (HoD) meetings, IPC and other specialist meetings. Feedback was provided to departments and staff of outcomes and HoDs cascaded information to the team. The Director of Clinical Services represented the breast nurse specialist, however, we saw evidence that the clinical breast nurse would be joining the outpatient team meetings from July 2018 to ensure they had the appropriate support and communication.
- The medical advisory committee (MAC), which was chaired by one of the consultants with practicing privileges, received reports from all the committees and reviewed all medical staffs practicing privileges. The MAC would also discuss new procedures to be undertaken to ensure they were safe, equipment was available and staff had relevant training. The MAC chair met with the hospital executive director regularly to discuss the MAC agenda and review complaints and incidents. Information from meetings was cascaded to staff through departmental meetings.
- There was a systematic programme of internal audit used to monitor compliance with policies such as hand hygiene, health and safety and cleaning schedules. Monthly integrated audits were completed by each unit according to an audit schedule and results were shared at relevant meetings such as the hospital clinical governance meetings. Audit records and meeting minutes, we reviewed (March to May 2018) confirmed that this process was embedded. For example, staff undertook monthly local audits of patient equipment, the WHO checklist and medicine management.
- Staff understood their roles and what they were accountable for, for example; the infection control lead was responsible for attending infection and prevention control meetings and reporting on concerns and compliance to protocol.
- All consultants applying for practising privileges were required to provide evidence of appropriate and adequate indemnity insurance. The consultants' handbook set out what the hospital's minimum consultant medical malpractice indemnity requirements were.
- The hospital had processes in place to ensure that medical professionals granted practising privileges maintained an accurate personal record and appraisal record in line with General Medical Council (GMC) requirements of registration. This process was managed by the executive director with input from the MAC when required.
- Nursing staff said they attended team meetings and we saw meeting minutes dated May 2018 for both the oncology and endoscopy services. These were available for staff to read in the staff room. Staff also confirmed learning from incidents, complaints, audits and other quality improvement initiatives were communicated to them in a variety of ways such as; team meetings, e-mails and information on the notice board. However, the cancer breast nurse did not attend and was represented in any of the team meetings. This meant that we could not be assured of the MACs oversight of the service regarding any issues of risks.

Managing risks, issues and performance

- The hospital had effective systems for identifying risks, planning to eliminate or reduce them, and coping with both the expected and unexpected.

- The hospital had a centralised risk register which was reviewed at monthly management meetings. We saw extracts of the risk register relevant to the location on display within the oncology and endoscopy units. Examples of endoscopic risks included:
  - The skill mix of clinical staff not meeting service requirement
  - The preventable death or injury of a patient
  - The ineffective monitoring of business performance
- Control measures were in place regarding these risks and they were regularly reviewed to ensure they remained current. Staff confirmed that additional control measures were added as relevant.
- Staff we spoke with were aware of the main risks within the endoscopy and oncology units. For example, leaders in oncology told us that their main risk was staff competency. We saw this had been addressed and all staff had recently completed their competencies.
- Consultants provided the interaction between their patients and the NHS multi-disciplinary team (MDT) meetings. However, these minutes were not provided to BMI Three Shires Hospital and not included on the risk register as an area of concern. The Director of Clinical Services was aware of this and had actions in place to mitigate.
- Information regarding the hospital's risks was shared with staff in a variety of ways, such newsletters, meetings and staff noticeboards.
- The hospital had a business continuity plan which provided guidance on maintaining services and dealing with business interruptions which might disable services or require special arrangements to be put in place to allow them to continue.

Managing information

- The service collected, analysed, managed and used most information well to support all its activities, using secure electronic systems with security safeguards.
- Leaders had a holistic understanding of performance. Information was used to measure improvements. There were clear and robust service performance measures in place, which were monitored at governance meetings.
- The service had a wide range of information available to them to enable service leads to assess and understand performance in relation to quality, safety, patient experience, human resources, operational performance and finances.
- The hospital produced a monthly integrated audit report for each clinical group which listed their performance. Hospital targets were set in relation to these indicators and performance was rated using the traffic light, RAG (red, amber, or green) rating system. This allowed managers to assess their performance at a glance and identify those areas which required further improvement or investigation.
- Information technology systems were used effectively to monitor and improve patient care. There were effective arrangements in place, which ensured data such as serious incidents were submitted to external providers as required.

Engagement

- The service engaged well with patients, the public and local organisation to plan and manage appropriate services, and collaborated with partner organisations effectively.
- Most staff within the oncology and endoscopy service felt engaged with their senior management and felt their views were reflected in the planning and delivery of services. Staff said they contributed to the annual staff survey and gave examples of improvements made following the staff survey such as improved access to leadership training.
- An independent survey of 116,747 patients from January 2017 to December 2017 showed that 99% of patients would recommend their hospital to their families and friends while 95% rated the overall quality of their nursing care as excellent or very good.
- At the beginning of the financial year 2017/18 (April 2017), the hospital completed a health and well-being survey which looked at eight key areas such as health and safety, mental health and wellbeing and leadership. Based on the findings of the survey the hospital created a purpose project plans. Areas identified included:

  - To equip the managers with the knowledge, awareness and skills to support their staff, manage attendance and change and reduce stressors in the workplace through offering briefings, updates or training as needed.
  - Encourage staff to take responsibility for their own health and wellbeing through effective health promotion programmes and initiative.
- The results from the end of quarter four 2017/18 (January to March 2018) showed that five of the projects had been completed with the remaining three, health and safety, mental health and wellbeing and healthy eating continuing to be "in progress."
- In the 2018 BMI staff survey, 84% of Three Shires Hospital staff said they would recommend the hospital. This was higher than the national average of 73%. Because of the survey, the senior management team said they would continue to foster open and transparent line of communication with staff as laid down in the hospital's vision and strategy.
- All staff that we spoke with recognised the value of raising concerns and taking appropriate action if required.

Learning, continuous improvement and innovation

- The service was committed to improving services by learning from when things go well and when they go wrong, promoting training, research and innovation.
- The endoscopy lead was new in post and was developing their role. The endoscopy lead was making links with the local NHS hospital endoscopy unit to support both their own and staff development. The endoscopy support group supported links with peers in another BMI hospital to support their development within the theatre.
- Endoscopy and oncology leaders and staff were continuously looking for opportunities to improve practice and develop ways of working to improve the quality of care. Staff at all levels attended national training sessions and events to discover new treatments and development opportunities for staff.
- The endoscopy service had maintained the Joint Advisory Group accreditation.
- The oncology unit had linked with the Lewis Foundation to provide gift packs to patients receiving chemotherapy.
- The Macmillan service in partnership with Coventry University had developed a HOPE programme which is a lifestyle coaching course to support patients to live well following cancer treatment. BMI Three Shires planned for the programme to be delivered within their premises which enabled their patients to enrol on the course.
- The breast care nurse attended the monthly Northampton Breast Friends Support Group as a way of reaching out to patients the receiving of feedback and ensuring services within the hospital were caring.

Requires improvement

Surgery

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

Are surgery services safe?

Requires improvement

Mandatory training

- The service had a mandatory training programme for all staff. This included topics such as infection prevention and control, moving and handling, fire safety, conflict resolution, and information governance. The mandatory training programme was tailored to the skill requirement of staff and was dependent upon their role. For example, clinical staff received training in adult immediate life support and non-clinical staff completed basic adult life support training.
- Most training was provided using e-learning courses, with some face-to-face sessions. Staff could access e-learning courses at work or at home. If staff completed training at home in their own time, they were reimbursed for it. There was a new on site clinical education room which contained computer terminals and this enabled staff to access the online training outside of the clinical environment.
- Staff could view their individual training needs, current compliance and access e-learning courses through the hospital's electronic training system. The system also alerted staff and their manager when mandatory training was due to be completed. However, not all staff had completed all of their mandatory training, and not all managers were aware of the outstanding training that was required by their staff.
- Mandatory training completion rates for staff working in the surgery service was 88% against a target of 90%. For example, 12 clinical staff had out of date infection prevention and control training and eight staff were out of date with their fire training and seven staff were out of date with their manual handling training.
- We looked at the ward staff electronic training records for completion of basic life support (BLS) and immediate life support (ILS) training. Training for BLS was 50% compliant; 15 staff out of 30 had not completed their BLS within the previous 12 months. Training for ILS was 63% compliant with 11 staff out of 30 not having completed their ILS within the previous 12 months. All registered nursing staff were expected to have training in ILS. The ward manager told us that there was a delay in updating training on the electronic system and that the clinical educators had more up to date records. The following day, we were told that there were five staff on the ward with expired training for both BLS and ILS. After our inspection, the service told us that 100% of ward staff and 83% of theatre staff were compliant to BLS, and 91% of ward staff and 80% of theatre staff were compliant to ILS. Due to the variety of figures obtained for this training, we were not assured of the quality of data management and record keeping with regards to mandatory training figures.
- Not all staff could identify items in the resuscitation trolley; two out of three staff (one nurse and one healthcare assistant) were unable to identify any of the items listed in the top draw, despite confirming they had attended BLS.
- During a review of an incident relating to resuscitation, it was reported that staff had not carried out the correct use bag mask ventilation (BMV). BMV is a basic airway

management technique that is essential in an emergency. We were not assured that in the event of an emergency, all staff on the ward would be able to assist in an appropriate manner.

- The Association of Anaesthetists of Great Britain and Ireland recommend that all specialist staff within theatre recovery areas have appropriate training in advanced life support (ALS). Nursing staff told us they were not trained in ALS, but anaesthetic medical staff did have ALS training. We saw evidence that the resident medical officer (RMO) had attended e-learning ALS.
- Not all staff had received training on how to use the new defibrillator which was supplied to the ward for use in a cardiac arrest. Some nursing staff told us they would not feel confident in using the new machine. We highlighted this as a concern to the hospital leadership during our inspection. We were told that the supplier of the new defibrillator had provided some training to some of the staff. On our unannounced visit, we saw that further training had been arranged.
- The senior management team told us they had oversight of training compliance. The director of clinical services received a weekly training compliance report, which was shared with the heads of department. Mandatory training compliance was also discussed at various meetings, including hospital governance and departmental meetings, and the daily communications cell meeting. However, we found that local managers had a lack of oversight of their whole team's compliance to mandatory training. For example, they were unable to tell us about local training compliance rates for the ward generally, or for individual categories like manual handling or BLS. We were told by local managers that they received an email when an individual's mandatory training was due or had expired. We found that this was not translated into an overall picture of current outstanding training needs nor of the risks associated with out of date training.

Safeguarding

- There were processes and practices in place to safeguard adults and children from avoidable harm, abuse and neglect that reflected relevant legislation and local requirements.
- Safeguarding adults and children policies were in-date and were accessible to staff through the hospital's intranet. They included clear guidance on how to manage suspected abuse and radicalisation, and details of who to contact for further support and guidance. The hospital received safeguarding support from the local clinical commissioning group (CCG) safeguarding team.
- Safeguarding training was provided using e-learning courses, with additional workshops held for female genital mutilation (FGM) training. Training covered all aspects of safeguarding adults and children, including professional responsibilities, the Mental Capacity Act, categories of abuse, safeguarding processes, child protection, and the Prevent strategy. Prevent training is a national government initiative which aims to improve awareness of how to protect people who may be a risk of radicalisation. Staff we spoke with knew how to access and complete safeguarding training.
- We were told clinical staff were required to complete safeguarding adults and children training at level three, which exceeded national requirements. Non-clinical staff were required to complete safeguarding training at level two. The director of clinical services was the dedicated safeguarding lead and had up to date level four safeguarding adults and children training.
- Most staff in the service at the time of our inspection (June 2018) had completed safeguarding training to the level required for their role. Level two adult safeguarding training for ward staff was 87% and 100% for theatre staff against a target of 90%. Completion rates for children safeguarding level two were 83% for ward staff and 94% for theatre staff.
- Staff we spoke with had a good understanding of their responsibilities in relation to safeguarding of vulnerable adults and children and were able to explain how to respond to and escalate a concern or make a referral.
- There had been no safeguarding concerns reported to CQC in the reporting period from February 2017 to January 2018. However, the service had identified one safeguarding concern regarding potential physical abuse of a patient while they were in a care home. We were told this was referred to the relevant safeguarding authorities and the police. Staff described the actions they had taken to ensure the immediate safety of the patient, which was in accordance with corporate policy and best practice.

- The hospital had a chaperoning policy and staff knew how to access it. Nursing staff accompanied patients while they were having procedures.
- The ward had a folder containing safeguarding information. Staff had displayed safeguarding information posters on office walls, which contained information on how to contact the local safeguarding authority.

Cleanliness, infection control and hygiene

- There were reliable systems in place to prevent and protect people from healthcare associated infections, however we observed at times staff did not follow the hand hygiene policy.
- The wards, and theatres were visibly clean and tidy. Cleaning schedules were displayed. In theatres, we saw detailed logs of daily cleaning which were completed by clinical staff working in the department.
- The hospital had policies and procedures in place to manage infection prevention and control. Staff accessed policies using the hospital intranet and could demonstrate how these policies were easily available.
- Most staff followed the hospital's policy on infection control, for example, we observed staff complying with 'arms bare below the elbow' and not wearing jewellery and applying gloves before handling bodily fluids.
- During our inspection in June 2015, we observed that surgical staff did not always comply with the hospitals hand hygiene policy. During this inspection this remained the same.There was limited opportunity to observe direct patient care due to each patient having their own single side room. However, we observed eight opportunities when hand hygiene should have been performed and it was only completed on four of these occasions. Missed opportunities included staff of all grades, for example, nursing staff did not always clean their hands before or after providing oral medication to a patient; anaesthetists did not always clean their hands following removal of gloves and a healthcare worker did not clean their hands after leaving a patient room wearing gloves. From March 2017 to February 2018, the service reported overall compliance to hand hygiene was over 90% each month. Patients we spoke to said staff washed their hands.
- The hospital had an infection prevention and control nurse and was supported by link nurses in each clinical area. Link nurses were responsible for collating audit data and producing actions to address any non-compliances. For example, they were involved in hand hygiene audits. The infection prevention nurse also carried out audits to ensure standards were maintained and that audit results were reliable. The infection prevention and control lead nurse (IPCN) networked with other infection control nurses within the BMI group. This meant that good practice and any themes or concerns could be shared.
- Infection control audits were carried out continually and reported on every two months. Environmental audits were also carried out. An observational infection prevention control audit in March 2018 showed all areas were compliant and scored more than 94%, except the physiotherapy staff who scored 73% for the correct use of standard precautions and the ward areas, which scored 81% for clean patient equipment. There was no action plan attached to the audit.
- The hospital had systems in place to manage, monitor and investigate infections. Hospital infections were reviewed by the infection prevention and control committee, and the infection prevention control nurse. Infections were reported to the clinical governance committee.
- Surgical site infections for replacement hips or knees, were reported in line with national guidance. This allowed the monitoring of surgical site infections and meant the service was able to benchmark performance with other healthcare providers.
- There had been no incidents of a hospital acquired infection such as MRSA, C. Difficile or MSSA.
- The hospital had carried out a total of 336 primary hip replacements and 334 knee joint replacements from January 2017 to December 2017. Incidents of surgical site infections were monitored and reported to the clinical governance committee. From July 2017 to June 2018 and there had been 17 surgical site infections. There were procedures in place to reduce the risk and monitor for signs of surgical site infections (SSI) in line with National Institute for Health and Care Excellence (NICE) CG 74 Surgical site infections: prevention and treatment.

Requires improvement

Surgery

- SSIs were investigated and nursing staff told us about a recent cluster of three infections. An appropriate investigation had been completed and learning from the incident had improved care for patients. Changes had been made following the investigation which included the standardisation of antiseptic used on patient's skin in preparation for their surgery and a change of post-operative dressings. The service had also agreed to be involved in a trial which looked at using warming devices during operations to lower infection rates.
- There were sufficient hand hygiene sinks in the clinical areas. Inpatient bedrooms had a clinical hand wash basin plus an ensuite bathroom which included a separate patient sink. This complied with Department of Health Guidelines 2013 HBN00-09.
- Flooring in patient bedrooms was made up of modern vinyl and was easy to clean and disinfect.
- There was an in-date MRSA screening policy. The policy required staff to carry out an MRSA risk assessment to establish if a patient required an MRSA screen. All screens were undertaken during the pre-operative assessment appointment. Screening involved taking a swab from the patient's skin or their nose to test for MRSA. This followed the national guidelines.
- The hospital had a service level agreement with the local NHS trust for infection control services. This included a consultant microbiologist who attended the infection control committee meetings to review infection control incidents, audits, water testing results as well as offering advice on antibiotic prescribing and any new building works in the hospital. Microbiology tests were also sent to the local trust's laboratories. Staff could access the results of swab tests online. The infection prevention and control meeting met quarterly and we saw evidence that the microbiologist attended these meetings. The hospital had 24-hour access to a microbiologist.
- The director of clinical services was the director of infection prevention and control (DIPC) and reported to the executive director. The DIPC was directly accountable for infection prevention and cleanliness of the hospital.
- Deep cleans were arranged following the discharge of patients with an infection and staff we spoke to were aware of the cleaning requirements following discharge of infected patients.
- The service provided a certificate of deep cleaning for their theatres which was dated December 2017. The Health and Social Care Act 2008: Code of Practice for the NHS for the Prevention and Control of Healthcare Associated Infections recommends a method of proactive deep cleaning is undertaken and documented every six months. We were not provided with evidence of previous cleaning or of dates for future scheduled cleans.
- Patients who required a urinary catheter or peripheral venous cannula (a thin tube inserted into a vein to deliver medication) had supporting documentation completed to promote best practice and care and to reduce the risk of infections.
- Reusable surgical instruments were decontaminated under a service level agreement by an NHS trust decontamination unit. We did not inspect this service. However, we were assured that the decontamination was undertaken following best practice guidance, including guidance from Health Technical Memorandum 01-01, which covers standards of cleaning and the management of surgical instruments used in acute care.
- There were processes in place for clinical waste management. Clinical waste bins were foot operated and once bags were full, they were removed to a secured waste area.
- Sharps bins were stored out of patient areas but were accessible to staff. Lids were temporarily closed for safety and the bins were not overfull.
- Spills kits were readily available. These allowed staff to safely collect and dispose of bodily fluids including blood and urine.
- During our previous inspection in June 2015, we observed that theatre shoes stored in the changing rooms were dirty and splashed with blood and that there were no facilities in place such as wipes or gloves for the cleaning of theatre shoes in the female changing area. During this inspection, all theatre shoes were stored cleanly.

- The hospitals Patient Led Assessments of the Care Environment (PLACE) 2017 indicators were better than the England average. Cleanliness scored 100% across all areas. This was higher (better) than the national average, which was 98%.

Environment and equipment

- There was generally sufficient equipment to maintain safe and effective care, such as anaesthetic equipment, theatre instruments, blood pressure and temperature monitors, commodes and bedpans.
- During our inspection in June 2015, we found that most patient rooms on the wards did not have piped oxygen, or suction. During that inspection, we were told that piped services to each room were included in an approved refurbishment plan, which was scheduled for 2015. However, during this inspection, we found that this had not been implemented and that all rooms on Cavell ward and eight rooms on Nightingale still did not have piped oxygen or suction. To address this, supplies of portable oxygen cylinders were placed in one of the wards. We found these to have been checked and in good working order during this inspection.
- There were 13 portable oxygen cylinders and three suction machines on the ward, including those on the emergency trolley. During our inspection, we found there was no risk assessment for the lack of piped oxygen and we were not assured that these would always be available when required. We were not made aware of any incidents reported due to a lack of oxygen or suction. The service told us that all patient rooms on Davidge ward, and four patient rooms on Nightingale ward had piped oxygen. Most adult surgical patients were nursed on Cavell and Nightingale wards, all children were nursed on Davidge ward.
- Nursing staff told us they were concerned about the lack of piped oxygen because there were more patient beds than there was supplies of oxygen. We were also told the cylinders were cumbersome to move and posed a trip and manual handling hazard. This was not on the service risk register. During our inspection we fed back our concerns regarding the lack of piped oxygen to the senior leadership team. We were told that they would look into this and carry out a thorough risk assessment. A risk assessment was carried out in July 2018 which deemed this risk as a low risk which required no further controls.
- We looked at a copy of the services most recent fire safety assessment which was done in June 2014, with a next due date of June 2015. The fire risk assessment highlighted concerns about the number of oxygen cylinders on the premises. Recommendations had been made to reduce these, and also to provide a safer storage environment. However, we were not provided with any evidence of actions taken or that these recommendations had been carried out.
- During our inspection in June 2015, we found that there was a lack of standardisation of anaesthetic rooms which meant there was a potential for delays in an emergency, if new staff were not familiar with each room's different layout. However, during this inspection we found this had improved and all anaesthetic rooms were now standardised and followed the same layout.
- Equipment was not always stored appropriately in the theatre department. We found ultra sound machines, patient trolleys, chairs and electrical items were stored in a corridor which was required for access. However, the equipment was visibly clean and stored tidily. As the equipment was stored in a corridor, there was a risk that this equipment may become contaminated, cause an obstruction in the event of an emergency, or be a trip hazard. We raised this as a concern during our previous inspection in 2015 and we were told that a risk assessment was about to be carried out to ensure there was always adequate access for patient trolleys. During this inspection, we requested a copy of this risk assessment, however this was not provided, and we were told that the theatre exits were wide enough for beds up to one metre wide. A fire risk assessment for the service, carried out in June 2014, highlighted an issue of medical equipment storage in escape staircases. We were not therefore assured that all staff were fully aware of the potential risks of inappropriate storage of equipment which may impede escape routes in the event of an emergency. During our unannounced inspection on 10 July we saw that the main theatre corridor had some diathermy equipment stored in it. The equipment was visibly clean and stored tidily, we were told that the theatre exits were wide enough for

beds up to one metre wide. Some equipment was temporarily stored in the corridor during a theatre list, for example prosthesis so that the correct size for the patient could be identified during the operation.

- Resuscitation equipment, for use in an emergency in operating theatres and the ward area was checked regularly and documented as complete and ready for use. The resuscitation trolley on Cavell ward had three pieces of emergency equipment recorded as missing from 18 June which were still missing when we checked on 27 and 28 June 2018. The ward manager told us that the items had been ordered. However, the long delays in obtaining replacement items meant we were not assured that emergency resuscitation equipment was always available and ready to use. We highlighted this concern to the ward manager during our inspection. We were told that the missing items, which were required for airway management (one endotracheal (ET) tube size 6.5; one ET tube size 8.5; one nasopharyngeal airway size 6), were items only required by BMI guidelines for resuscitation, but not for the national guideline published by the Resuscitation Council, UK. However, Resuscitation Council guidelines list size 6 nasopharyngeal airways as an essential item which should be available for immediate use at all times. On our unannounced inspection, we saw that the missing items had been replaced and staff told us spare equipment was available in the theatre department.
- Resuscitation trolleys were secured with tamper proof tags, which were removed weekly to check that all required items were available and within their use by date. Paediatric resuscitation equipment was available in the areas where children were seen and treated.
- An external review of resuscitation facilities in the service had been carried out in February 2018. One of the actions which had been marked as completed, was the removal of pocket masks from the resuscitation trolley. However, during our inspection, we saw that these were available on the resuscitation trolley located on Cavell ward.
- There were systems to maintain and service equipment as required. However, not all equipment had undergone essential annual safety testing to ensure it remained safe to use. We found an electrical cable attached to a urinalysis machine on Nightingale ward which had a sticker indicating it was lasted tested on 11 March 2010 and the next test was due by 19 March 2011; in the main theatre department we saw a portable ultra sound scanner with an out of date sticker and the defibrillator in recovery had a sticker which was unclear. Additionally, information gathered during our inspection indicated that eight TV's on Cavell ward had out of date extension cables. On our unannounced inspection, we saw that a safety check had been carried out on the defibrillator, and this was now in date. We also saw records demonstrating that all electrical equipment and extension cables had been checked throughout the hospital.
- There were service level agreements (SLA) with external organisations for general maintenance at the hospital and a separate maintenance contract for specialist equipment, for example, endoscopy washers and anaesthetic machines. There was a dedicated electronic system to manage the maintenance programmes and alert staff when specific equipment required maintenance. SLA's were also in place to ensure blood pressure monitoring machines and pumps were calibrated along with the electrocardiogram machines.
- Operating theatres were compliant with Health Technical Memorandum 03-01 Specialist ventilation for healthcare premises. This meant there was an adequate number of air changes in theatres per hour, which reduced the risk to patients of infection.
- We saw hazard warning lights with controlled area sign notices in place outside the minor operating theatre. These were appropriately displayed during X-ray guided procedures. We saw laser signage was available for laser eye surgery.
- All consumables that we looked at were within their expiry date and stock rooms appeared well organised and clutter free.
- Most chemical products deemed as hazardous to health were in locked cupboards or rooms that were only accessible to authorised staff. However, during our inspection, we found hazardous chemicals used as part of spillage kits were stored in unlocked dirty utility rooms. This was raised at the time of our inspection and the ward manager removed these to a locked storage area immediately.
- Nursing staff told us they used commode chairs to transport patient's short distances as there were no

wheelchairs available on the wards. We were told patients were wheeled to bathrooms on commode chairs if they were unable to walk themselves, post operatively. We were also told staff had used commode chairs to assist patients following a fall or who had collapsed in the corridor. Commode chairs are designed to be used when static only and there was a risk to patient safety in using them to transport patients.

- There was limited bariatric equipment available in the service, although staff said this could be hired and would be organised in advance of a patient's admission if required. Theatre staff told us about an incident they had reported where an operation was cancelled as the bariatric theatre table they had was unsuitable for a specific procedure.
- The Patient Led Assessment of the Care Environment (PLACE) for the period for 2017, showed the hospital, scored 88%, for condition, appearance, and maintenance, which was lower (worse) than the England average of 94%. This included assessment areas such as decoration, the condition of fixtures and fittings, tidiness, signage, lighting and the external appearance of buildings and maintenance of grounds.

Assessing and responding to patient risk

- Patients for elective surgery attended a nurse led pre-operative assessment clinic before their operation. During the assessment all required tests were undertaken, for example, MRSA screening and blood tests. This was in line with NICE guidance CG3: Preoperative assessments and NG45: Routine tests for elective surgery (April 2016) and guidance from the Modernisation Agency.
- The service used the American Society of Anaesthesiologists (ASA) classification system to grade a patient's level of risk. For example, ASA1 was low risk and used for healthy patients, ASA3 was a higher risk, and used for patients with severe systemic disease. Grades were recorded during pre-assessment by nurses and on admission for surgery by anaesthetists. High risk patients are more likely to have complications following surgery, and are more likely to require high dependency nursing following their procedure. Patients identified as being at higher risk or who had complications diagnosed following their test results were referred to the consultant for further review. Most patients operated on in the service were classed as ASA1 or ASA2 risk. ASA3 patients were accepted if the anaesthetist was happy with the risk following their assessment. The service had an exclusion criterion, which included unstable ASA3 patients, and all patients ASA4 or higher. ASA3 patients were thoroughly risk assessed by the consultant, the anaesthetic team and the clinical manager prior to being accepted for surgery.
- The National Early Warning Score 2 (NEWS 2) was used to identify deteriorating patients in accordance with NICE Clinical Guidance (CG) 50: 'acutely ill adults in hospital: recognising and responding to deterioration' (2007). Staff used the NEWS2 to record routine physiological observations, such as blood pressure, temperature, and heart rate. The NEWS2 prompted staff to take further action, such as increasing the frequency of monitoring vital signs and requesting a review from the RMO. During our inspection, we looked at eight patient NEWS2 scores and saw that they had been calculated accurately. However, the service did not audit its compliance to NEWS2, and we saw a serious incident involving a sick patient where staff had not calculated the NEWS2 score correctly or escalated it appropriately. Following our inspection, the service told us it looked at NEWS completion as part of its monthly documentation audit. However, this only checked to see if a NEWS had been recorded within the previous 12 hours. The audit did not look at the accuracy of the NEWS score, or if the appropriate escalation had been carried out.
- Information was available to help staff identify patients who may become septic. Sepsis is a serious complication of an infection. The service followed guidance from the Sepsis Six. This is the name given to a bundle of medical interventions designed to reduce the death rates in patients withsepsis. The Sepsis Six consists of three diagnostic and three therapeutic steps – all to be delivered within one hour of the initial diagnosis of sepsis. We saw posters in staff offices which alerted staff, patients, and relatives to the signs and symptoms of sepsis. The ward had access to a 'sepsis box', which contained equipment such as blood taking vials, intravenous fluids plus sepsis guidance, so that staff could access the right equipment quickly. We were

told that patients suspected of having sepsis would be transferred to the local NHS hospital for ongoing monitoring and treatment, and we saw evidence of this. Compliance to sepsis screening was not audited.

- BMI Healthcare group had introduced a new training module to help staff recognise sick and deteriorating patients; 'care and communication of the deteriorating patient training', was provided for all clinical staff. This training also included the recognition, diagnosis and early management of sepsis. As of July 2018, 66% of ward staff and 46% of theatre staff had completed the training. We were told that most staff were booked to attend this training.
- There were arrangements in place with a local acute trust to provide 24-hour emergency support if patients deteriorated and required high dependency nursing or urgent diagnostics. However, this was organised by the patient's consultant who planned for the transfer, following discussions with staff in the local NHS trust. In an emergency, staff called an ambulance and patients were transferred to the emergency department. An ambulance with a paramedic crew would be requested to ensure an appropriately trained clinician accompanied the patient to hospital. A service level agreement (SLA) was in place with the ambulance service for the safe transfer of patients to the local NHS trust. There had been 16 unplanned patient transfers to the local NHS trust from July 2017 to June 2018.
- The hospital had a 'massive blood loss' protocol and nursing staff were aware of where the emergency blood was stored and how to obtain it. Two units of O rhesus negative emergency blood were stored on site and further blood was obtained through the local NHS trust blood bank. This blood type can be given safely to most patients. There was a flow chart attached to the blood loss protocol to remind staff how to obtain extra blood supplies. The blood fridge temperature and stock was checked and recorded daily. There was an alarm system that would alarm both on the ward and the local NHS trust if there were any temperature safety issues. This meant that staff would be alerted to issues out of theatre hours.
- Patients were transferred from theatre to the recovery area with the anaesthetist, surgeon and scrub nurse, who verbally handed over the treatment carried out in theatre and discussed the aftercare including any medication requirements, immediate post-operative mobilisation and positioning of the patient.
- Items used in theatres, known as 'accountable items' were checked by two members of the theatre team using an instrument sheet. Accountable items are reusable or disposable which by nature are at risk of being retained in a patient, such as swabs and needles. These were documented on a count board in theatre and in the patient care plan. This was checked pre and post operatively and staff signed to confirm this had been undertaken.
- The theatre team followed the National Patient Safety Agency five steps to safer surgery as part of the World Health Organisation (WHO) surgical safety checklist in the operations we observed. Before surgery, staff gathered for a team brief to go through the WHO checklist and ensure all safety elements of each operation were considered before starting. This included checking patient identity, checking the operating site, and checking that all the staff involved were clear in their roles and responsibilities. Staff followed the WHO checklist and there was no distraction during the process, which included all members of the surgical team.
- The service audited its compliance to completion of the WHO checklist. Results from March 2017 to February 2018 showed compliance above 90% every month except for August 2017 when it was 79%. An observational WHO audit carried out in April 2018 in endoscopy, minor ops and theatres, showed compliance of 100%. However, in a separate audit of medical records, carried out from January to April 2018, WHO documents had not been correctly completed in 24 cases out of 39 (61%). We asked the service about this discrepancy and they told us that the audit of medical records looked at errors in the documentation of WHO only. The different compliance rates showed there was inadequate processes to assure the service it was using the WHO checklist correctly.
- Risk assessments were carried out on patients when they were admitted to the service. This included risk assessments for falls, malnutrition, and pressure ulcers. These were documented in the patient's records and included actions to mitigate any identified risks.

Assessments were updated weekly or following any changes, such as a new fall. The service used nationally recognised risk assessments, such as the Malnutrition Universal Screening Tool (MUST) and Waterlow score. MUST is a five-step screening tool to identify patients, who are malnourished, at risk of malnutrition or who are obese. The Waterlow score gives an estimated risk for the development of a pressure sore in a patient. We observed that patients identified at risk were placed on care plans and were monitored more frequently by staff to reduce the risk of harm.

- Risk assessment for venous thromboembolism (VTE) were completed during the preoperative assessment by nursing staff. However, we found that further risk assessments had not been carried out on admission to hospital in four out of eight patient records we looked at, despite these patients being prescribed, and given VTE prophylactic treatment. This was not in line with NICE guideline NG89, 2018, venous thromboembolism in over 16s: reducing the risk of hospital-acquired deep vein thrombosis or pulmonary embolism, which recommends patients have a VTE risk assessment on admission to hospital. BMI policy stated that consultants were responsible for completing this risk assessment. We fed our findings back to the senior leadership team during our inspection and they told us they were aware of the poor compliance in this area and had taken steps to address this with the consultants concerned. However, audits carried out by the service from March 2017 to February 2018 showed compliance was 100% every month, except August 2017, when it was 87%. We were therefore not assured that the audit reports had been robust enough to identify gaps in performance. Following our inspection, BMI issued a change of policy regarding VTE assessments. This dictated that all patients must have a VTE assessment signed by the consultant before they could be anesthetised. The policy would by supported by theatre managers and the anaesthetic team and was effective immediately. We saw that the senior management team had sent letters to all consultants to ensure that all VTE assessments were signed preoperatively. If this had not been done the surgery would not be allowed to commence until it was signed and an incident would be raised.
- National Safety Standards for Invasive Procedures (NatSSIPs) were not available in the theatre department. NatSSIPs provide a framework for the production of Local Safety Standards for Invasive Procedures (LocSSIPs). Dedicated LocSSIP checklists were not in place for invasive procedures, such as catheters and arterial line insertion and removal. Staff we spoke with in the theatre department were unaware of national and local safety standards. We raised this as a concern with senior staff following our inspection and they told us that the theatre department had a system of standard operating procedures (SOP's), which they said followed NatSSIP guidance and were based on best practice. Following our inspection, the service supplied a list of some of their policies, which they said covered SOP's. These included for example, the BMI safer operating policy for elective and scheduled surgery, and the BMI policy for consent. These policies were not specific to BMI Three Shires Hospital.
- The practising privileges agreement required surgeons to be contactable at all times when they had patients in the hospital. The granting of practising privileges is a well-established process within independent healthcare whereby a medical practitioner is granted permission to work in an independent hospital or clinic, in independent private practice, or within the provision of community services. Most doctors working in this service were also employed in local NHS hospitals. Practicing privileges doctors needed to be able to attend the hospital within 30 minutes, according to the level of risk to the patient. Surgeons had a responsibility to ensure suitable arrangements were made with another approved practitioner to provide cover if they were not available, for example when they were on holiday. If a patient's health deteriorated, staff were supported by a resident medical officer (RMO). The RMO was a registrar level doctor who was on duty 24 hours a day and was available on site to attend any emergencies. The hospital had a transfer agreement in place with the local acute trust should a patient require a higher level of care. Staff could contact consultants by telephone 24 hours a day for advice or to raise concerns about patient care.
- The service had a named laser protection supervisor and laser protection advisor based at a local NHS trust. We saw evidence that the named laser protection supervisor had completed the required training in September 2017.

- Each patient room and bathroom had emergency call bells to be used to alert staff when urgent assistance was required, these were routinely tested to ensure they were fit for purpose.
- In the event of an emergency, for example, a cardiac arrest, the service used a 'two tier' call system. This required staff to initially press an emergency buzzer, and follow this up with a telephone call in order to get the emergency team to respond. Nursing staff told us there was a risk of a delay due to this two-tier system. This was on the service risk register and had been scored as a medium level risk, however we did not see any evidence of mitigating actions as a result. The risk was due for review in October 2018.
- Patients with known allergies wore a coloured wristband, which acted as an alert to staff providing care and treatment. Allergies were documented in the patients notes.

Nursing and support staffing

- Staffing levels were planned in advance and were reviewed by managers on a daily basis. Managers used an evidence based acuity tool to enable patient acuity and dependency to be assessed and ensure that nursing establishments reflected patient needs. This tool was used to plan skill mix five days in advance, with continuous review on a daily basis. The actual hours worked, were also recorded and this allowed staff to understand any variances from the planned hours and the reasons for these.
- Two registered nurses were always on duty on the ward, one of whom was a substantive member of staff, plus a health care assistant (HCA). This ensured there was an appropriate skill mix. We saw nursing rotas for June 2018, which corroborated this. A minimum of four staff were on duty in theatres, plus an on-call team each day. We reviewed theatre nursing rotas over 10 days, which were compliant with safe staffing levels. Theatre managers told us they would cancel a theatre list if safe staffing numbers were not available and senior nursing staff told us that they would work in the clinical areas if there were insufficient staff on duty. There had been no cancelled operations due to staff shortages from July 2017 to June 2018.
- Patient admissions were known in advance and staffing levels calculated using an electronic labour monitoring tool in line with the BMI rostering policy, this ensured safe staffing numbers were planned according to the number of patients. The tool could be manually adjusted to take account of individual patient needs.
- Managers told us that there were ongoing difficulties with recruitment of theatre staff. This was recorded on the hospital risk register. In January 2018, the vacancy rate for both nurses and operating department practitioners was 14%.
- Data provided by the service showed that from November 2017 to January 2018, all theatre shifts were fully staffed, despite sickness rates in theatres being approximately 20% from September 2017 to January 2018.
- Bank and agency nurses were usually regular staff who were familiar with the hospital. From February 2017 to January 2018 between 0 and 10% of agency staff were used within the hospital. This was recorded on the hospital risk register. Staff were recruited from specific agencies with which the hospital had a preferred provider arrangement. This ensured that the staff provided met key requirements such as having completed mandatory training.
- New agency staff, were provided with an orientation when new to the hospital, which included access to and the location of emergency equipment and fire exits. New agency staff had their curriculum vitae (CV) assessed by the service before they were accepted to work for a shift. This allowed managers to review their previous experience and to ensure they had the necessary skills to work in the department.
- The inpatient wards were generally well staffed and we were told there were no healthcare assistants vacancies in January 2018 and the vacancy rate for nurses was 1%. However, we saw that the sickness rate for healthcare assistants was 7%. This had improved from September to October 2017, when it had been 15%. The sickness rate for nursing staff in January 2018 was 1%
- Agency staff were used to cover any staffing gaps. From November 2017 to January 2018, there was no unfilled shifts on the surgical wards.
- Staff turnover in theatres was high and had increased from January 2017 to February 2018 when it was 18% for nursing staff and 22% for health care assistants. The

service told us it had removed a previous theatre manager and that staff turnover from February to April 2018 had reduced to 9% as a direct result of this. Additional actions to reduce turnover included one-to-one meetings with all staff to identify issues and exit interviews to establish reasons people were leaving.

- Senior staff were on call out of hours if staff needed support.
- We observed effective handovers between nursing staff, which took place in a quiet area away from patients. New patients admitted and outstanding tasks were discussed alongside any abnormal test results or missed doses of medication.
- Nursing handover sheets were typed by the ward administrator and each member of staff had their own copy. We saw that information printed on the handover included every patient's full name, date of birth, hospital number and the procedure they were admitted for. Nurses carried their copy in their uniform pocket, and referred to it throughout their shift to ensure essential tasks were completed. However, there was a risk that handover sheets could be dropped, or accidentally left at a patient's bedside, and that confidential patient information could be seen by unauthorised staff, patients or visitors. We raised this as a concern to the service and we were told that all staff had undergone data protection training and information governance training. They also said that there were shredding bins on site and that no staff had reported an incident regarding lost handovers.

Medical staffing

- Patient care was consultant led. There were 142 consultants with practising privileges working at the hospital. All consultants carried out procedures that they would normally carry out within their scope of practice within their substantive post in the NHS.
- The hospital practising privileges agreement required that all patients were reviewed daily while on the ward and more frequently if necessary according to clinical need, or at the request of the executive director, director of clinical services or registered medical officer (RMO).
- Staff we spoke with confirmed that consultants were available and reviewed patients when requested to do so. We saw evidence of this in patients notes. We saw consultant contact numbers were available for staff. Patients we spoke with said they had seen their consultant at least once post operatively.
- Consultant anaesthetists had practising privileges at the hospital and provided on call cover when needed.
- The service had a resident medical officer (RMO) supplied by an agency, who provided medical advice and assistance 24 hours a day, seven days a week on a rotational basis. A standby RMO was also scheduled by the agency in case of sickness or absence.
- The RMO provided cover for all of the services on the hospital site, including surgery, outpatients, physiotherapy, imaging and children's services. RMOs worked a one week on, one week off, Monday to Monday rota and ensured routine tasks were completed before 10pm, to ensure adequate periods of rest were available. Nursing staff said they only contacted the RMO overnight in an emergency. RMO's handed over to each other at the end of their rota.
- The RMO provided support to the clinical team in the event of an emergency as well as carrying out routine jobs such as prescribing medication and taking blood from patients.

Records

- The hospital used a paper based system for recording patient care and treatment. NHS patient's records were available for patients whose treatment was funded by the NHS.
- We looked at 10 sets of patient's records and saw that they were generally legible, up to date, and stored securely. Not all entries were signed with the authors' designation, and some entries were not timed.
- Medical and nursing records were integrated and contained information about the patient's journey including pre-operative assessments, investigations, results and treatment provided. There were separate pathways for each speciality or procedure. However, not all of the paperwork was secured within the record, and there was a risk that loose pages may get lost and breach patient confidentiality.
- The service audited its compliance to documentation standards for patient care records. Results showed that

from March 2017 to February 2018, compliance mostly ranged between 81% and 85%, except for two months when compliance fell to 75% and 77%. A further notes audit carried out from January to April 2018 showed only February achieved the required standard of 90% compliance. Details of noncompliance included; all sheets of notes not secured together; notes not fully signed and dated by the consultant or nursing staff; consultant discharge summary not completed; nurse discharge checklist not completed. Scores for individual elements of the audit were as low as 51%, for completion of discharge summarise by consultants. There were no action plans attached to the audit results.

- Patient records had stickers which identified the equipment used and the serial codes used for implants, for example replacement hip joints. This enabled patients to be tracked and equipment identified if a problem became apparent at a later date.
- Nursing staff sent discharge summary letters to GP's following a patient's discharge. This gave details of the operation performed and any medication required as a continuation of their care. Consultant and RMO contact details were provided to GP's so they could contact them for further advice if required.

Medicines

- Surgery was the main service at BMI Three Shires Hospital, therefore medicines information may also relate to other services.
- The pharmacy department was open Monday to Friday, from 9am to 5pm. A senior pharmacy technician was on-site Monday to Friday and was supported by a pharmacy manager and a clinical pharmacist regularly throughout the week. Out of these, a clinical pharmacist was on-call 24-hours a day, seven days a week to advise and support staff as needed. In addition the registered medical officer (RMO) and the nurse in charge could jointly access stock items from the pharmacy. Medicines for patients to take home were stored in a specific cupboard on the ward. A service level agreement was in place with a local pharmacy for patient prescriptions out of hours and with the local district hospital to access medications and chemotherapy.
- Staff followed procedures for the safe administration of medicines in line with guidance from the Nursing and Midwifery Council, safe medicines management. Staff had good knowledge of safe medicines management and had access to the hospital's medicines management policy on the intranet. The policy covered obtaining, recording, using, administration, and disposal of medicines. We observed two registered nurses checking an intravenous medicine before administration as per the hospital's protocol. The staff followed correct procedure when checking the drug against the prescription chart and correctly checked the patient's wristband and name both verbally and against the prescription chart.
- Not all policies related to the administration of medication were up to date. We saw that the adult peripheral intravenous therapy policy was issued in October 2013 and due for review in August 2016. There was a risk that staff were following out of date practice. This was not on the service risk register.
- Medicine was not always administrated as prescribed on the medication chart. On three out of five medication charts we looked at, drugs prescribed were not signed for as being given, and there was no reason code documented to explain the omission. Drugs missed, included regular paracetamol, regular ibuprofen, apixaban (for VTE prophylaxis) and lactulose. Additionally, we saw one prescribing error in that Ibuprofen was prescribed both as a regular drug and as an 'as required' drug.
- The pharmacy department carried out an audit of missed medication doses in the ward areas in January 2018. Results showed that 13% of prescribed drugs had not been administered. Furthermore, 73% of these missed medicine doses were recorded incorrectly on the prescription chart. This included, no reason code for the missed medicine dose and therefore it was unclear if the dose had been given, or if it had been intentionally omitted.
- In June 2017 a medicines reconciliation audit showed the service was 76% compliant. There were failures at the time in that patient allergy status was not document on all pages. A medicines management quarterly audit carried out in April 2018 across all areas of the hospital showed compliance ranged from 89% to 100% and a controlled drug quarterly audit carried out in March 2018 in theatres, showed compliance was 100%.

- The pharmacy department undertook frequent audits and reported the results back to staff. Action plans were seen and signed off. Medicines audit was discussed at the medicine management, clinical governance and medical advisory committee (MAC) meetings.
- Medicines were supplied and stored securely in all clinical areas. All medicines were kept in locked cupboards with only appropriate staff having access to keys. Controlled drugs, (CD's), were stored separately and the nurse in charge each day was responsible for holding the keys for this cupboard. CD's are drugs which are subject to strict legal controls and legislation which determines how they are prescribed, supplied, stored and destroyed. We saw that CD's had been reconciled each day and that there were no anomalies recorded.
- A pharmacist reviewed the medication needs of all planned patient admissions and medicines were ordered as needed on a weekly basis. Stock of commonly used medicines such as antibiotics, analgesia and anticoagulants (medicines used to prevent the formation of blood clots) were also available. The majority of medicines were stored in the various departments such as outpatients, the ward and theatre. The pharmacy staff checked and maintained agreed stock levels in the departments and ensured there was appropriate stock rotation.
- Medicines were stored in secure temperature controlled rooms that had suitable storage and preparation facilities for all types of medicines such as controlled drugs and antibiotics. All intravenous fluids were stored safely behind locked doors and only accessible to appropriate staff.
- Staff monitored and recorded temperatures of fridges used to store medicines and of the ambient room temperature in the clean utility rooms. We reviewed fridge temperature record checks, which showed that fridge temperatures were checked daily to ensure they were in line with the correct temperature range.
- An antibiotic stewardship audit carried out from July to December 2017 showed a compliance rate of 88%.
- The pharmacy manager was the hospitals' antibiotic steward. An antibiotic steward seeks to achieve the optimum clinical outcomes related to antibiotic use to minimise toxicity and other adverse events and limit the selection for antimicrobial restraint strains. This reduces the effect of antibiotics becoming less effective. We observed a strong reporting culture within the pharmacy department and saw that incidents, including near misses, were routinely reported. Pharmacy staff described examples of incidents they had reported and actions taken to minimise the risk to patients. Medicine incidents were reported using the hospital's electronic reporting system. From January 2018 to April 2018, the hospital reported 4 medication incidents. One incident was graded as causing low harm, one was graded as causing no harm and the remaining two were not graded. We saw evidence that action was taken as a result of incidents reported and learning was cascaded to staff. For example, action plans were developed and interventions were taken, concerns were discussed with the departmental managers, and at the medicine governance meeting
- Anaesthetic drugs were drawn up in syringes and prepared ready for use on the next patient. Most syringes were labelled as per hospital policy. However, we saw that Propofol (a powerful anaesthetic drug) was not labelled in either of the two operations we observed, and in one of the cases, the syringe was left unattended. We highlighted this to theatre staff during our inspection. They confirmed that all drugs should be labelled and not left unattended at any time. We were told that compliance to labelling Propofol was poor. There had been no incidents reported regarding this.
- The pharmacist reviewed all medication prescriptions. This included venous thromboembolism (VTE) assessments to ensure patients were prescribed the correct dose and/or duration of anticoagulant medication. If a pharmacy intervention was needed following the identification of a prescribing error, such as a medicine interaction, wrong dose, wrong frequency or inappropriate medication, the pharmacist would correct the prescription and discuss the error with the registered medical officer (RMO) or consultant who had prescribed the medication. These pharmacy interventions were also reported on the electronic reporting system, which meant any trends could be identified and acted upon.
- Staff told us that medicine incidents were reported to staff through ward meeting minutes. Managers spoke to staff regarding medicine errors. Managers formulated action plans and staff were reassessed as part of their

learning. We looked at four medication incidents and saw that they had been investigated fully and that where appropriate, actions had been implemented to help prevent future medication errors and incidents.

- BMI Health care held monthly pharmacy teleconference meetings where medicines incidents reported across the BMI group were discussed and learning was shared. The teleconference meetings were repeated three times during the month to enable pharmacy staff to attend when they were available.
- Medicines management was a standard agenda item at the hospital governance meetings. We saw evidence of this from the meeting minutes we reviewed which included information regarding medication incidents, national guidance updates and drug safety alerts.
- The pharmacy manager submitted a quarterly controlled drugs occurrence report to the local intelligence network (LIN). This was in accordance with national requirements (Department of Health, The Controlled Drugs (Supervision of management and use) Regulations 2013. Controlled drugs are prescription medicines which are controlled under the Misuse of Drugs legislation (and subsequent amendments), these include drugs such as morphine.

Incidents

- Most staff understood their responsibilities to raise concerns, to record safety incidents, and near misses, and to report them internally and externally. There was an incident reporting policy dated November 2017 in place. Heads of departments and clinical leads had completed root cause analysis and human factors training.
- The hospital had introduced a new electronic incident reporting system, had updated policies to closely mirror the serious incident-reporting framework, and had completed a full review of incidents to gain assurance that incidents had been graded and reported correctly.
- Most staff were comfortable with using the reporting system and gave examples of incidents that they had raised. However, the RMO told us that they had never reported an incident, and only verbally reported any concerns to the senior management team. We were not therefore assured that all potential incidents and near misses were reported on every occasion.
- Clinical staff told us they were encouraged to report incidents and most staff said they received feedback from incidents they had reported.
- Incidents were generally reported well by staff, however managers told us that some areas were more effective at recognising and reporting incidents. However, we found that not all investigations were robust. We examined a random sample of six incidents and identified that key questions were not addressed. For example, a 12 year old drugs fridge that was out of warranty and had broken had not been subject to a maintenance programme. This meant that drugs were at risk of being damaged due to being stored inappropriately. There was no identification of other pieces of equipment that may have been similarly at risk. Actions to be taken following investigations were emailed to staff but audits were not undertaken to ensure that actions had been taken and were embedded into practice. Another example was of an unsafe staffing incident when the staffing agency had failed to respond to a request. There was no evidence that this had been investigated. We were not assured therefore that the hospital investigated all incidents robustly.
- There had been a total of 1044 clinical incidents reported from July 2017 to June 2018 within the service. 768 incidents were reported within the ward area, and 276 incidents were reported within theatres. Of the incidents reported in the wards and theatres, 772 resulted in no harm, 243 resulted in low harm, 24 resulted in moderate harm, and there were four deaths.
- We reviewed the root cause analysis undertaken (RCA) in relation to the four deaths. The RCAs identified several areas for improvement as there was a lack of capnography on the defibrillator which meant that no information was retained following the arrest, suction equipment, one bed's cardiopulmonary resuscitation (CPR) release button did not work, there was a delay in commencing resuscitation in one case and although a staff member was present with advanced life support training (ALS), they did not lead the arrest. Documentation and completion of the national early warning score (NEWs) had omissions. The RCA's included action plans which included staff training and replacement of the defibrillators. Following our unannounced visit the director of clinical services told

us that all senior staff were trained in undertaking root cause analysis. Two senior staff undertook an RCA which was then reviewed by another member of the senior management team, the medical advisory committee for sign off before being forwarded to the corporate management team.

- We looked at an incident where a patient unexpectedly returned to theatre and was later transferred out of the hospital due to complications. A root cause analysis was undertaken and the incident had been fully investigated, correctly graded and there was evidence of actions taken.
- Where incidents had been reported staff were encouraged to complete reflective writing. This reflection was saved within the staff file and helped towards revalidation of their professional registrations and learning.
- All serious clinical and non-clinical incidents were analysed at the hospital clinical governance meetings to ensure that lessons were learnt and trends were analysed, no trends were identified. This information was disseminated to staff through head of department meetings through ward handovers, meetings, and safety briefings. The director of clinical services and risk and quality manager would attend some of these meetings. Following our inspection, the hospital provided further information detailing investigation processes, the tracking of incidents and review of action plans at governance and board meetings.
- The hospital had an up to date incident policy in place, which staff were familiar with.
- The hospital had no 'never events' from February 2017 to January 2018. 'Never events' are serious incidents that are wholly preventable as guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and should have been implemented by all healthcare providers.
- From November 2014, all providers were required to comply with the Duty of Candour Regulation. The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain notifiable safety incidents and provide reasonable support to that person. Nursing staff we spoke with were aware of the duty of candour and gave examples of when and how it would be used. The RMO was not familiar with duty of candour but was able to provide a brief description around safe care.
- Patient deaths were discussed at the medical advisory committee (MAC).

Safety Thermometer (or equivalent)

- The hospital gathered patient information such as hospital acquired infections and reviewed these through its clinical governance processes. We did not see this displayed in the hospital. However, information provided by the hospital showed clear information about overall incidence of MRSA which is a bacterium which causes infections in different parts of the body, and C. difficile which is a bacterium that is one of the most common causes of infection of the colon.
- From February 2017 to January 2018, there had been no incidents of MRSA, Escherichia coli (a type of bacteria that normally live in the intestines of people and animals) or C. difficile.
- Staff carried out risk assessment for venous thromboembolism (VTE) in accordance with National Institute for Health and Care Excellence (NICE) guidelines. Data showed quarterly audits had been undertaken for compliance to VTE assessment. Results had exceeded the hospital target of 95% except in August 2017 when the score was 87%. VTEs are blood clots that can form in a vein and have the potential to cause severe harm to patients. There was one incidence of VTE or pulmonary embolism in the reporting period.

Are surgery services effective?

Good

- The hospital used evidence-based guidance and quality standards to inform the delivery of care and treatment. For example, the pre-operative assessment clinic assessed patients in accordance with National Institute for Heath and Care Excellence NG45 'Routine pre-operative tests for elective surgery' (2016).
- The service participated in relevant local and national audits which were based on national guidance, standards and legislation, including NICE, the Royal

College of Surgeons, and the Health and Safety Executive. For example, surgical site infections were audited in line with NICE guidelines QS49 'Surgical site infections' (2013); and the audit of Patient Reported Outcome Measures (PROMS), National Joint Registry (NJR).

- Staff could access national and local guidelines through the hospital's intranet. Nursing staff told us they were kept informed of updated policies by email, the weekly corporate newsletter and staff noticeboards. However, not all policies and procedures were in date. The BMI adult intravenous therapy guideline, issued in October 2013, had been due for renewal in October 2016 but this had not been undertaken.
- Some corporate policies were under review including the complaints policy. A corporate policy and risk lead had been newly appointed and was rolling out two updated guidelines per week. We saw that the corporate adult intravenous therapy policy was out of date and had been due for review in 2016.
- Hospital policies were assessed to ensure guidance did not discriminate because of race, ethnic origin, gender, culture, religion or belief, sexual orientation and/or age.
- The hospital had an audit programme, and collated evidence to monitor and improve care and treatment. We were provided with the local audit programme for the hospital, which was set corporately by the BMI Healthcare group. The hospital was able to benchmark the results from the audits with other hospitals within the BMI Healthcare group. Audits included consent, resuscitation, hand hygiene, health and safety, the World Health Organisation (WHO) safer surgery checklist, and medicines management. We saw evidence that actions were taken to improve compliance where indicated.
- BMI Healthcare participated in the Private Healthcare Information Network (PHIN). This enabled effective comparison with data available from NHS providers to assist with information transparency and patient choice.
- Staff within surgery undertook local audits for example, the WHO safer surgery checklist, venous thromboembolism (VTE), consent and record keeping.

Some staff were aware of the results for their areas and told us about measures the service had undertaken to improve compliance. For example, further training on hand hygiene was provided and increased auditing.

Nutrition and hydration

- Staff completed an assessment of patient's nutritional status and their needs when they were first admitted and updated this during their stay.
- Patient's nutrition and hydration needs were assessed monitored and recorded by using the Malnutrition Universal Screening Tool (MUST). This was in line with NICE guidance QS15 statement 10: 'Physical and psychological needs' (2012). During our inspection, we observed MUST assessments were up to date and consistently completed. Staff used fluid balance charts to monitor patients' fluid intake.
- Patients waiting for surgery were kept 'nil by mouth' in accordance with national safety guidance to reduce the risks of aspiration during general anaesthesia. Staff followed guidance from the Royal College of Anaesthesia, Raising the standards (2012), and offered specially formulated drinks to patients up to two hours before surgery to ensure optimisation of energy (calories) and fluid before surgery. Elective patients were given clear instructions about fasting before admission. Information was given verbally at the pre-operative assessment and in writing. For example, patients were told not to eat for six hours before a general anaesthetic and were encouraged to drink clear fluids up to two hours before a surgical procedure.
- Patients had jugs of water within reach. These were regularly refilled. We saw that there was a water cooler on the ward so that patients could access additional drinks if they wanted. Staff had access to snacks and drinks, which they could provide to patients between mealtimes. This helped to support patients' nutritional intake and hydration.
- Patients with nausea or vomiting were prescribed antiemetic medicine (a drug effective against vomiting and nausea). Patients were given antiemetic's intravenously in the recovery area if they complained of nausea post operatively.
- We observed lunch being served. The hot food was delivered in a timely manner on warmed plates and

there was a variety of food options, including vegetarian, and gluten free. This encouraged patients to eat and it ensured their nutritional needs were met. All of the patients we spoke with said they enjoyed their meals and had sufficient food to meet their daily requirements. However, feedback from the Clinical Commissioning Group (CCG) highlighted that patients had expressed concerns that the quality of the food had deteriorated.

Pain relief

- The surgical care pathway used prompted staff to assess, record and manage pain effectively. Patient's records showed that pain had been assessed using the pain scale within the NEWS charts.
- Appropriate medicines were given as prescribed and the effect of analgesia was individually evaluated. Staff assessed patient's pain regularly post operatively. Patient's told us that they had had effective pain relief when they needed it.
- Consultants and anaesthetists prescribed pain relief medicines for the immediate post-operative period. This included pain relief using pumps if necessary. The RMO was available to provide further pain relief and advice for patients 24 hours a day, seven days a week.
- An audit of pain management carried out March 2017 to February 2018 showed compliance of 88%. This was lower (worse) than the service target or 95%. There was no action plan attached to the audit.
- Pharmacy staff told us they reviewed all patients' pain relief needs and gave them advice on how best to take them, in order to optimise their effect. On discharge, patients were given leaflets to remind them to collect their prescriptions and contact numbers to call if their pain relief medicines were not sufficient or they needed more.

Patient outcomes

- BMI Three Shires Hospital participated in the BMI hospitals corporate audit programme. This included audits of patient health records, infection prevention and control, controlled drugs, consent, safeguarding, hand hygiene, medicines management and consent.
- Results on patient outcomes were compared with other locations within the region and across BMI Healthcare through the corporate clinical dashboard, which used data from the incident and risk reporting database. The service was able to review their data and compare it with hospitals of a similar size within BMI Healthcare. BMI Three Shires achieved results showing it was in the top third of hospitals in the BMI group.
- The service took part in the national patient satisfaction survey for orthopaedic surgery, Patient Reported Outcome measures (PROMS). PROMS data showed that patients who had undergone total hip replacement surgery at BMI Three Shires had reported a higher satisfaction rate than the England average. Patients who had undergone total knee replacement surgery reported satisfaction rates similar to the England average.
- There had been 16 unplanned in-patient transfers to another hospital from July 2017 to June 2018 and six unplanned readmissions to BMI Three Shires hospital within 28 days of discharge from January to December 2017. There had been eight patients returned to theatre in the same period. The service monitored the number of transfers out of hospital and reported each one as an incident. However, there were no action plans to reduce the number of transfers, and the transferring of patients out of hospital was not on the service risk register.
- The service took part in the private patient reported outcomes collection. This covered, hip, knee and hernia surgery. Private patients having this surgery had their data sent to the Private Healthcare Information Network (PHIN). This collected the minimum data and made it available to the public on the PHIN website so people could compare outcomes between different private providers. PHIN was provided through an external provider alongside the BMI patient satisfaction survey.
- The hospital participated in quality assurance systems such as the Joint Advisory Group (JAG). The Joint Advisory Group on Gastrointestinal Endoscopy (JAG) accreditation quality assurance (QA) standards are designed to provide a framework of requirements to support the assessment of endoscopy services. The endoscopy service maintained its Joint Advisory Group Gastroenterology Society (JAG) accreditation (June 2018). The accreditation was based on the results of audits which were based on JAG quality and safety in endoscopy global rating scale (GRS) (British Society of

Gastroenterology Quality and safety indicators for endoscopy, 2009). The GRS audit is divided into four areas which are: clinical quality, patient experience, workforce and training.

- Patients we spoke with were happy their outcomes and were satisfied with their treatment.

Competent staff

- All new hospital staff attended a corporate induction and had a local orientation to their department. Dependant on their role, some new staff were classed as being supernumerary for a period and this allowed them to understand their new environment before having full responsibility for their role. For example, newly qualified nurses were classed as supernumerary for the first two weeks of their employment.
- New staff completed a variety of mandatory and role specific training through an e-learning system and face-to-face training.
- The hospital employed two full time nurse trainers to help improve the skills of clinical staff working in the service. The trainers covered all practical sessions, for example manual handling skills, intravenous medication administration and taking blood.
- Staff had annual and mid-year appraisals and we saw that in the wards and theatres, most registered nurses and health care assistants had had an appraisal within the previous 12 months. In theatres, 88% of staff had had an appraisal, and 87% of ward staff had had an appraisal. This was just below the service target of 90%.
- Nursing staff told us that they found the appraisal system helpful and were able to identify any training or development needs through this process. Managers discussed competencies and training needs with staff at this meeting.
- Poor or variable staff performance was identified through complaints, incidents, feedback and appraisal. Staff were supported to reflect, improve and develop their practice through education, clinical supervision and one to one meetings with their managers or the practice educators.
- The service had competencies in place, which were general to the BMI healthcare group. These included intravenous drug administration, use of display equipment and ward equipment. Competencies were self-assessed and then assessed by the ward manager or a competent or experienced practitioner. Nurses who had undertaken a mentorship course had annual updates from the university.
- Medical device training, for example, intravenous therapy pump training, and training for feeding pumps was undertaken once only, and following an initial assessment, staff were deemed competent without a requirement for any further evidence of continued competence. However, some nurses told us they did not feel confident operating some devices because they had used them infrequently. The service told us that training guides were available online for staff to undertake at any point.
- Clinical staff were required to undertake blood transfusion training. This training included an annual update online and a practical assessment, every two years. The electronic training records we were shown did not include a record of when the latest practical assessment had been done. We saw from nursing staff's personal files, that the two-yearly updates were recorded on paper. However, it was unclear from the paperwork if a new practical assessment, including observation of practice, had been carried out. This was because new assessment documents were not completed every two years. Instead, staff signed and dated their original paperwork. We found that nurses who had worked in the ward for a long time, had lots of signatures added to the bottom of their original competency assessment. We were therefore not assured that the required practical assessment had been completed rigorously. Compliance to blood transfusion training for ward staff was 88% and 75% for theatre staff.
- Not all staff had received specific training required for their role. Clinical managers told us they had not undertaken leadership training, despite being responsible for large departments with high staff numbers. We raised this as a concern during our inspection and we were told that plans were in place for all managers to attend leadership training and that courses for the staff concerned were booked. The service provided a list of training which some mangers had attended which included sickness and absence management and a labour tool management workshop.

- The service had some link nurses. Link nurses provided education and support for staff in areas of special interest. There were link nurses for dementia, infection prevention and control and first aid. Extra training was provided to link nurses who cascaded information to the rest of the staff. For example, infection prevention control nurses had regular study days where different topics were discussed.
- We reviewed ten staff files, including consultant practising privileges, and found that they contained relevant information such as an up to date disclosure and barring service check (DBS), references and evidence of registration with the Nursing Midwifery Council (NMC) or Health and Care Professionals Council (HCPC). The Disclosure and Barring Service (DBS) is a criminal records check and helps employers make safer recruitment decisions and prevent unsuitable people from working with vulnerable groups, including children. We saw that the hospital had a process to check when staff information was due for renewal.
- RMO's had their competencies assessed and mandatory training provided and updated by the external agency provider. Before commencing work at the hospital, the RMO's curriculum vitae (CV) including employment history, training certificates, qualification certificates, references and certificate of enhanced Disclosure and Baring Service (DBS) were forwarded to the director of clinical services. These were kept in the RMO induction packs, which were completed within their first week working at the hospital and updated as appropriate. DBS is a criminal record check and indemnity insurance is designed to protect professionals when they are found to be at fault for a specific event.
- RMO's were a senior grade with anaesthetic experience. This ensured they were confident in managing acutely unwell patients. The RMO told us that they were never asked to complete a procedure that they did not have the skills to undertake.
- Procedures were carried out by a team of consultants and anaesthetists who were predominantly employed by other organisations such as the NHS. Their annual appraisals were carried out with their employer. It was the responsibility of the registered manager, with advice from the medical advisory committee (MAC), to ensure consultants were skilled, competent and experienced to perform the procedures they undertook. The hospital checked registration with the General Medical Council (GMC) and the relevant specialist register. In addition, in line with the BMI practising privileges policy, checked that consultants had no criminal record through DBS checks and that they had up to date indemnity insurance. Indemnity insurance is designed to protect professionals when they are found to be at fault for a specific event. We saw evidence that there was a system in place to check that all information was up to date and this was discussed and reviewed in the MAC meeting minutes.
- Practising privileges for consultants were reviewed every other year. The review included all aspects of a consultants' performance. The review included an assessment of their annual appraisal, volume and scope of practice plus any related complaints or incidents. The MAC advised the hospital about continuation of practising privileges. We saw that the hospital used an electronic system to check when privileges were due to expire.
- Staff in the theatre department told us not all of the clinical staff working in the theatre department had all of the skills required to assist in each operation. For example, some staff were unable to assist in total hip replacement operations, and others were unable to assist in hernia repairs. To help reduce this risk, theatre staff tried to ensure only agency staff they knew worked in the department. This was on the service risk register.
- Newly qualified nursing staff were provided with a competency framework book and aligned with an experience nurse who worked alongside them. This ensured newly qualified nurses obtained the necessary confidence, skills, and experience to work safely and independently. We looked at a newly qualified nurse's competency book and saw that appropriate assessments and opportunities for learning had been clearly documented.
- Agency staff had a brief induction, which covered the layout of the department, emergency procedures, paperwork and how to access essential information. Theatre staff told us it was sometimes difficult to complete inductions for theatre staff due to timing of lists and shift start times and the availability of staff to provide an induction. We were told that most agency staff in theatres were regular members of the team and had a good understanding of the theatre environment.

Multidisciplinary working

- We observed good internal multidisciplinary team (MDT) working. For example, medical, nursing staff, physiotherapists and clerical staff collaborated well and reported effective working relationships. The pharmacy department were working collaboratively with the physiotherapy department to support orthopaedic patients with their medication.
- Managers, medical and nursing staff reported good working arrangements and relationships with the local NHS trust. The majority of consultants were employed by the local NHS trust. The pharmacists had regular contact with the local trust's pharmacy department. There were service level agreements (SLAs) in place for the transfer of patients to an NHS hospital if their condition deteriorated, if they needed access to blood for transfusion, and with the pharmacy department for specific medications including chemotherapy. An SLA was also in place with the local ambulance service to transfer patients promptly to an NHS hospital if their clinical condition deteriorated.
- The service had an escalation policy for patients with sepsis who required immediate review. Staff could describe the process if they needed to contact the RMO, anaesthetist or consultant quickly.
- Staff began discharge planning at the pre-assessment appointment so that effective plans would be in place to meet patient need when discharged. There were systems in place for working with local social services and other agencies to enable extra support to be set up for patients who required extra support at home following their operation. GP's were sent copies of patient discharge letters to ensure they were kept informed of any surgery that had been performed plus any follow up requirements.
- We saw evidence of multidisciplinary team communication across all departments. The hospital had introduced a daily communications cell meeting which was attended by the senior management team and a representative from each department, including theatre and ward staff, pharmacy, outpatients the catering department and patient services. We saw that all staff contributed to providing an overview of the hospitals activity and there was clear analysis of hospital activity. This included sickness, staffing levels, cancellations for theatre, patient admissions, any medical alerts, complaints, incidents and risks. Staff on call for emergencies were also highlighted. Compliments and complaints were also discussed. Any information discussed was taken back to each department and cascaded to each team.
- The RMO had a daily handover with nursing staff and discussed each patient. The RMO also attended and contributed to the daily huddle meeting. The RMO would contact the consultant, an anaesthetist and the director of clinical services with any concerns and reported having a good working relationship with the hospital pharmacist.
- Staff attended a safety huddle in theatres in the morning to ensure all patient needs and risks were identified. Heads of department attended a daily communications cell meeting each day.

Seven-day services

- The hospital only undertook elective surgery, and operations were planned in advance. The exception to this was if a patient was required to return to theatre due to complications following a procedure.
- Consultants were on call 24 hours a day for patients in their care. There was 24-hour RMO cover in the hospital to provide clinical support to consultants, staff and patients.
- Consultants provided details of cover arrangements for when they were not available. This was a requirement of their practising privileges.
- A senior nurse was always available for advice and support during working hours. The management team operated a 24-hour, seven day a week on-call rota system. Staff could access them for advice and support as needed.
- The pharmacy was open Monday to Friday 9am to 5pm. Out of these hours the nurse in charge and RMO could access pharmacy for stock items, medicines for patients to take home were stored on the ward or patients could have a prescription which could be taken to a specific local pharmacy.

- The physiotherapy department was staffed Monday to Thursday, 8am to 7pm and 8am to 5pm on Fridays. In addition, there was a weekend rota to provide support to inpatients.

Health promotion

- Patients attended pre-operative assessment appointments where their fitness for surgery was checked.
- Patients having elective surgery were provided with a booklet of advice about their hospital stay. The booklet also contained some health promotion guidance including dietary advice, smoking cessation and alcohol consumption.
- The physiotherapy staff saw patients who were to undergo orthopaedic surgery. These appointments provided health promotion opportunities, including how to maintain mobility.
- There were health promotion information and materials available for patients and patients had access to a smoking cessation nurse.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- The service had a consent policy which BMI Healthcare had recently updated. This was based on national guidance and relevant legislation contained within the Royal College of Surgeons Consent: Supported Decision-Making. A Guide to Good Practice, 2016. This included guidance for staff on obtaining valid consent, patients who lacked capacity to consent, and refusal of treatment.
- Consent audits were carried out by the service every three months. From March to December 2017, audit results showed compliance ranged from 92% to 97%. Most non-compliances related to a lack of documented evidence that patients had been provided with information about their procedure.
- We looked at the consent forms in four patient records and saw that consent had been obtained in advance of the patient's admission and there was clear evidence in the medical records that the patient was aware of all risks and benefits of the planned treatment.
- Staff told us that patients with a learning disability or those living with dementia would be involved in a pre-operative meeting with the carer and consultant to put a plan in place for their admission. Carers were encouraged to stay with the patient and operating lists would be adjusted to suit patient need.
- Nursing staff we spoke to were clear about their responsibilities in relation to gaining consent from people including those who lacked capacity to consent to their care and treatment. There were no admitted patients who lacked capacity during our inspection.
- The hospital had an up to date policy regarding the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). Staff could access this on the hospital intranet.
- Training on MCA and DoLS was included in the mandatory safeguarding adults training. However, the RMO told us that they had not completed any training in either MCA or DoLS.
- Staff were briefly able to describe when DoLS might be needed. However, none of the staff we spoke with said they had made a DoLS referral. Staff explained that they would contact the director of clinical services and involve the consultant and relatives if they had concerns about a patient.

Are surgery services caring?

Good

Compassionate care

- We observed staff to be caring and compassionate with patients and their relatives throughout our inspection. Staff promoted privacy, and patients were treated with dignity and respect. Staff spent time with patients, and interacted with them during tasks and clinical interventions. We saw staff talking to patients, explaining what was happening and what actions were being taken or planned. Staff responded compassionately to pain and discomfort in a timely way.
- Feedback from patients confirmed that staff treated them very well and with kindness. Patient-Led Assessment of the Care Environment (PLACE) audit for 2017

Requires improvement

Surgery

- The service gathered patient feedback through three patient questionnaires. These were analysed by an independent provider, and the results were published and shared monthly. The friends and family test feedback results from August 2017 to January 2018 scored between 99% and 100% satisfaction. Response rates were variable, from 5% to 80%. The patient feedback response rate had significantly dropped since October 2017, following the corporate decision to use electronic feedback forms only. However, this had been recognised as an issue and BMI Healthcare group had subsequently reintroduced the use of paper feedback forms, as well as electronic.
- Patient feedback from the CQC "tell us about your care" comment cards collected before and during our inspection included remarks such as; 'I cannot fault the staff, they were professional in every aspect of their work. While in their care, I felt safe and cared for'. Another response included, 'They put me at ease, they were friendly yet professional. They listened and I believe they truly cared about me and my wellbeing. They gave me all the information I needed, explained everything. They respected my privacy and treated me with dignity'.
- The ward office displayed many 'thank you' cards, which staff had received from patients and relatives.
- Patients told us they would be happy for their friends and family to come to the hospital for treatment.

Emotional support

- Staff told us that they had time to spend with patients to reassure them and provide emotional support.
- Pre-admission assessments included consideration of patient's emotional well-being.
- Patients had access to counselling services if needed and staff would liaise with the GP as necessary.
- Referrals could be made to a chaplaincy service if required by patients.

Understanding and involvement of patients and those close to them

- Patients told us that nurses explained what they were doing, and asked for permission and agreement first. Patients said medical staff explained plans for their treatment and provided opportunities to ask questions, this included family members when required. Patients told us they were given choices regarding their treatment options at their pre-operative assessment. Family members were encouraged to attend the appointment to ensure they were aware of any post-operative care that might be required at home. Physiotherapists discussed post-operative care needs with patients and relatives to ensure a smooth and safe discharge home.
- Patients told us that they were involved in their care planning. We saw care plans that reflected this. Staff provided leaflets to support the verbal information given.
- Patients we spoke to could name the nurses caring for them and knew who their doctor was.
- Patients told us that staff clearly explained the risks and benefits of treatment to them before admission.
- Patients who were paying for their treatment privately, told us that the costs and payment methods available had been discussed with them before their admission.

Are surgery services responsive?

Good

Service delivery to meet the needs of local people

- The services provided reflected the needs of the population they served and ensured flexibility, choice and continuity of care. A variety of surgical procedures were available within the service, including orthopaedic surgery, plastic surgery and general surgery.
- The hospital was committed to providing surgery to private patients as well as providing services for NHS patients through agreements with the local commissioners. All patients were treated equally whether self-funded, through insurance schemes, or through the NHS.
- The hospital worked collaboratively with NHS commissioners to ensure services were planned and developed to meet the needs of the local population. The hospital also carried out extra operating lists when needed to help with additional NHS hospital demands.

- The booking system was conducive to patient needs in that where possible, patients could select times and dates for appointments to suit their family and/or work commitments.
- Theatre lists for elective surgery were planned with the theatre manager and with the bookings team. This helped to ensure operating lists were utilised effectively and patient choices were accommodated wherever possible. A staffing acuity tool was used to ensure that enough staff were on duty to meet the needs of patients.
- The hospital had service level agreements with a local acute hospital to provide extra services they were unable to supply themselves. This included pathology services, blood products and critical care services.

Meeting people's individual needs

- Reasonable adjustments were made to take into account the needs of different people on the grounds of religion, disability, gender, or preference.
- Services were mostly planned and delivered to take account of the needs of different people.
- Patients with mobility difficulties had access to the wards from a lift. The corridors were wide, which meant there was easy access for wheelchairs.
- Individualised care was provided for patients living with dementia and their carers. The service had dementia link nurses to support staff if patients with dementia were admitted. There was a ''dementia friendly'' patient room which staff had adapted to help meet the needs of patients with dementia. This included adapted lighting and signage and a picture menu. There was also a dementia friendly box which contained a selection of colouring books, crayons, and dolls.
- The service's Patient-Led Assessment of the Care Environment (PLACE) audit for 2017, which looks at how the environment supports patients living with dementia or a disability, scored 73% for dementia and 77% for disability. This was lower (worse) than the England average score which was 77% for how the environment supports patients living with dementia and 83% for disability.
- Patients told us that they were given detailed explanations about their admission and treatment in addition to written information. We saw clear explanations and reassurance being given to patients who were about to undergo a procedure in theatres.
- The service had access to interpreting services for patients whose first language was not English. A telephone line was available and face-to-face interpretation services could be obtained if required.
- Staff answered call bells promptly; patients also told us that nursing staff responded quickly to their needs, for example to help them to the toilet. Relatives needs were considered and we saw them offered food and drinks when they visited patients.
- Staff provided information leaflets for a range of conditions and to support care given. These were written in English but could be obtained in other languages.
- Health promotion posters and information leaflets were available in the pre-assessment area. We saw information was available for reducing alcohol intake, smoking cessation and health awareness.
- There was limited equipment available for bariatric patients. Staff told us some equipment could be hired and would be organised in advance of a patient's admission if required. However, theatre staff told us there was only one theatre table safe for bariatric patients and this was not suitable for every type of procedure. Staff told us about an incident where a patient had their operation cancelled as the bariatric theatre table they had was unsuitable for a specific procedure. In this instance the service managed to obtain a demonstration bariatric table from a loan company and the operation was carried out at a later date.

Access and flow

- Patients had timely access to initial assessment and treatment and the service mostly met national targets for access to treatment.
- National waiting time targets for referral to treatment (RTT) times within 18 weeks in surgery were 91% against a target of 92% (for completed admitted pathway). The

hospital exceeded the 90% target for complete non-admitted pathways where it achieved 98%. For incomplete admitted pathways the service achieved 93% against a target of 92%.

- The service tried to avoid cancelling operations and told us they rebooked any cancelled patients as quickly as possible. Procedures that were cancelled or delayed were recorded as a clinical incident and appropriate actions taken. From January to June 2018, there had been 63 operations cancelled. Of these, 46 were cancelled due to clinical reasons, and 17 were due to non-clinical reasons. Some of the operations cancelled due to clinical reasons were avoidable. There were eight cancelled operations due to problems which should have been picked up during the pre-assessment process, or through effective pre- admission communication. For example, three patients were cancelled due to a BMI over 40; one patient was cancelled due to a known latex allergy; two patients had not starved themselves on the morning of their operation, and two patients hadn't received appropriate instructions regarding medication to either stop, or start. Of the non-clinical reasons, lack of time, lack of appropriate staff or patient choice were most common.
- Cancellations were rescheduled within 28 days and there was no distinction made between NHS and private patients.
- Staff informed us the number of admissions and planned treatments reduced at weekends with the provision of only one operating list on Saturdays. However, following our inspection the hospital informed us that there was a provision of up to two operating lists on a Saturday.
- The service provided an on-call theatre team who were called to attend any emergency readmissions to theatre. Additionally, in the event of a patient deteriorating and requiring higher levels of care, the patient was transferred to the local NHS trust via ambulance.
- Most patients left hospital on the day planned and there were few reported delayed discharges. This ensured a smooth flow of patients into and out of the service. Nursing staff said arrangements were in place to assist patients who required unplanned further care following their procedure. Discharge planning started at the patient's pre-assessment appointment so that any specific needs could be met and planned for.
- A theatre utilisation tool (TUT) was used in the theatre department to automate the analysis of theatre department processes. The TUT aims to increase the efficiency of the department by matching staff allocation to patient numbers and type of procedures. We were told this reduced staffing costs, created extra capacity for additional operations, improved patient safety and increased satisfaction for patients and staff.

Learning from complaints and concerns

- The hospital had a clear process in place for dealing with complaints. There was a complaints policy in place which staff could access. Staff we spoke to were aware of the complaints procedure. We saw complaints leaflets, 'Please tell us', were available and saw the hospital website had a section detailing how to make a complaint. Complaints could be made in person, by telephone, and in writing by letter or email. We saw that copies of complaints leaflets had not been enclosed in all complaints folders so we could not be assured that all patients had received them.
- Clinical staff told us they always tried to resolve any issues or complaints at the time they were raised. If this was not possible, patients could be referred to the nurse in charge in the first instance.
- There had been 46 complaints in the service from November 2017 to April 2018. Most complaints received were about the cost of treatment (10 complaints), followed by post-operative care which had nine complaints and the attitude of consultants received seven complaints. We were told that actions taken included providing information about costs in advance and the patient administration lead providing information and discussing self pay processes before admission. No complaints had been escalated to stages two or three of the complaints procedure and none had been referred to the ombudsman or the Independent Healthcare Sector Complaints Adjudication Service (ISCAS).
- The complaints policy stated that complaints would be acknowledged within two working days and routine complaints investigated and responded to within 20

working days. Where the complaint investigation took longer than 20 working days a holding letter was sent to the patient explaining why the response was delayed. If the complainant remained dissatisfied with the response, stage two of the complaints process was instigated and BMI Healthcare would review the complaint.

- The executive director had overall responsibility for the management of complaints. Complaints were logged on the electronic incident reporting system. This alerted staff that there was a new complaint and heads of department would investigate the complaint as appropriate. Complainants were offered a face to face meeting or telephone call with the executive director and appropriate staff such as the director of clinical services.
- Complaints were responded to within the timeframe. During our inspection we reviewed six complaints but we saw limited evidence that all of the substantive concerns had been addressed or that all of the actions in the action plan were taken before the complaint was closed. For example, following a complaint an email had been sent to staff asking them to ensure that correct information was sent to patients, however there was no evidence that practice was audited to ensure that the actions were embedded. There was no documentary evidence recorded of conversations between the investigator and consultants in all circumstances nor actions taken therefore we could not be assured that there was sufficiently clear oversight to ensure learning and prevention of similar complaints occurring again in the future.
- At our unannounced inspection we saw that a complaint tracking tab had been added to the electronic complaints register. The tab included details of information to be provided for example, the date and reference number, agreed actions to take and by whom, support and resources required, the responsible person, evidence of completion, future assurance, evidence, a red, amber, green (RAG) status and the completion date. Managers planned to send this information to all of the heads of department on a monthly basis so that complaints could be tracked to ensure that all actions were taken. Managers acknowledged that all conversations had not been recorded and reported that this would occur in future. There had been no complaints since our inspection therefore the new system had not yet been tested.
- Senior staff told us complaints were reviewed at the hospital governance meeting, heads of department meeting, medical advisory committee and department meetings. The ward manager also said complaints were mentioned at the daily communications cell meeting. Nursing staff told us outcomes of complaints were fed back at departmental meetings. We saw minutes of the relevant meetings that confirmed this. Complaints were also discussed at the daily safety huddle communications meeting. Staff were further informed of complaints in a notice that was attached to their monthly pay slip, consultants were also kept updated through the consultants newsletter if they had been unable to attend the MAC.

Are surgery services well-led?

Requires improvement

Leadership

- The hospital had a clear management structure in place with defining lines of responsibility and accountability. The hospital's senior management team consisted of an executive director, who had overall responsibility for the hospital, the director of clinical services, the quality and risk manager and the operations manager. The Medical Advisory Committee (MAC) chair and heads of department supported the senior management team. All of the heads of department reported to one of these leaders.
- Staff told us that the executive director was well respected, visible and supportive. Nursing staff also told us that the director of clinical services (DCS) was always available and very visible in the clinical area most days.
- The executive director attended regular meetings with other executive directors within the region, and told us they were well supported by the corporate senior management team and the hospital board.
- Managers in the service told us they were supported by their peers and by the DCS. Additionally, clinical

managers said they could contact clinical managers at other BMI hospitals in the region for advice and support as needed. The infection prevention control nurse also received support from the local NHS trust infection prevention control team.

- Local leadership was variable in terms of leadership and management development, however staff told us that the director of clinical services was very supportive. The director of clinical services told us that leadership courses and development for heads of department and ward and department managers who were new in post had been arranged. We saw minutes of meetings that had been held and evidence of courses that had been attended and future planned courses. Heads of department attended away days to support the development of their talents. The director of clinical services was also introducing heads of department meetings, this was evidenced in the clinical governance meeting minutes.
- Senior managers had utilised a creative recruitment process to employ a new theatre manager. This process had ensured that there was good staff engagement to ensure the right person was recruited.
- All grades of staff in the service told us that they felt departmental managers were approachable. Departmental managers worked clinically and provided clinical cover for sickness when required. We saw that ward and theatre staff worked together effectively.
- Staff we met with were welcoming, friendly and helpful. It was evident that staff cared about the services they provided and told us they were proud to work at the hospital. Staff were committed to providing the best possible care to their patients.

Vision and strategy

- The hospital was committed to the BMI Healthcare corporate vision, which was to offer "the best patient experience and best outcomes in the most cost-effective way".
- Staff in the service told us they were committed to providing a positive experience for patients. There were eight strategic priorities, which were:
  - Governance framework
  - Superior patient care
  - People, performance and culture
  - Business growth
  - Maximising efficiency and cost management
  - Facilities and sustainability
  - Internal and external communications
  - Information management
- The service had local visions which were displayed on staff room walls. Some staff told us they had been involved in discussions surrounding the local visions. For example, in the ward areas, part of the vision was to increase training resources. To help achieve this, the service had a dedicated training room and had employed two full time trainers.
- Each department had developed a five-year vision which aligned to the corporate and hospital vision. Staff we spoke to were aware of the hospital and departmental vision and strategies.
- We saw that the hospitals operational business unit plan was aligned to the corporate vision and strategic priorities, however it was dated 2016-2017. There was an efficiency improvement plan in place for 2017-2018. Progress against achieving objectives was reviewed and monitored at various committee meetings including the hospital governance and heads of department meetings.
- The hospital's 2018 strategy for service development outlined a number of proposals aimed at organising, delivering and developing services with more integration with the local community and other providers. These included the development of a paediatric team, an ambulatory care unit and minor operations procedure room and the recruitment of staff for theatres.

Culture

- The hospital culture encouraged openness and honesty. Processes and procedures were in place to meet the duty of candour. When incidents had caused harm the duty of candour was applied in accordance with the regulation.
- The service had a caring culture. Staff told us that they enjoyed working in the department and felt supported by their departmental managers. Department managers

told us that they had an open-door policy and that they were proud of their staff and their departments. A lot of clinical staff working on the wards had worked in the organisation for over 10 years. They told us they had stayed in the organisation for a long time because of the team they worked with.

- The senior management team spoke with pride about the work and care their staff delivered on a daily basis. All of the staff we met were welcoming, friendly and helpful.
- The hospital celebrated staff success. The BMI Healthcare group ran an annual recognition awards scheme entitled "above and beyond". The categories included "true inspiration", "outstanding care", "brilliant leadership", and "amazing support". Staff were invited to nominate a colleague who they felt had gone "above and beyond" and deserved recognition. We saw that compliments were shared with staff through the staff newsletter, noticeboards and meetings. The hospital also held annual long service awards, which recognised every staff member who had worked at the hospital for five years.
- There were arrangements in place to promote the health and well-being of staff. For example, the hospital held listening events, health and wellbeing weeks, mindfulness, massage, reflexology and resilience training. This was in alignment with the hospitals health and wellbeing charter. A duty manager was always available in the event of any concerns being raised.
- Staff were offered free bacon sandwiches and ices creams periodically in recognition of their hard work and continued support.

Governance

- The hospital had a clear governance framework in place with a variety of committees including safeguarding, infection prevention and control, and medicines management which fed into the hospitals governance meetings and ultimately reported to the BMI corporate board. All of these committees had terms of reference which reflected their role in the hospital, their structure and purpose. We reviewed four sets of governance meeting minutes and saw that they were well attended by the senior management team, heads of department and clinical leads. Standard agenda items for discussion included clinical incidents, complaints, audits and risks. However, minutes were not always detailed so the of depth of discussion at meetings was unclear. For example, the depth of discussion and review of complaints, incidents and the actions taken. We raised this with the senior management team and were provided with evidence detailing actions taken, how this was tracked, training provided to staff and reports that were disseminated to staff. The director of clinical services told us that the board robustly reviewed incidents at the board meetings.
- The medical advisory committee (MAC) was chaired by one of the consultants with practising privileges and received reports from all of the other committees. The MAC would review medical staffing practising privileges, discuss audits, and any new procedures that that were to be undertaken to ensure that they were safe, equipment was available and staff had the relevant training. Complaints and learning from incidents was also discussed. The MAC chair met with the hospital executive director regularly and was informed of any incidents. We reviewed five sets of minutes and saw that the meetings were well attended apart from one meeting where the date had been changed at short notice. The MAC occurred every three months however the terms of reference stated they occurred every two months. The MAC chair told us that the committee were considering whether the meetings should occur every two months. Information from meetings was cascaded to consultants through the consultants' newsletter therefore minutes were not circulated to all staff but were available on the intranet and cascaded to staff through team meetings.
- Other meetings held included regional and senior management meetings, heads of department and clinical lead meetings with the director of clinical services and ward and department meetings. These meetings were structured and minuted.
- Not all policies were in date. We found a policy related to the management of patients requiring intravenous medication to have been two years beyond its review date.
- Recommendations from previous inspections and risk assessments were not always carried out. This included, the removal of pocket masks from resuscitation trolleys which was recommended following a safety review in

February 2018 and a reduction in the number of oxygen cylinders, or safer storage, which had been recommended in the latest fire risk assessment from June 2013.

Managing risks, issues and performance

- The hospitals risk register was managed through the electronic reporting system. The hospital risk register included 10 mandated permanent risks which remained open, for example preventable death or injury to a patient and failure of infection prevention and control processes. We reviewed the risk register during our inspection and found that risks were adequately detailed with a description of the mitigation and controls in place. The dates when risks were to be reviewed, an assessment of the likelihood of the risk materialising and its possible impact was included. Key risks such as the failure to recruit adequate and appropriate staff were included on the risk register. However, there were omissions for example a 12 year old drugs fridge was out of warranty and was not subject to a maintenance programme, this had not been added to the register as a risk nor was there recognition that there may be other pieces of equipment similarly at risk. However, we saw on our unannounced inspection that all equipment had been safety checked. Lack of piped oxygen was also not on the service risk register and cylinder oxygen had also been reported as a risk in a fire assessment carried out in June 2014 and remained the same now without any mitigation in place. Similarly, before our inspection, the risk of introducing new resuscitation equipment before all staff had training or were competent to use the devices had not been recognised as a risk to patient safety, and missing emergency equipment from the resuscitation trolley had not been replaced at once, despite the risk to patients of it being unavailable.
- We could not therefore be assured that all risks were monitored thoroughly. A separate register of closed risks was held, heads of departments were able to access their own closed risks. Managers told us that all closed risks were reviewed annually. Risks were reviewed at clinical governance and medical advisory committee (MAC) meetings.
- The hospital also had paper risk assessments for health and safety risks which were kept at departmental level. Staff signed to say they had read these. Managers told us that these risks would be cross referenced as necessary and triangulated so that similar risks were identified across the hospital.
- During the previous inspection in June 2015, review of the risk register had not been part of the terms of reference for the Clinical Governance or MAC meetings. We reviewed the terms of reference and saw that the review of risk had been added as an agenda item to all senior staff meetings.
- Performance was not always monitored. We found that the service did not audit its compliance to NEWS2 escalation or its compliance to sepsis screening. Audits were carried out for compliance to VTE assessments. Results of the audits generally were compliant. However, during our inspection, we observed VTE was not adequately risk assessed on a patient's admission to hospital.
- We also found when audits were carried out and areas for improvement had been identified, action plans were not always put into place to ensure lessons were learnt.
- The hospital had an up to date incident policy and a risk management policy.
- The timeframe for reviewing incidents was 20 days, however there was no flagging mechanism on the electronic system to ensure that all incidents were reviewed within the timeframe. During our inspection there were 46 open incidents on the system, 11 of these were overdue. We reviewed a random sample of six incidents and found that no deadlines had been set for responses to incidents, therefore managers could not be sure that incidents were responded to within the timeframe. When responses had been gathered the incident was closed, however there was no quality check to ensure that all actions had been completed. At our unannounced inspection on 10 July 2018 we saw that there were no overdue incidents on the system. Following our inspection an additional tab had been created to highlight when incidents needed review.
- Service leaders did not always have a full appreciation of their responsibilities or an awareness of some of the risks and issues in their departments. For example, the acting theatre manager was unaware that they were also responsible for the minor operating theatre and its staff, despite previously being the deputy manager for

theatres before the acting manager role; and they were unable to tell us about local safety standards used in their department. The ward manager was aware that not all of their staff had in date resuscitation training, however, they were unaware of how many staff or which ones. Additionally, not all staff had received training on the new resuscitation equipment, however there was no action plan to address this. There was also no follow up for items missing on the resuscitation trolley.

- There was a systematic programme of internal audit used to monitor compliance with policies such as hand hygiene, health and safety and cleaning schedules. Audits were completed monthly, quarterly or annually by each department depending on the audit schedule. Results were shared at relevant meetings such as the hospital clinical governance meetings. Audit records and minutes that we reviewed confirmed that the process was embedded. For example, the pain management audit was discussed at ward meetings reminding staff to undertake pain assessments on admission but did not identify if there had been any improvement. However, some minutes were brief with limited discussion of the audit and outcomes. Following our inspection, we were provided with evidence of auditory review if compliance was poor.
- The hospital participated in national audits including the National Joint Registry, Patient Reported Outcome Measures (PROMS), Friends and Family Test and Patient Led Assessment of the Environment (PLACE).

Managing information

- Information needed to deliver effective care and treatment was available to relevant staff in a timely and accessible way.
- The service used paper records. Nursing and medical patient records were combined within the same record; this meant that all health care professionals could follow the patient pathway clearly.
- Results of x-rays and blood tests were available electronically which all relevant staff could access.
- Patient discharge letters were printed and sent to the patent's GP. The service kept a copy and a third copy was given to the patient.

Engagement

- Patients views and experiences were gathered and acted on to shape and improve the services and culture. Service user feedback was sought in various means, including the Friends and Family Test (FFT), NHS Choices website, BMI patient satisfaction survey, and Patient-Led Assessment of the Care Environment (PLACE) audits.
- From July to December 2017, the BMI hospital patient satisfaction response rate varied from 5% to 28%. However, feedback was consistently good, with between 98% and 100% of patients recommending BMI hospital as a place of treatment. In January 2018, the FFT scored 98% and the response rate was 80%. This was higher than the England average.
- In the 2017 BMI staff survey, 58% of hospital staff said they would recommend the hospital as a place to work. The overall staff engagement score for the hospital was 63, this was thirteenth out of the BMI group of hospitals.
- Some staff in theatres told us there had been a lack of staff engagement recently due to issues with the previous theatre manager. However, we were told that since that manager had left, staff engagement had improved. The director of clinical services had met with all of the theatre staff to discuss any issues they wanted to raise. Staff in the theatre department said they felt positive and were looking forward to the new manager commencing their role.
- The hospital engaged with various stakeholders including the local Healthwatch, the clinical commissioning group (CCG), the local university and NHS trust. There was also a corporate agreement with the Royal College of Nursing (RCN) to provide education and support.
- Members of the public were invited to attend a variety of open events held throughout the year when a consultant would talk about particular health topics, including the various treatment options available.
- Patients and the public were able to access a wide range of detailed information about the hospital from the hospital's website. This included information about the consultants with practising privileges, treatment and payment options.

- Managers held regular departmental team meetings which enabled staff to discuss any areas of concern, be informed about incidents or risks and to be kept updated about any issues in the hospital.

Learning, continuous improvement and innovation

- The ward manager was new in post and developing into their role. There was a planned new theatre manger due to start soon.
- The lead nurse for infection prevention and control had strong links with the local NHS hospital and attended some of their infection control meetings and learning events. The service was improving infection prevention and control in line with national guidance, for example, early recognition of sepsis, and intra operative patient warming to reduce patient infections.
- An education hub had been developed in order to allow staff dedicated time and access to training. Additionally, two full time clinical educators had been appointed.
- Senior managers had implemented a creative recruitment process for the recruitment of a new theatre manager due to recent instability in theatre management. Theatre staff had been included and were fully engaged in the recruitment process, this meant that there had been a triangulated approach to ensure that the most appropriate candidate was appointed to meet the needs of the service.

Good

Services for children and young people

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

Are services for children and young people safe?

Good

Mandatory Training

- The hospital provided mandatory training in key skills to all staff and made sure everyone completed it. Staff received training through the BMI online learning package (BMI Learn), face-to-face and in practical sessions.
- Staff in the service completed a number of mandatory training modules. These included infection prevention and control, basic life support, Control of Substances Hazardous to Health (COSHH), fire, equality and diversity, documentation, display screen equipment and safeguarding children and vulnerable adults.
- Documentation provided by the Lead Paediatric Nurse (LPN) showed staff in the CYP service had completed 96% of their mandatory training requirements which exceeded the hospital target of 90%.
- New mandatory training had been introduced in 2017 and included care and communication of the deteriorating patients, female genital mutilation and safeguarding chaperoning. Staff in the CYP service were compliant with the 90% target.
- Resident medical officers (RMOs), the LPN and one recovery nurse were trained in Advanced Paediatric Life Support (APLS) which was completed face to face.
- Mandatory training was predominantly completed through the electronic teaching packages and staff in the CYP service told us they were allocated time during the working day. The LPN said it was sometimes difficult to release staff to attend the face-to-face and practical training sessions and extra dates had been requested from the BMI academy. Staff told us they received an email from the LPN to remind them to complete mandatory training and refresher training, and were also reminded at safety huddles and team meetings.

Safeguarding

- At our previous inspection the hospital did not have a system to identify CYP who may have been at risk. During this inspection we saw appropriate arrangements were in place to ensure patients were kept safe from avoidable harm. The hospital had a Safeguarding Children Policy (2017) and a child protection flowchart for referral (2016) including out of hours contact details for hospital staff. The policy reflected relevant legislation and local requirements for safeguarding. The policy identified how to seek advice from the safeguarding team including advice on 'did not attend/was not brought' and described the system for following up children who missed one or more outpatient appointments. The LPN was the named safeguarding lead for CYP and the director of clinical services was the hospital safeguarding lead for adult and children's safeguarding and both were trained to safeguarding level four.
- Staff were able to explain safeguarding arrangements and said they would raise any queries with the LPN. Staff were able to describe when they might be required to report issues to protect the safety of vulnerable patients. The child protection flowchart was displayed across the

hospital which identified what to do if staff had concerns or were worried about a CYP (0-18 years). Staff were able to name the CYP safeguarding lead and the hospital safeguarding lead for the organisation.

- Staff attendance at training for safeguarding CYP met national guidelines as set out in Safeguarding Children and Young People: Roles and Competencies for Staff heath care professionals Intercollegiate Document (2014). The document states that: "Any clinician who is responsible for planning or assessing the needs of children who may be vulnerable or at risk of harm, require level three safeguarding training. Therefore, level three safeguarding training is the required level for people caring for and assessing the needs of CYP.
- At our previous inspection only one of the registered nurses (adult branch) had been trained to the appropriate level to support CYP who used the service. The hospital set a target of 90% for safeguarding training for CYP. The service was meeting the hospital target for safeguarding training for children and adults for level 1, 2 and 3 and we saw evidence of this.

Cleanliness, infection control and hygiene

- At the time of the inspection all areas in children's services were seen to be visibly clean and dust and clutter free. There were no reported cases of MRSA or Clostridium difficile in the previous 12 months in CYP services.
- We noted there were hand washing facilities and hand sanitizing dispensers at the exit and entry to the children's area and hand washing technique information posters were displayed above the sinks in the CYP designated four rooms.
- Hand hygiene audit results for CYP services from January to May 2018 were 100% compliant with hand hygiene techniques. Staff received annual training on infection prevention and control (IPC) as part of their mandatory training. Staff were observed to be 'bare below the elbows' and in line with the hospital infection policy.
- There were cleaning schedules displayed in the CYP area. We noted they were all signed and dated to evidence regular cleaning took place. We noted that 'I am clean' stickers were used to indicate that equipment had been cleaned and these stated the date the equipment had last been cleaned.
- We saw the weekly toy cleaning log; in addition, toys were cleaned after use and before being put away.
- We noted personal and protective equipment (PPE) such as gloves and aprons were readily available in consulting and CYPs rooms through the use of wall dispensers.

Environment and equipment

- Specialist equipment for all age ranges cared for in the hospital, including that required for resuscitation was available and fit for purpose. Where children were anaesthetised, resuscitation drugs and equipment including an appropriate defibrillator were available.
- Consideration had been given regarding risks presented to children by sharing the same facilities as adults. CYP were cared for in single ensuite rooms with facilities for parents to stay with them. The LPN had designated four adjacent rooms for CYP undergoing day case surgery.
- The designated rooms had been risk assessed in December 2017. Adaptations had been made to facilitate the environment for CYP. The hospital had met the Department of Health guidance (HBN 23 Hospital accommodation for children and young people 2004 states, "Door control systems should be provided to all entrance/exit doors to prevent accidental egress"). Electronic security operated doors at the entry to the area where designated rooms for CYP were sited, were in place. Cleaning materials which could be hazardous to children were stored in locked (keypad) rooms.
- The hospital had opened a new service for children and teenagers in August 2017. The service aimed to provide CYP with a positive clinical experience where clinic rooms were designed with children in mind and had ride on toys to take children to theatre. There were no dedicated rooms on Davidge ward used solely for caring for CYP but en-suite rooms had been decorated in a way that was suitable for use by adults and children. When the rooms were in use for weekly day theatre sessions

they were equipped with child friendly and age appropriate bed linen and toys. A hospital bear was present on each bed to welcome the child to the ward and could be taken home.

- An environmental safety check was undertaken each time a room was allocated to a child. This ensured the environment was safe and age appropriate for CYP. For example, there were closures on all windows, cords on blinds were made safe and cleaning materials were stored in locked cupboards.
- A designated outpatient consulting room with an adjoining waiting area was available on the ward and enabled children to be seen by the named paediatric consultant in an appropriate environment. The consulting room and waiting area had involved children and families in designing and equipping the room. Whenever possible the room was used for CYP's outpatient clinic appointments and pre-assessment clinics and acted as the hub for the new children's service. The room was bright and clean with a wide range of age appropriate toys and distraction materials. A round table and bright orange sofa provided an environment that was child friendly and could be used by children of all age ranges. Children told us they 'liked' the new rooms and said they enjoyed playing with the toys.
- There were limited facilities for CYP attending outpatient services. Due to design constraints of the environment it was not possible to provide a dedicated CYP waiting area. Children and young people were seen in outpatient consulting rooms which were checked weekly to ensure they were safe and fit for purpose for CYP. For example, window closures were in place and sharps boxes were not accessible and a selection of toys were available and were cleaned weekly in line with hospital policy.
- A resuscitation site review had been undertaken in March 2018 at the request of the hospital to ensure resuscitation provision was fit for purpose. In the CYPs service resuscitation trolleys were checked and seen to be 'sealed, tagged and clean'. Where recommendations had been made these had been completed and recorded on the resuscitation site review action plan.
- During the inspection we saw paediatric resuscitation equipment was available on the ward, in theatre and outpatients. Resuscitation trolleys were tamper evident and emergency equipment and drug boxes were locked in line with hospital policy. Staff clearly documented daily equipment checks. A paediatric airway management box had been developed by the LPN and was available in each of the rooms designated for the use of CYP. This ensured emergency equipment was immediately available for CYP.
- There were systems to maintain and service equipment as required. Equipment had undergone safety testing to ensure they were safe to use.
- Children and young people were cared for in the theatre recovery area that was not designed to be used by children. However, reasonable adjustments had been made to make the area more child friendly. For example, CYP were cared for in the far corner of the recovery area and child friendly curtains and pictures were in place.

Assessing and responding to patient risk

- At our previous inspection risks to CYP who used services were not always assessed and their safety monitored and maintained. During this inspection we saw systems and procedures were in place to assess, monitor and manage risks to patients. For example, the service used a Paediatric Early Warning Score (PEWS) system to alert if a CYP clinical condition deteriorated. Nursing staff we spoke with were aware of the appropriate actions to take if the patient's score was higher than expected. We reviewed 10 completed PEWS charts which showed staff had escalated correctly, and repeat observations were taken when required and within the necessary time frames. We were told audits of PEWS scores would be included in future CYP documentation audits.
- Children and young people were assessed as being suitable for treatment according to hospital policy before being accepted for any procedure. The CYP LPN oversaw the pre-assessment and booking arrangements for any procedure planned for CYP under 16 years of age. Young people aged 16 to 17 years were pre-assessed and cared for as part of the adult surgical pathway unless issues were detected at pre-assessment which identified them as requiring CYP services.
- We saw an inpatient paediatric sepsis screening tool was in place for children aged five to 11 years who had a suspected infection or had clinical observations outside

of normal limits. Staff told us the PEWS tool would trigger the sepsis screening tool if it was required but we saw there were no prompts on the PEWS chart to trigger its use. We raised this with staff at the time of the inspection. Staff in the service had received sepsis awareness training and knew how to escalate the sepsis screening tool if PEWS did not trigger it. There were poster displays across the hospital from the UK sepsis trust.

- The service had implemented WET FLAG to manage the care of children and young people whose condition was deteriorating. WET FLAG is a framework to help reduce the risk of error in a stressful situation and applies to children between the ages of one and 10. It stands for weight, energy/electricity, tube (endotracheal), fluids, adrenaline, glucose. Laminated copies of the WET FLAG tool were available at the end of each patient's bed and staff had been trained in its use. This meant that nursing staff (child branch) were able to respond promptly to children whose condition suddenly deteriorated.
- There were emergency procedures in place in the CYP service including call bells to alert other staff in the case of a deteriorating patient or in an emergency.
- The service always had access to a RMO who was trained in APLS. The RMO provided support to the CYP service if a patient became unwell. Patients who became medically unwell were transferred using the children's acute transport service (CATS) to the local NHS acute trust in line with the emergency transfer policy.
- In the past 12 months one child had become unwell following their admission for day surgery. The child was transferred to the local NHS acute trust by the CATS service. We saw feedback from the consultant paediatrician in the acute trust to the LPN who said the CYP service "had gone beyond what was expected of them".
- The anaesthetic consultant remained in the hospital until the CYP was discharged from recovery and had been reviewed on the ward.

Nurse staffing

- In our previous inspection we saw staffing levels for CYP services had been reassessed and the number of registered nurses (child branch) had been increased. We were told the children's service was now fully staffed. There was always at least one registered nurse (child branch) on duty for children over 12 years of age and two nurses if the child was younger. However, children on occasions were cared for by adult nurses, under the supervision of the registered nurses (child branch) who had received no specific training to do so.
- During our inspection we saw a new hospital service for CYP had been launched in August 2017 and the nursing establishment had been increased to meet the demands of the new service. A full time equivalent (FTE) LPN was now in post who oversaw the service. The LPN was supported by two registered nurses (child branch). At the time of the inspection there were 2.2 FTE registered nurses (child branch). This meant the service was meeting the Royal College of Nursing guidance on 'Defining staffing levels for children and young people's services' (2013) which states, 'for dedicated children's wards there is a minimum of 70% : 30% registered (child branch) to unregistered staff with a higher proportion of registered nurses (child branch). The service was staffed above the minimum requirements.
- However, the BMI policy for children's service (September 2017) required two registered nurses (child branch) to be present when a CYP received a local anaesthetic for a minor procedure in the day unit. Currently one registered nurse (child branch) was available in the day unit. The LPN told us they would ensure a second registered nurse (child branch) from the ward would be made available for any current procedures and plans were in place to recruit two bank registered nurses (child branch). This would enable CYP to be supported in the day unit by two appropriately qualified nurses when they were required.
- The BMI policy also states for CYP day theatre services, one of the registered nurses (child branch) must hold a valid APLS qualification. The service was meeting this requirement.

Medical staffing

- There were 50 consultants who had been granted practising privileges at the hospital who were able to treat CYP. Practicing privileges is a term used when doctors have been granted the right to practice at an independent hospital. The majority of these also worked at other NHS trusts in the area.

- There was a corporate BMI 'Practising Privileges Policy, including consultants and medical and dental practitioners' (dated November 2015), which included the granting of practising privileges, and roles and responsibilities. The Executive Director and the Medical Advisory Committee (MAC) had oversight of practising privileges arrangements for consultants. We saw evidence in the MAC minutes of decision-making for renewing or granting of practising privileges.
- Consultants seeing CYP were approved by speciality and by age range in order to see CYP in outpatients. Generally, consultants only saw CYP from three years to 18 years of age in outpatients. However, there were consultant specialists approved to see younger children. For example, consultant paediatricians for consultation only. All consultants caring for CYP were required to provide documentary evidence of safeguarding level three training and evidence of seeing CYP in the last six months. We saw this recorded in the minutes of the MAC meeting in December 2017.
- The hospital had a resident medical officer (RMO) who provided a 24-hour a day, seven days a week service on a rotational basis. The RMO provided support to the clinical team and in the event of an emergency or with patients requiring additional medical support. At our previous inspection there was no assurance the RMO's had the appropriate training and experience to deal with CYP. During our inspection we saw the RMO's had undertaken paediatric resuscitation training and was supported by the LPN and a recovery nurse who were trained in advanced paediatric life support (APLS).
- The CYP service was supported by a named paediatric consultant paediatrician. There were two additional consultant paediatricians with practising privileges if additional support was required.

Records

- Patient records contained information of the patient's journey through the service including, investigations, test results and treatment and care provided. Patients' records were largely paper based, with the exception of digital images of x-rays and ultrasounds. All records we saw (ten) were accurate, complete, legible and up-to-date and were stored securely.
- We reviewed ten sets of patient records. Information was easy to access and records contained information about the patient's journey through the hospital including pre-assessment, investigations, results and treatment provided. Theatre records included the five steps to safer surgery checklist. We saw these were completed fully and appropriately.
- Discharge letters were sent to the patients' GP immediately after discharge, with details of the treatment, including follow up care and medications provided.

Medicines

- The service prescribed, gave, recorded and stored medicines well. Paediatric pharmacists provided support when required and reviewed medicines.
- Paediatric pharmacists generally dispensed over the counter medicines which were safe for use without the height and weight of the CYP being taken into account. Any uncommon medicine prescription would be checked against the height and weight of the CYP and would be checked to see if it was licenced for use by.
- At the previous inspection we found four CYP had not had their weight recorded on their medication chart. However, the weight was recorded on the CYPs anaesthetic record which enabled the correct calculations to be made and the appropriate medication given. During this inspection we saw the height and weight and allergies of all CYP was recorded on all the ten medicine charts we reviewed.
- Parents were given a 'discharge medication information' leaflet before their child was discharged from the hospital. The leaflet requested parents to discuss their child's needs with the nurse (child branch) in relation to pain management and who to contact if they had any concerns about their child's pain or medication. A discharge medication checklist was recorded on the back of the leaflet and was completed by the nurse (child branch) following discharge.
- Blank NHS private prescription pads were stored securely in the CYP consultation suite and robust monitoring systems were in place to ensure all prescriptions were accounted for.

- Treatment room and fridge temperatures were checked and recorded daily in the CYP service to ensure that medicines were kept at the correct temperature. Staff understood the procedures to follow if temperatures were not correct.

For our detailed findings on medicines please see the Safe section in the surgery report.

Incidents

- During our inspection we observed that staff understood their responsibilities to report incidents and CYP and parents were informed when things went wrong. Incidents were reported and investigated and were subject to high quality review by the LPN in the CYP service. Evidence of decisions and discussions at team meetings were consistent and learning outcomes were recorded in the minutes of team meetings and in the daily safety huddle.
- The hospital used an electronic incident reporting tool to record incidents. The staff we spoke with were confident in the use of the system and told us they always reported incidents. Staff we spoke with told us they were given feedback about incidents at daily handovers and team meetings. Where incidents had occurred, actions were identified to limit the risk of a further occurrence. Actions were monitored through the clinical governance committee meetings and we saw evidence of this in the meeting minutes for January 2018.
- The hospital did not report any 'never events' between February 2017 and January 2018. 'Never events' are serious incidents that are wholly preventable as guidance or safety recommendations that provide strong systematic protective barriers are available at a national level and should have been implemented by all healthcare providers.
- Data received from the hospital showed between April 2017 and March 2018 there had been nine clinical incidents in the CYP service. Four of the incidents related to poor quality documentation in the theatre recovery area relating to CYP. The LPN said that following an investigation, the learning from the incidents was identified as a lack of understanding in the completion of the paediatric early warning system tool (PEWS) in the theatre recovery area. This was addressed by the LPN at face-to-face training sessions. Staff were also required to undertake paediatric competency training and required by the hospital for staff caring for CYP who were not children trained.
- Staff described the principle and application of duty of candour, Regulation 20 of the Health and Social Care Act 2008, which relates to openness and transparency. It requires providers of health and social care services to notify patients (or other relevant person) of 'certain notifiable safety incidents' and provide reasonable support to that person. Patients and their families were told when they were affected by an event where something unexpected or unintentional had happened. We spoke to the LPN who gave us an example of duty of candour following an incident they were involved in. They explained how they had contacted the parents of the patient, explained what had happened and apologised.

Safety Thermometer (or equivalent)

- BMI Healthcare was compliant with the reporting guidelines in relation to the NHS Safety Thermometer. This forms part of the BMI Healthcare's Hospitals' engagement with the local clinical commissioning groups nationwide. The measures reported monthly related to the following:
  - Venous thromboembolism (VTE)
  - Falls
  - Catheter related urinary tract infection
  - Pressure areas by category

Are services for children and young people effective?

Good

Evidence-based care and treatment

- The service provided care and treatment based on national guidance and evidence of its effectiveness. The National Institute for Health and Care Excellence (NICE) guidelines were routinely discussed and reviewed at hospital quarterly clinical governance and monthly heads of department meetings. For example, in the minutes of the heads of department meeting in April

2018, NICE guidance with regard to the development of a BMI pre-operative policy was discussed. The lead paediatric nurse (LPN) explained that NICE guidance was followed for the pre-assessment of children and young people (CYP) before surgical day case procedures.

- The hospital had a BMI Care of Children policy (September 2017) which was in line with the Department of Health's guidance on the National Service Framework for Children. This meant the hospital had taken steps to ensure CYP were cared for in line with best practice. For example, Royal College of Nursing (RCN) on staffing and the use of Gillick competence. This is a term that is used to assess whether a child (16 years or younger) is able to consent to their own medical treatment.
- Anaesthetists undertaking procedures on children worked within the Royal College of Anaesthetists "Guidance on the Provision of Paediatric Anaesthesia Services," 2013.
- Policies were up to date and assessed to ensure they did not discriminate based on race, nationality, gender, religion or belief or sexual orientation or age. Staff in children's services had a good understanding of and had read local policies and were able to access them using the hospital's intranet. We observed audit and policies was a regular agenda item on the heads of department meetings. For example, in January 2018, the indexing and tracking of policies was discussed as the system required updating. All heads of department were required to review the policy and feedback their findings to enable a revised service level agreement to be agreed.
- At our previous inspection the hospital did not have an audit programme specific to the needs of CYP. This meant it was not possible to see outcomes in relation to this service. During this inspection we saw CYP's services were involved in a hospital wide programme of annual and weekly local audits. For example, hand hygiene, patient equipment, medicines management, environmental and monthly spot check audits, pain management and documentation audits.
- The hospital participated in an integrated audit review in 2017, and published in 2018. The audit report identified areas for improvement across the hospital and action plans were monitored through senior management team meetings (monthly) and the clinical governance committee (quarterly). The plan (for CYP) identified the responsible named person and timescales for the target completion of actions and we saw these were being achieved. For example, a lack of signage and inappropriate siting of paediatric resuscitation equipment, a service level agreement (SLA) for the transfer of CYP who show signs of deterioration was not in place and the ward area for CYP was not secure which could compromise the safety of CYP on the ward. We saw from the action plan there was good compliance with completing outstanding actions and deadlines were being met. For example, the resuscitation trolley had been sited closer to the allocated CYP beds, new signage had been ordered, electronic security doors were in place and the SLA for the transfer of CYP who showed signs of deterioration was in place.

Nutrition and hydration

- Children and young people's nutrition and hydration needs were assessed at pre-assessment and documented on their care record. Where CYP had specific dietary requirements, appropriate arrangements were put in place. For example, a child who was a vegetarian was able to choose from a vegetarian menu.
- A dietician with practising privileges was available to see CYP who were identified at pre-assessment as having issues with nutrition and hydration.
- In the CYP survey food was rated highly and often rated as being ten out of ten. We were told by the catering staff that if a child wanted something different to the choices offered on the menu they would do their best to meet the child's needs. During our inspection a child requested a type of biscuit that was not available on the ward. Following contact with the catering department the child's choice of biscuit was obtained.
- The hospital provided suitable meals and drinks for CYP and alternative menus were available for children to choose from to encourage them to eat and drink normally. These included foods to appeal to younger children such as finger food, ice cream and yogurts.
- Parents told us there was a good selection of appropriate food available for their child who was able to choose what they wanted to eat.

Pain relief

- Pain assessment charts were embedded into the paediatric pathway. The assessment tool used 'smiley faces' where children were asked to choose the face that best described how comfortable or uncomfortable they were feeling. We reviewed ten sets of records and all had completed pain assessments.
- Pain was monitored from surgery through to discharge. Both the surgeon and anaesthetist were available in the hospital until at least the child left recovery should there be any issues with pain before discharge.
- Parents we spoke with told us their child's pain had been well managed and medicine records showed clear prescribing of pain relief.
- The LPN told us registered nurses (child branch) would also assess a child's pain in recovery ensuring it was well managed before taking the child back to the ward and we saw evidence of this during the inspection.
- A pain audit was undertaken for CYP twice a year as part of the hospital annual audit timetable. In the reporting period June to July 2017 audit compliance was 100%. In the reporting period November to December 2017 audit compliance was 92%. This meant CYP were not experiencing undue pain during their treatment at the hospital. The difference in results (100% to 92%) was due to the question "If a CYP was in pain at pre-assessment" which had not been completed on the audit.

Patient outcomes

- There were no national audits undertaken by the hospital involving CYP. Changes to practice were put in place to promote good patient outcomes for CYP. For example, all CYP attended a face-to-face pre-assessment clinic to assess their suitability for surgical intervention. We did not see any evidence of monitoring for post-operative complications, however there was also no evidence of post-operative complications that had occurred.
- Following the appointment of the LPN, children's services were incorporated into the overarching audit tool for the hospital. Ten sets of records were reviewed each month and identified good patient outcomes for CYP. For example, pre-assessment and discharge checks, completion of risk assessment tools and pain assessment tools and consent. However, not all entries in patient records were signed and dated by the consultant. This was being addressed by the LPN through the CYP advisory group.
- During the last inspection in 2015, not all CYP had their height and weight recorded on admission. During our inspection we saw in ten patient records we reviewed, all records contained the height and weight of the patient and had been signed twice to demonstrate observations had been witnessed and were correct.

Competent staff

- The service ensured staff were competent in their roles and we saw evidence that staff had received an annual appraisal to support their clinical development. New hospital staff undertook an induction, which included a corporate induction and a local orientation. Staff we spoke with confirmed they had completed all mandatory training and competency assessments and told us they were given time to complete electronic learning.
- All staff were supported to complete additional training available at the BMI corporate academy. Staff told us development opportunities were identified during their appraisals and they were supported by the LPN in their requests for additional training at other times as required. For example, in the use of the WETFLAG, an approach to the care of sick children whose condition had suddenly deteriorated. We saw laminated copies of the tool on each CYP's bed and staff had been trained in its use by the LPN.
- Data provided by the hospital showed nursing and medical staff (in the service) were appropriately registered with their professional body. This meant the hospital conducted checks to make sure the nurses and doctors were registered with the Nursing and Midwifery Council or the General Medical Council.
- There were 50 consultants who provided care for CYP in the hospital. Consultants were required to undertake safeguarding training level three and provide evidence of seeing CYP in the last six months as part of the hospital practising privileges (PPs) requirements. We saw this recorded in the medical advisory meeting

minutes for December 2017. The LPN was aware of the PPs arrangements in place for their service and told us where necessary would raise concerns with the executive director.

- When CYP were seen in the outpatient department, one of the registered nurses (child branch) was present within the hospital and could be called on if necessary.
- During our previous inspection in 2015 a competency framework was not in place to ensure adult trained nurses could demonstrate they were competent to care for CYP. This meant there could be a risk that staff did not have the appropriate skills to support the care of CYP. The LPN had implemented a competency framework for all areas of the hospital where CYP were treated. For example, outpatients and theatre and recovery departments. An electronic register was in place to monitor attendance. Staff from the designated areas of outpatients, physiotherapy and theatre were compliant. Two (out of six) staff in the theatre/recovery area were the only staff yet to complete the competency framework which they were due to compete in July 2018. Bank staff were required to undertake the hospital induction and local orientation programmes and the CYP training competencies to ensure they were competent to care for children in the hospital.
- At our last inspection registered nurses were not receiving supervision. During our inspection staff (CYP) told us they attended clinical supervision sessions and found them to be helpful. The LPN attended quarterly safeguarding supervision sessions provided by the children's safeguarding lead for the local commissioning group.

Multidisciplinary working

- There was a strong multi-disciplinary (MDT) approach across all areas we visited. Staff of all disciplines, clinical and non-clinical, worked alongside each other throughout the hospital. Staff reported good multi-disciplinary working with access to medical staff and physiotherapy staff as required.
- Throughout our inspection we were told how the LPN had developed strong multidisciplinary relations with consultants, heads of departments, senior managers and administrative and support staff. Staff felt able to raise issues and concerns about CYP services and had welcomed the opportunity to learn more about the care and support for CYP at the hospital.
- The LPN worked with all the staff that cared for CYP across the hospital. Booking and medical records staff told us how beneficial the LPN was as there was now a coordinated approach to the pre-assessment and booking of CYP attending the hospital.
- The named consultant paediatrician was the paediatric representative on the MAC and co-chaired the CYP advisory committee with the LPN. This meant there was CYP representation across the hospital which supported the development of CYP services.
- We observed in patient records that GPs were kept informed of treatments provided; follow up appointments and medications to take on discharge.

Seven-day services

- Resident Medical Officers (RMO's) provided a 24 hour a day, seven days a week service on a rotational basis. The RMOs were paediatric resuscitation trained and had undertaken level three safeguarding training.
- Parents were able to access clinics outside of working hours. For example, pre-assessment clinics were held on Saturday mornings as required as well as during the week and the named paediatric consultant held CYP's clinic one evening a week.

Health promotion

- The CYP service gave parents a Just Ask 'could it be sepsis' card issued by the The UK Sepsis Trust to help raise awareness of the risks associated with sepsis, particularly in children under the age of five. Information posters about sepsis were displayed across the hospital.
- Admission criteria were in place for CYP undergoing a day surgery procedure to ensure CYP with additional pre-existing conditions for example, obesity, diabetes and epilepsy would not be operated on.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- We looked at ten patient's records and saw consent forms were fully completed, signed and dated by the consultant and patient/parent. The planned procedure

was identified, the associated risks, benefits and intent of treatment was described. In addition, the patients had been assessed as having capacity to consent for treatment.

- The hospital consent policy for the examination and treatment of CYP was available on the hospital intranet for staff to view. This included information to guide staff on consent issues such as where a parent was unable to consent on behalf of a child due to a lack of mental capacity and gaining consent from young people as well as their parents. Nurses were aware of the relevant consent and decision-making requirements of legislation and guidance, including the Mental Capacity Act 2005 and the Children's Acts 1989 and 2004.
- Mandatory e-learning about safeguarding provided for staff included information about the Mental Capacity Act and Deprivation of Liberty Safeguards (DoLS). Training compliance for the CYP service was 100%.
- We were told when young people aged 16 and over lacked the mental capacity to make a decision, 'best interest' decisions were made in accordance with legislation. Young people were supported to make decisions by nurses and consultants. Consultants were aware of assessing young people's ability to consent for treatment using the Gillick competency guidelines (used to help assess whether a child had the maturity to make their own decisions and to understand the implications). Staff told us they were always present with under 16-year olds when gaining consent.
- Nurses were aware of the appropriate procedures in obtaining consent, talked to children and explained procedures to children in a way they could understand. We saw examples of how nurses would seek a child's consent before doing anything, for example, taking a pulse.

Are services for children and young people caring?

Outstanding ☆

Compassionate care

- At the last inspection services for children and young people were not rated due to children not being present on site at the time of the inspection. We were unable to observe the interactions between nursing staff, children and young people (CYP), parents and/or carers. The hospital did not gather CYP or their relatives/carers feedback on the service provided. This meant the hospital was unable to use the patient experience to improve the service.
- During the inspection we spoke with eight children and 13 parents in the hospital. All spoke positively about the care stating that their wishes had been respected and they were well informed about their treatment.
- All staff understood and respected the cultural, social and religious needs of the patients they care for. Throughout our inspection, we witnessed children and young people (CYP) being treated with compassion, dignity and respect. Parents and relatives told us staff were kind and attentive to their child. Parents and children were extremely positive about the care and treatment they received regarding day case and outpatient services at the hospital.
- We observed staff responded quickly and compassionately to patients who called for assistance. Staff used distraction techniques and 'bravery gifts' to promote compliance and with treatment and minimise distress to patients.
- Nurses, doctors and support staff were friendly and welcoming to children and their families and were skilled in communication with CYP. Staff understood and respected the cultural, social and religious needs of the children they cared for. A relative told us "You always feel so well informed and you are made to feel that your opinion really matters".
- Another relative said their child had recently attended the hospital for the first stage of a two-stage day surgery treatment process. The relative said how well their child had been cared for during their first hospital admission and had requested the same nurse to assist during their child's second admission. This demonstrated that parents believed that staff went the extra mile and their care and support exceeded their expectations.
- During our inspection, we saw excellent interactions between staff and CYP and their parents. Interactions were kind, compassionate and very caring. Staff were skilled in communicating with CYP and we observed this in all the areas we visited.

- We observed a nurse undertaking a child's admission process. The nurses was calm and caring and gave a clear explanation about the medication that would be administered and the effect it would have on the child in an age appropriate manner. The parent and child expressed confidence in the care and support about their treatment and felt they had been listened to and were able to raise any issues or concerns.
- The CYP lead paediatric nurse (LPN) had developed an age appropriate patient survey for CYP. We reviewed 28 surveys in the period January to May 2018. Children who had completed the survey said, "Thank you for looking after me so well, as I was a bit frightened about the needle in my hand" and "I felt so much better when the nurse used the 'magic cream'' which I was told about as part of my pre-assessment appointment". Another child said, "The room was great and the bed really made it homely and fun". Another child said, "The nurse was brilliant and made me feel familiar with my surroundings so I was not so concerned about my operation". Parents had added comments to the survey and said, "Excellent hospital environment for children", and "Wonderful and kind service from the front door to the discharge home". Other parents said, "All staff were caring, reassuring and friendly", and "The care of my child throughout their hospital stay was excellent, I could not fault the care at all".
- The NHS Friends and Family Test is a satisfaction survey that measures patients' satisfaction and asks people to identify if they would recommend the service to their friends and family. In the period January to May 2018, 29 surveys were completed by parents of CYP. The surveys were unanimous in their praise for the CYP service. Parents had rated the service as being 'highly likely' or 'likely' to recommend the service to friends and family. Parents said, "friendly and empathetic staff in a very child friendly environment", and "very professional staff who made my daughter feel comfortable on her first visit to the hospital", and "staff were very patient and appreciated from our child's perspective the operation was a frightening experience especially the anaesthetic. Our ten-year-old was relaxed which was due to the LPN and the other nurses". The ward had a 'How did we do' board where children's feedback was displayed. At the time of the inspection all the comments from children were positive and praised the nurses and doctors about the care they received. We saw where actions were taken as a result of feedback from children. For example, a child had commented that they did not like the 'lumps' (vegetables) in the soup and had drawn a picture of the bowl of soup. The catering supervisor told us the hospital provided homemade soup which was very popular with adult patients which often had vegetables in it. Following the feedback from the children's ward additional soups had been added to the children's menu. The soups were in the three flavours and texture preferred by children.
- Feedback from CYP and parents was unanimously positive about the quality of the children's service. The surveys stated that staff always 'went the extra mile' and nothing was ever too much trouble for them when meeting their children's needs.

Emotional support

- Staff throughout the hospital understood the need for emotional support for parents and their families. We spoke with children and their relatives who all felt that staff cared for the emotional wellbeing.
- Staff were able to build relationships very quickly with CYP and their parents and families. For example, in day surgery where staff were able to support the child and parent and ensured they (both) understood the procedure.
- Children and parents told us they were supported by nurses and consultants if they were worried about their test results and were given the necessary time and support they required. We observed throughout the inspection how nurses and consultants provided emotional support to parents, families and CYP. A parent said, "The nurse held my hand throughout my child's procedure and answered any questions I had which was very reassuring". Another parent said, "I have been reassured by the nurses and consultants involved in my child's care throughout the hospital which has really made me feel supported and cared for and exceeded my expectations".
- Children and young people attending pre-assessment were shown the type of equipment that would be used when they were admitted to the hospital. For example, syringes, cannulas and blood pressure cuffs. Younger children had the equipment demonstrated on a toy and were able to familiarise themselves by playing with the equipment.

- Children were told the cannulas would not hurt as local anaesthetic cream (magic cream) would be applied in advance. However, feedback from the children's survey showed that some children experienced pain despite the use of the anaesthetic cream, and others said it did not hurt at all.
- Children and young people requiring day surgery were accompanied by a parent to the anaesthetic room and stayed with them until they were asleep. This ensured parents were able to continue to provide emotional support for their child. Parents were able to see their children in the recovery area as soon as they were awake to provide reassurance and support.

Understanding and involvement of patients and those close to them

- Children and parents were actively involved in care and treatment and their views were considered when planning care. This was evident throughout all departments and older children were given the opportunity to speak to clinicians without their parents being present. A young person told us they were asked questions by the nurse and the doctor at their outpatient appointment and were encouraged to answer for themselves although their parents were present. The young person said they had been involved in planning their future care plan and felt they were listened to whenever they attended the hospital.
- Children and their parents we spoke with felt well informed about their care and treatment and were kept informed of changes to their child's care by the multidisciplinary team. For example, parents told us the doctors (surgeon and anaesthetist) had come to tell them what had happened during their child's surgery. Children and young people attending for day surgery received comprehensive information in a clear and simple format before admission. It detailed what they should expect at their admission and facilities available for them to use. It also included information about anaesthesia and their hospital stay and discharge arrangements.
- A child told us, "I got to see the mask (for the anaesthetic) and I was told everything about my operation so I knew what was going to happen".
- All parents we spoke with told us how they were fully involved in the assessment, planning and delivery of the care and support to their child throughout hospital experience. Parents attending the pre-assessment service praised the nurses on how they felt engaged with their child during the pre-assessment process. Nurses addressed the fears and concerns of each child (where appropriate) so children knew what was going to happen to them. For example, a child described to us their treatment plan in great detail and knew what was planned for them on their day of surgery and what would happen in the coming weeks.
- Parents told us they were 'listened to' and their views and opinions were always considered when their child's care was being reviewed.
- Staff minimised emotional distress to children by encouraging parents to lie or sit beside their child to distract them whilst waiting for their procedure. Parents were encouraged to accompany their children to the anaesthetic room and stay whilst their child was anaesthetised. We saw a parent lying on their child's bed and holding them when they returned from theatre. This demonstrated staff had communicated with the parent and were involving them in the care of their child.
- Children were able to keep their comforters, for example their favourite toys with them before theatre and in the anaesthetic room. In the recovery room we saw comforters beside the child in preparation for them waking up from anaesthetic. A distraction box from the ward accompanied the child to theatre and used by the nurses as required.
- We observed nurses walking parents back from the anaesthetic room, talking to them and giving them information about how long their child was likely to be in theatre.

Are services for children and young people responsive?

Good

Service delivery to meet the needs of local people

- At our previous inspection children and young people's (CYPs) services were not always responsive to the needs of patients and were rated as inadequate. During this inspection we saw the service provided reflected the

needs of the population they served and ensured flexibility, choice and continuity of care. CYP accessed the following services in the hospital: outpatients, pre-assessment the hospital ward for day cases, theatres and physiotherapy.

- The service did not undertake acute or emergency surgical admissions for CYP.All surgical interventions were undertaken as day cases. The hospital had no critical care facilities and CYP were screened at pre-assessment to ensure the hospital had suitable facilities to treat them. A service level agreement was in place with the children's acute transport service (CATS), if the condition of a CYP deteriorated and they required an urgent transfer to an NHS acute hospital.
- All CYP attending the hospital were overseen by the lead paediatric nurse (LPN) and the booking team. This ensured all aspects of a patient's requirements were assessed and considered before booking a patient onto a surgical list or into an outpatient clinic.
- Consideration had been given regarding the risks presented to CYP sharing the same facilities as adults. Children and young people on the ward were cared for in single en-suite rooms with facilities for parents to stay with them. The LPN had allocated four designated adjacent rooms for CYP undergoing day case surgery. The designated area had been risk assessed in 2017 and adaptations had been made to the environment. For example, secure doors on the entry/exit to the CYP ward and key pad locks on treatment rooms and offices.
- Younger children were able to access a play area on the ward which had recently been upgraded as part of the dedicated paediatric facilities available at the hospital. Children, their parent's and families had been involved in planning the new facilities and we saw where children's requests for specific equipment had been met. For example, 'hop scotch' mats on the floor and wall displays children could draw on. Two large toy cars were stored in the play area for children who wanted to drive themselves to theatre for their procedure rather than walking or being transferred on a hospital bed.
- There was no designated waiting area in outpatients for CYP and where possible patients were seen at the start of clinics. A limited supply of toys was available and older children were able to access WI FI. Weekly safety checks were undertaken on the (14) outpatient consulting rooms to ensure the environment was safe and suitable for CYP. For example, window closures on all windows, a cleaning policy for toys and cleaning materials were stored in locked cupboards. This demonstrated the hospital had taken steps to ensure areas where CYP were treated were safe and suitable for the age group.
- Children and young people attending day surgery received comprehensive information in a clear and simple format before admission. It detailed what they should expect at their admission and facilities available for them to use. It also included information about anaesthesia and their hospital stay and discharge arrangements.
- Faculties were available for parents and relatives in the outpatient and ward area of the hospital. Parents were able to access a vending machine for drinks and snacks in the outpatient area and toilets had nappy changing facilities. Staff told us parents would be allocated an empty consulting room for breast feeding if it was required.
- Staff said the hospital worked closely with other paediatric health services. For example, GPs and health visitors.

Meeting people's individual needs

- The individual needs of CYP were assessed by the LPN and the paediatric team. CYP with complex needs were supported by staff to access the hospital facilities. For example, access for CYP who were in a wheelchair or with a learning disability. This was to ensure the safety and wellbeing of CYP.
- At our previous inspection not all patients were pre-assessed in line with the hospital policy and discharge checklists were incomplete. During our inspection we saw patients undergoing a general anaesthetic, endoscopy or local anaesthetic attended the paediatric nurse led pre-assessment clinic before their surgery. The National Institute of Health and Care Excellence (NICE) guidelines were used to assess patient's anaesthetic risk at pre-assessment. The service had strict admission criteria and did not admit patients with complex co-morbidities. We reviewed the notes of ten patients and all patients had a completed pre-assessment checklist.

- We saw a child had chosen a particular toy when they had attended the pre-assessment clinic. On admission to the ward for day surgery the paediatric nurse had placed the toy in the child's room. The child was delighted and provided reassurance to the parent that the child had been listened to and their choices met.
- The LPN told us when children under 12 years of age attended an outpatient clinic, a registered children's nurse was required to be on site and depending on the type of clinic, would be in attendance to provide support and guidance. Otherwise the child would be chaperoned by outpatient staff who had undertaken the hospitals children's competency training required by all staff caring for CYP in adult areas.
- Parents and CYP told us they were given detailed explanations about their admission and treatment. Parents said age appropriate language was used by doctors and nurses to explain procedures to their child and pictures and toys were used to help in explanations to younger children. In addition, there were information leaflets for a range of conditions and to support care given. These were written in English but could be obtained for other languages. However, there was no written information for younger children in an 'easy read' format. The LPN told us there were plans to develop a pathway leaflet for children from admission to discharge and parents and children would be involved in the development.
- The hospital's Patient-Led Assessment of the Care Environment (PLACE) audit 2017 had recently included parents in the assessment process. Children and parents told us the quality of the food was good and many children commented on how much they 'enjoyed' the meals. Parents were able to order from a day case menu while their child was in hospital.
- Children and young people had access to drinks by their bedside. Staff checked that regular drinks were taken where required. We saw water dispensers on the ward for patients and relatives use.
- On the ward, each designated room (four) was decorated in a child friendly way. Each room had age appropriate bed linen and younger children were given their own hospital bear that was waiting for them on their admission to the ward. CYP were encouraged to take their favourite toys into hospital. Older children were able to access WI FI and television during their hospital stay.
- Discharge planning started at the patient's pre-assessment appointment so any specific needs were identified and planned for. All CYP remained under the care of the consultant for their care episode. The hospital provided a 48 hour follow up service and we observed the paediatric nurse contacting the families of CYP who had undergone a surgical intervention the previous day. We saw the outcomes of the follow up service recorded in patient's notes which was not in place at our previous inspection. We reviewed the notes of ten patients' and saw all discharge checklists were complete.
- Further developments were being planned as part of the CYP vision and strategy to extend the service from a short stay day service to a long stay (overnight service).

Access and flow

- Processes were organised for care and treatment to be provided by the hospital in a timely way. General paediatric outpatient care assessed children from early infancy to 18 years of age with symptoms across the general paediatric spectrum. Commonly managed problems included, feeding difficulties, respiratory complaints (asthma, chronic cough, and exercise limitation), congenital and acquired heart disease, gastrointestinal and neurological symptoms. Child development was assessed up to the age of two years. All CYP were treated privately.
- A number of treatments were offered for children and teenagers over three years of age. These included, ear, nose and throat (ENT), urological problems, audiology, general paediatric surgery and dental surgery. Children were seen from the age of three to18 years unless assessed to be treated on the adult pathway (between the ages of 16 and 18 years) by the paediatric team.
- Patient's had timely access to initial assessment and treatment through a private paediatric referral pathway at the hospital. The booking system was conducive to meeting patient's needs. Patients/parents could select

times and dates for appointments to suit their child's school commitments or the child's family. Appointments could be before or after school and between school terms.

- A parent told us "The first appointment my child was given was not convenient so I spoke to the receptionist who accommodated my child's needs and made the appointment at the end of the school day".
- Parents told us throughout the inspection there were minimal waits to get an appointment for outpatient clinics. If there were delays on arrival parents and young people were notified. We observed there were no waits throughout the inspection.
- There were 104 children under two years of age, 957 children between the ages of three and 15 years and 275 young people between the ages of 16 and 17 years who attended outpatient clinics in the period February 2017 to January 2018. There were 140 CYP between the ages of three and 17 years who underwent day case procedures.
- The LPN told us if a child did not attend (failed to be brought) for an outpatient appointment they would be advised and contact would be made with the child's parent to identify the reason for a non-attendance. If concerns were identified or it was not possible to contact the parent by telephone, a letter would be sent to the parent and copied to the GP and health visitor.
- When procedures had to be cancelled or were delayed, this was recorded as a clinical incident and appropriate actions taken. In the period from February 2017 to January 2018, one procedure was cancelled as the patient became unwell on the day of surgery. Cancellations were rescheduled as soon as possible in discussion with the LPN and the paediatric team, the CYP and their family.
- Day theatre lists for CYP were planned weekly by the LPN, the theatre manager and the booking team for a maximum of four CYP. Day theatre lists were shared with adults so all CYP were allocated the first slots on the list. Criteria was in place to ensure that CYP recovered from the anaesthetic by 4pm to allow them to go home at a reasonable time. All operating dates were published in advance to ensure the safe planning of CYP surgical lists. This ensured the hospital was compliant with the Royal College of Nursing guidance and standards which state a minimum of two registered children's nurses should be on duty throughout the time children are cared for. The physiotherapy lead told us they supported the care of CYP and received referrals from consultants which were triaged by the clinical services manager. The LPN liaised with the service following CYP pre-assessment to ensure appropriate equipment was made available following surgery.

Learning from complaints and concerns

- The hospital had a clear process in place for dealing with complaints. There was a complaints policy in place and staff we spoke to were aware of the complaints procedure. We saw information on how to make a complaint in the reception area of the hospital.
- If a child, young person, parent or carer wanted to make an informal complaint they would be directed to the LPN or a senior staff member. Patients would be advised to make a formal complaint if their concerns could not be resolved informally.
- There were no complaints reported in the CYP services in the previous 12 months.

Are services for children and young people well-led?

Good

Leadership

- The service had managers at all levels of the service with right skills and abilities to run a service providing high-quality sustainable care. BMI Three Shires Hospital was led by an executive director, a director of clinical services, a manager of operations and a quality and risk manager. All the heads of department reported to one of these four leaders.
- At our previous inspection children's services were rated as being inadequate with regards to being well-led. There was no one person who had clear responsibility for leading the service for CYP. Children's services were now led by a full time equivalent (FTE) lead paediatric nurse (LPN) who planned for and oversaw the care of

children and young people (CYP) in all departments of the hospital. The LPN was based on the ward which had a dedicated consulting suite that was designed and age appropriate for CYP and paediatric users.

- The LPN was qualified in European paediatric advanced life support and was supported by a named consultant paediatrician. There were two other consultant paediatricians with practising privileges if additional support was required.
- Nurses, consultants and support staff told us the LPN had raised the profile of children's services and was recognised as being the clinical expert in matters relating to CYP. Staff told us the LPN visited the areas where children were treated daily and oversaw all paediatric admissions to the hospital. All staff told us the LPN was visible and accessible in the hospital should they require advice and support in relation to any CYP undergoing treatment.
- At department level staff in children's services reported to the LPN who reported to the director of clinical services. All staff felt they could be open with colleagues and managers and were able to raise concerns and felt they would be listened to. Staff said any inappropriate behaviour would be dealt with immediately.

Vision and strategy

- The hospital had a vision for what it wanted to achieve and workable plans to turn it into action developed with involvement from staff, patients and key groups representing the community. The hospital's five-year vision 2015-2020, was to deliver the best patient experience in the most effective way where people, patients, communication, growth, governance, efficiency, facilities and information were at the heart of developing their core business.
- At our last inspection there was no vision or strategy for the service. There was now a service vision and strategic objectives had been mapped to the hospital vision and adapted for children's services.
- The CYP advisory group supported the implementation of the strategy for CYP 2015-2020 and was chaired by the LPN and the named consultant for paediatrics. The group had hospital wide representation and met quarterly. A work plan monitored changes to children's services. For example, ensuring all staff that cared and supported CYP in the hospital had undertaken the children's competency training programme and a child centred family environment for the whole of the patient journey. We saw a pre-assessment pathway for all CYP was in place which included face-to-face pre-operative assessments and a tour of the area they would be admitted to help reduce anxiety, and follow up telephone calls from the consultant and paediatric nurses following discharge.
- Staff in the children's service had been involved in the development of the service strategy and were proud to share the developments undertaken and plans for the future of CYP services.

Culture

- Staff spoke positively about working in the hospital and described a culture that was open and friendly with an emphasis on delivering high quality care to adults, children and young people.
- All staff told us the senior management team were approachable and visible and they saw the executive director and service managers every day.
- We saw the culture of all the areas we visited during our inspection centred on the needs and experiences of CYP and their families. For example, if a mistake happened this was handled in a sensitive and open way. The LPN and named consultant paediatrician promoted a culture of 'child centred' care and staff across the hospital told us they were proud to be involved in promoting the needs of children and would recommend the service to their own family and friends.

Governance

- At our previous inspection we saw governance processes had a focus on risk and quality but the Business Plan 2014/15 did not identify objectives for CYP services. During our inspection we saw strategic objectives for CYP services were included in all hospital planning documents. This meant the delivery children's services were an integral part of hospital performance.
- The hospital held meetings through which governance issues were addressed. The meetings included, clinical governance meetings, medical advisory committee,

heads of department meetings, infection control and medicines advisory committee. All meetings had reprentation from the LPN or the named paediatric consultant.

- The service had clear governance systems in place. The LPN and the named paediatric consultant chaired the paediatric advisory group which was attended by supporting departments and monitored the delivery of children's services across the hospital. For example, ensuring all CYP are booked under the appropriate patient pathway and paediatric patients are recorded separately on information systems, learning is shared across children's services from incidents, complaints and patient and parent feedback, and policies are maintained in line with corporate directives.
- The Heads of Department met monthly and the minutes showed items discussed included complaints, clinical governance, audit results and key departmental feedback. These meetings also shared staff experiences and information was shared back with staff in departments.
- Heads of department identified training needs with staff through appraisal and the BMI training academy. Staff in children's services told us that due the small numbers in the service (three) it was sometimes difficult to release staff to attend face-to-face training.
- Children's services were audited in line with the hospitals governance policy. For example, patient documentation, infection control and pain management audits to ensure continuous monitoring and enhancement of the quality of care delivered to CYP.
- The LPN was a member of the BMI CYP national steering group and had developed links with the Royal College of Nursing (RCN) to further develop children's services at the hospital.
- The LPN was trained to safeguarding level four and attended the local safeguarding children's board meetings held at the hospital.

Managing risks, issues and performance

- During our last inspection there were no risks identified for children's services on the risk register. During our inspection we identified risks to CYP had been identified and were recorded on the children's service risk register. One risk had been recorded which related to providing a secure environment for the care of children on the ward. This had required the installation of security doors which had been achieved. The risk continued to be monitored by the service and had been removed from the departmental and hospital wide risk registers. During the inspection we identified two risks not recorded on the risk registers; the BMI policy for children's services (September 2017) which required two paediatric nurses (currently one paediatric nurse) to be present when a child received a local anaesthetic for a minor procedure in the day unit. The service was in the process of recruiting additional appropriately qualified staff to mitigate the risk. The second risk was the care of CYP sharing the same facilities as adults. The service had made adaptations to the shared recovery area in theatre but the area still posed a risk and needed to be recorded on risk registers. However, although the service and the hospital were aware of the risks to CYP they were not recorded on risk registers.
- At our previous inspection CYP were not identified within completed audits. This meant we could not be assured that risks assessed, monitored and mitigated against. During the inspection we saw CYP were included in the annual audit timetable. For example, CYP audits into infection control, pain and patient documentation.
- At our previous inspection there was no system in place to support nursing staff supervision. During the inspection we saw clinical supervision was in place for paediatric nurses and the LPN had three monthly safeguarding supervision with the safeguarding lead for the local clinical commissioning group.
- The executive director held daily 'safety huddles' which were attended by representatives from all of the service departments to identify issues that could impact on the delivery of patient services. For example, staffing levels, patient dependency, availability of beds and patient safety incidents.

Managing information

- There were clinical and non-clinical systems in place that captured areas such as incident reporting which directly contributed to the quality of patient care through the identification of themes and trends which helped in the development of safer working practices.

- Audits were used by the service to ensure CYP services continually improved patient care in line with patterns of incidents and clinical data outcomes. An audit timetable was in place and the outcomes of audits was discuss at the CYP advisory group and actions were agreed and recorded in the minutes and shared with staff in the children's service and at heads of department meetings.
- Staff in the CYP service had access to up-to-date accurate and comprehensive information on staff training records. Staff were aware of how to use and store confidential information. We reviewed staff information on mandatory training compliance figures in June 2018. This showed that all staff (three) were compliant with their mandatory requirements and had scored 96% which was above the hospital target of 90%.

Engagement

- During our previous inspection we identified CYP were not engaged through survey feedback and managers were in the process of introducing a "smiley face" questionnaire for the service. During our inspection we reviewed 36 CYP questionnaires from the period January to June 2018. All responses from CYP were very complimentary about the service and reported 'how wonderful' the nurses and the food were.
- Parents completed the Family and Friends questionnaires on the quality of care and the service and to identify if they would recommend the service to their friends and family. All responses from the period January to June 2018 (34) reported they were 'highly likely' or 'likely' to recommend the service.
- Parents were also involved in the patient led assessment of the care environment (PLACE) audits.
- The LPN used the results of the survey to improve the service and the development of the paediatric consultation suite had involved patients and their parents in the design, decoration and provision of appropriate toys and equipment.
- We observed the corporate BMI 'Reward and Recognition' scheme had been introduced, and each month an employee would be nominated to receive reward recognition for going above and beyond their normal duties.
- Other staff recognition schemes included service recognition awards for staff who had worked at the hospital for five, ten, 15, 20 and 25 years.

Learning, continuous improvement and innovation

- There was a culture of continuous staff development in the children's service. Staff training folders identified a wide range of in house and external training courses completed by staff. Staff told us they were supported by the LPN to undertake professional development opportunities to support them in their roles.
- At our previous inspection there was no monitoring of registered nurse skills and competencies which had led to staff with no paediatric training caring for children. We saw training had been developed to improve outcomes for CYP, such as emergency scenarios and identification of the deteriorating child (PEWS) for adult trained nurses. Nurses and support staff had completed Intermediate Life Support (ILS) training for children to enable them to respond appropriately in an emergency.
- All staff involved with the care of children were required to undertake the children's competency framework to improve the outcomes for CYP. The LPN had been supported by two practice educators in the delivery of face-to-face training sessions, clinical assessments of practice and ongoing support to staff to complete the competency work books. All areas for example, outpatient services, theatres and recovery where children were cared for, were recorded on a register for 2018 as completing the children's competency framework.
- Mentorship training was in place and student nurses were undertaking a five-week placement in the children's service. Feedback from a student nurse praised the care of children and their parents and thanked the staff for the personal support they had received from their mentor who had gone above and beyond to support them in their first clinical placement.
- Records we saw indicated that opportunities to improve children's services were acted upon whenever possible. For example, using audit, comments from CYP and their families and visiting other providers and views of staff members. The LPN was undertaking a programme of

Good

Services for children and young people

visits to other BMI providers and the NHS to enhance their knowledge and skills of paediatric services and support the development of new services at the hospital.

Good

Outpatients and diagnostic imaging

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

Are outpatients and diagnostic imaging services safe?

Good

Mandatory training

- Staff received effective mandatory training in safety systems, processes, and practices. Staff told us they had completed mandatory training, which was delivered either face to face or by e-learning. It included topics such as safeguarding for adults and children, Mental Capacity Act 2005 (MCA) deprivation of liberty safeguards (DoLS), infection prevention and control, manual handling, fire safety, information governance, and consent. A mandatory training matrix was in place which detailed the training course, the frequency of the training and which roles it was applicable to.
- Staff knew how to access mandatory training and told us they could find out when they were next due for an update. Staff spoke positively of mandatory training modules and felt able to access further assistance if required. Staff were confident they would be supported to attend additional training if required.
- Data provided by the hospital showed compliance for mandatory training in the outpatient and physiotherapy department was 100%. The target set by the hospital for completion rates was 100%.
- To encourage staff to remain up to date with their mandatory training, their annual incremental pay rise was dependent on them being up to date with their mandatory training.

Safeguarding

- The hospital had safeguarding policies and procedures available to staff, including details of who to contact in the event of a safeguarding concern. Staff we spoke with understood their responsibilities and were aware of the safeguarding policies and procedures.
- Staff were able to name the safeguarding lead for the organisation. Staff told us that the safeguarding lead was very proactive and always available for help and advice.
- During our last inspection, we could not be fully assured that staff would be able to protect vulnerable patients. However, during this inspection we found staff demonstrated a good understanding of safeguarding vulnerable children and adults at risk.
- Staff were able to describe what would constitute a safeguarding concern and the action they would take to raise concerns. Staff also showed an awareness and understanding of recognising female genital mutilation (FGM).
- All staff we spoke with told us they had completed safeguarding training for adults and children. Safeguarding training data showed that 100% of staff in outpatients and physiotherapy, including medical staff, had received safeguarding training levels one and two. In addition, 100% of staff working with paediatrics were level three safeguarding trained.
- Visitors to the hospital were required to sign in and wear a visible identification badge. This made sure patients and staff were protected from unauthorised personnel.

Cleanliness, infection control and hygiene

Good

Outpatients and diagnostic imaging

- The service controlled infection risk well. Staff kept themselves, equipment and the premises clean. They used control measures to prevent the spread of infection.
- Effective standards of cleanliness were maintained across outpatient areas and physiotherapy, with reliable systems in place to prevent healthcare-associated infections.
- We found the outpatient department and physiotherapy waiting areas were visibly clean and dust free. Consultation rooms and equipment, including the physiotherapy gym, were tidy and clean. This is an improvement from the last inspection when we were unable to see clearly when equipment was last cleaned.
- There were specific environmental daily cleaning schedules in place throughout all outpatient and physiotherapy areas. We were told that domestic staff clean all areas daily, and nursing staff clean between patients. We noted that cleaning schedules were all signed and dated to evidence regular cleaning took place. We saw clean equipment and examination couches were labelled with dated 'I am clean' stickers so staff knew the items were clean and ready for use.
- During the last inspection, not all the environment was maintained in accordance with Department of Health guidance (Health Building Note (HBN) 00-09: Infection Control in The Built Environment). During this inspection, we saw that flooring in clinical areas, sinks and taps in outpatients and physiotherapy complied with relevant HBN requirements. This was in line with the HBN 00-10 regulations that consider floors should be washable, and have curved edges to prevent bacterial growth.However, we did note carpet was present on a small section in the general waiting area in outpatients. Staff informed us that nursing staff would be responsible for clearing any spillages such as bodily fluids or blood in the first instance, if this were to occur. Domestic staff would then steam clean the area. Staff told us carpets are highlighted as a risk and the plan was to remove all carpeted areas in the future.
- Staff had received training about infection, prevention, and control (IPC) during their initial induction and part of their mandatory training. Data provided by the hospital showed that as of June 2018, 100% of staff across outpatient services and 100% of physiotherapy staff had completed their IPC training. This meant we were assured staff had up to date infection prevention and control knowledge.
- There were reliable systems in place to protect and prevent people from healthcare-associated infections. Data confirmed there had been no cases of hospital acquired MRSA, Methicillin-sensitive Staphylococcus aureus (MSSA), Clostridium difficile (C. difficile) or E.Coli in the reporting period January 2017 to December 2017.
- We noted that there were handwashing facilities and hand gel dispensers in every treatment room in the outpatients and physiotherapy departments. Hand washing technique information posters were displayed above each sink and on staff noticeboards.
- We noted paper towels were readily available in areas where people wash their hands.
- We saw that staff followed the hospital policy regarding hand hygiene and infection control. This included staff being 'arms bare below the elbow'. We did not have the opportunity to observe many occasions of staff hand hygiene, however, of the two consultations we did observe, both followed the hand hygiene protocol.
- We saw hand gel dispensers located at the entrance of outpatients' department and physiotherapy unit. However, we did not see posters displayed promoting and encouraging hand hygiene for visitors.
- Hand hygiene audit results from May 2018 showed that there was 100% compliance with hand hygiene techniques in the outpatients' department and 97% compliance in the physiotherapy department.
- We noted that personal protective equipment (PPE) such as gloves and aprons were available in sufficient quantities and was readily available in each consulting and treatment room. This was an improvement from our last inspection when we found that not all consulting and treatment rooms had the required personal protective equipment.
- The examination couches seen within the consulting and treatment rooms were clean, intact and made of wipeable materials. This meant the couches could easily be cleaned between patients.

- Disinfectant wipes were available in the outpatients and physiotherapy departments to wipe down treatment couches between patients. We also noted white paper rolls were used on examination couches and changed between patients.
- Although there were no designated waiting areas for patients with communicable or infectious diseases like diarrhoea, tuberculosis or seasonal flu, staff informed us that these patients would be seen in a separate treatment room, which would be deep cleaned after use.
- We observed that disposable curtains were in use around areas that contained patient treatment couches. These were dated with the date on which they were last changed. We noted that all curtains we checked had been changed within the last month, in line with hospital policy.
- We noted that there were several sharps disposal bins located in outpatients and physiotherapy departments. We saw that sharps bins were emptied every three months as a minimum, in line with hospital policy. Sharps disposal bins were washable and were managed by an external organisation, who provided a specialist waste disposal and collection service. We were assured that sharps were disposed of safely.
- We saw waste was separated and in different coloured bags to signify the different categories of waste. This was in accordance with the Health Technical Memorandum (HTM) 07-01, control of substance hazardous to health (COSHH), health, and safety at work regulations.
- We observed good waste management processes with offensive and hazardous waste bags being readily available and regularly disposed of.
- We noted that there was a biohazard spill kit (containing the relevant equipment to manage blood and other bodily fluid spillages), which was easily accessible and in date. There was a secure cupboard for storage of chemicals in line with control of substances hazardous to health (COSHH) regulations.
- We noted there was a good decontamination process and defined cleaning pathway in place for naso-endoscopes. Staff we spoke with told us all naso-endoscopes were sent for decontamination through a washer-disinfector, at the end of clinic each day. This was fully compliant with HTM 01-06 part A-E: safe management and decontamination of nasoendoscopes.
- Naso-endoscopes were appropriately tracked and traced, in line with best practice. Once a scope was used on a patient, the unique identifying number was recorded in a logbook and in the patient's notes. This allowed identification of patients who may be affected if cross-infection occurred.

Environment and equipment

- The service had suitable premises and equipment and looked after them well.
- The outpatient service had 14 individual consulting rooms, a dirty utility room and an outpatient waiting area. All consulting rooms we saw each had a couch area for procedures, appropriate hand wash and hand sanitiser facilities, personal protective equipment dispensers, pocket masks for resuscitation, emergency call bells and chaperone posters on display. All consulting rooms we saw were lockable and were equipped with a desk and chairs for discussions with patients.There were three toilets in the outpatient department, including one disabled toilet, for use by male and female visitors which we saw was clean and regularly inspected for cleanliness.
- The physiotherapy department consisted of a gymnasium and four treatment rooms, including a hand therapy room. The department was tidy and well equipped with handwashing and hand sanitisation facilities. There was a reception area by the entrance which was manned by a receptionist and provided a waiting area for patients attending a physiotherapy appointment.All equipment we checked was within its expiry date.
- During our inspection, we did not see any equipment, such as specialist chairs or couches, for larger patients. However, staff told us bariatric equipment could be obtained from the ward area if required.
- We noted that all patient furniture in both the outpatient department and physiotherapy unit, such as chairs and couches, was in a good state of repair and was compliant with HBN 00-09 (that is it was fully wipeable).

- Most equipment we observed had evidence of electrical safety testing where appropriate. However, we saw an extension cable in one of the consulting rooms where this had expired in November 2015.Electrical safety testing on two computer cables we saw had also expired in November 2015.
- The outpatient manager told us some of the equipment used in the outpatient department, such as the ultrasound machine, belonged to consultants and remained onsite. They explained that the consultant is responsible for ensuring their equipment was maintained. Copies of records evidencing that the equipment had been maintained and calibrated had been received as required and kept with the consultant's practising privileges. The granting of practising privileges is a well-established process within independent healthcare whereby a medical practitioner is granted permission to work in an independent hospital or clinic, in independent private practice, or within the provision of community services.
- There were sharps disposal bins available in all the consultation and rooms and we noted the bins were correctly assembled, labelled, and dated. None of the bins were more than half-full, which reduced the risk of needle-stick injury. This is in accordance with HTM 07-01: Safe management of healthcare waste.
- There was a service level agreement with the local acute NHS trust for the decontamination and maintenance of equipment. Staff reported that equipment was usually returned to the department promptly, and stated they had sufficient equipment to meet the demands of the service.
- Fire extinguishers were visible and dated. Staff we spoke with explained the evacuation procedure and told us that they regularly attend fire prevention updates.
- We inspected resuscitation trolleys, one adult and one paediatric, in the outpatient department, which were located in the main waiting area. Physiotherapy staff had access to an adult resuscitation trolley, which was located in the endoscopy corridor. A paediatric resuscitation trolley was located in main theatres recovery area. Physiotherapy staff told us that the trolleys and equipment could be accessed in a timely manner should it be needed.
- All resuscitation trolleys were locked and there was evidence of appropriate daily and weekly checks in line with hospital policy. This is an improvement since our last inspection where we found inconsistencies in checks of resuscitation trolleys.
- All drawers had correct consumables and medicines in accordance with the checklist. We noted consumables were in date and trolleys were clean and dust free. The automatic electrical defibrillator worked and suction equipment was in order. During our last inspection, we found several items of equipment were stored incorrectly on the trolley, and we were unable to determine how long equipment had been stored out of its packaging.

Assessing and responding to patient risk

- Systems and procedures were in place to assess, monitor and manage risks to patients.
- We saw that emergency call bells were located in all treatment rooms and areas in outpatients and physiotherapy. These sounded an alarm when activated, which triggered a 'crash' response from staff across the hospital so that an unwell or deteriorating patient could receive prompt assistance.
- The service always had access to a resident medical officer (RMO) who provided support to the outpatient and physiotherapy staff if a patient became unwell. Staff informed us that if a patient was to deteriorate whilst in the department, the RMO would be called to assess the patient. Nursing and physiotherapy staff could provide examples of actions taken when a patient had become unwell in the department. This meant in the event of a patient becoming unwell, appropriate action was taken to assess and respond to the patients' needs without putting them at risk of deterioration.

Nurse staffing

- An electronic rostering tool was used across all departments in line with the BMI rostering policy to ensure safe staffing levels. The outpatient department planned staffing levels four weeks in advance.
- The outpatient department manager told us that there were safe staffing levels in the department and that there was a full establishment of staff in post. Data provided by the hospital showed that there were 6.4 whole time equivalent (WTE) registered nurses in post

and 3.9 WTE health care assistants. Hospital data showed that there had been no agency staff use for registered nurses or health care assistants from February 2017 to January 2018.The outpatient manager told us that any shortage in staff was covered by regular in-house bank staff who were familiar with the service. This meant patients could be assured that staff were familiar with the service provided and the needs of the patients.

- All professional staff within the outpatient and physiotherapy department had their registration with their respective professional register checked as part of the hospital's recruitment process.
- Data provided by the hospital showed staff sickness in the outpatient department, as of January 2018, was reported at 0.7% for nursing staff, and 3.9% for health care assistants.
- In the physiotherapy department, there was a team of 10 physiotherapists, two hand therapists and two bank staff who worked weekends, who were led by a physiotherapy manager.

Medical staffing

- Medical staff practising within the outpatient department had their registration with the General Medical Council verified as part of the hospital's recruitment process. Most consultants employed at the hospital held substantive posts in neighbouring NHS trusts.
- There were a total of 142 medical staff employed within the hospital under practising privileges rules. These staff worked across the outpatient department and inpatient wards. In the outpatient department, medical staff delivered clinics for specialties, which included orthopaedics, general, gynaecology, urology, ophthalmology, ENT, dermatology, neurology, plastics, maxillofacial, cardiology, gastroenterology, respiratory, rheumatology, and neurology.
- Consultants attended the outpatient department on set days at set times. This meant the department knew in advance of which consultant was attending and was able to allocate nursing staff appropriately to the clinics.
- The RMO provided a 24 hour a day, seven days a week service on a rotational basis.

Records

- Staff kept appropriate records of patients' care and treatment. Records were clear, up-to-date and available to all staff providing care.
- We reviewed 10 patient records and noted that all records were clearly written, legible, signed, and dated. In each set of records, the World Health Organisation (WHO) checklist, National Early Warning System (NEWS) score, patient medical history, consent and allergies information was completed. In addition, all records reviewed included a VTE, waterlow, MUST and falls assessment.
- During our last inspection, we found records were not stored appropriately which meant patient identifiable data was not protected at all times. At this inspection, we saw that patient's records in all departments were stored securely.
- Consultant patient records were stored in the medical secretary's office safely and appropriately in a locked cabinet.
- We noted the hospital had recently introduced a new medical record service for outpatients. Historically medical records for private patients were held by consultants' medical secretaries. NHS patient records were held by the medical records team and were available for initial consultation. Staff told us the new service ensured the same standard of record keeping for all patients and included but was not limited to; referral letter, health questionnaire, notes from outpatient appointment and direction from consultant as to next steps. If a patient was subsequently admitted, the outpatient record was incorporated into the admission record.
- Patients medical records were always available for their clinic appointments. Data requested from the hospital confirmed that from July 2017 to June 2018, there had been no incidences when a patient had been seen in the outpatients without a medical record. Staff were aware of the process to request medical records in the event that they were not available when a patient arrived for their appointment.
- Staff we spoke with told us that hospital medical records were not to be removed from site by a consultant. Consultants had their own medical records,

for private patients, which their medical secretary would store. The outpatient services manager confirmed that consultants were encouraged to keep medical records on site and were required, as part of their practising privileges, to evidence their Information Commissioner's Office (ICO) registration.

Medicines

- Arrangements for managing medicines in outpatient services were suitable to ensure patients were kept safe from avoidable harm.
- We found no controlled drugs being stored within outpatients or physiotherapy. A controlled substance is generally a drug or chemical whose manufacture, possession, or use is regulated by a government, such as illicitly used drugs or prescription medications that are designated a Controlled Drug in the United Kingdom.
- During our last inspection, we found FP10 prescription pads were not stored appropriately. We noted during this inspection, that the hospital use private prescriptions and not NHS prescription pads (FP10s).Procedures were in place for the safe storage and use of private prescriptions. These were used by consultants when prescribing individual patient medicines. The service kept a log of each prescription for audit and tracking purposes. The process for management of prescriptions was safe.
- Patients used the hospital pharmacy to obtain their medication, which was located on the ground floor next to the outpatients department. Pharmacy opening times were Monday to Friday, 9am to 5pm.
- All the medicines we inspected were within their expiry dates and records showed that the fridge temperatures were maintained within the required temperature for the safe storage of medicines, between 2 and 8°C. We saw that fridge temperatures were monitored daily and recorded.
- All medicines cupboards and fridges were clean and tidy. The medicines refrigerators, which were used for the storage of items such as single dose units of eye drops, were kept locked.
- We saw evidence that room temperatures were taken and below the recommended 25°C. Staff told us that if the room temperature reaches above 25°C, pharmacy would be contacted and the incident would be recorded on the risk register. This meant medicines were stored in a safe manner.
- There were robust systems in place to ensure that medicines were safely managed and accounted for. Pharmacy staff regularly checked stock levels and had processes to monitor expiry dates.

For our detailed findings on medicines please see the Safe section in the surgery report

Incidents

- The service managed patient safety incidents well. Staff recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support.
- There were no never events in the reporting period from February 2017 to January 2018.Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.
- Data provided by the hospital showed there had been no serious incidents reported for outpatient services in the period from July 2017 to June 2018.
- During the period from January 2017 to December 2017, there were 97 clinical incidents and 42 non-clinical incidents reported within outpatient services. Actions to improve these were discussed at departmental meetings. There were no incidents reported which had resulted in patient harm.
- There was an electronic reporting system in place to allow staff to report incidents. There was a positive incident reporting culture in the department; all staff we spoke with had received training and were encouraged to report incidents. Staff knew how to access the system and their responsibilities to report incidents. Staff told us they were provided with feedback after reporting an incident and that learning from incidents was shared across areas through staff meetings, daily huddles and emails. Staff we spoke with in the outpatient

department told us information was shared through the monthly Clinical Governance and Risk Bulletin, which included lessons learned from incidents and action plans.

- All staff were able to give examples of when they have or would need to report an incident.
- When things went wrong, staff apologised and gave patients honest information and suitable support. Staff were aware of the duty of candour regulation and described how they applied the principles by being open and honest with patients at all times and admitted any mistakes. Staff could give us examples of where they had used this in practice or instances where they would use it. We spoke with the outpatient manager who gave us an example of how duty of candour principles were applied following an incident, where a blood sample was not labelled correctly, requiring the patient to come back for a repeat test. They explained how they contacted the patient, explained what had happened and apologised. The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support to that person, under Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At our last inspection, most staff we spoke with were unaware of what duty of candour meant.

Safety Thermometer (or equivalent)

- A patient safety thermometer was in place on the ward at the hospital and measured patient outcomes in relation to falls, pressure ulcers, hospital acquired infections and VTE assessments. There was no dedicated safety thermometer in place for outpatient services.

Are outpatients and diagnostic imaging services effective?

Good

Evidence-based care and treatment

- The service provided care and treatment based on national guidance and evidence of its effectiveness. Managers checked to make sure staff followed guidance.
- Specialities within outpatient services delivered care and treatment in line with the National Institute for Health and Care Excellence (NICE) and national guidelines where appropriate. Policies were up to date and assessed to ensure they did not discriminate based on race, nationality, gender, religion or belief, sexual orientation or age. Staff in outpatients and physiotherapy had a good awareness of policies and procedures. They were able to give us examples of how to find policies and when they had used them.
- There was a regular audit programme for all departments across the hospital. This included, but was not limited to, audit of health records, infection prevention and control, hand hygiene, pain management, VTE, WHO checklist and consent.Physiotherapy also had a programme of audits, such as audit of treatment records, discharge procedures, and outpatient procedures. We saw that there was good compliance with completion of these audits and that there were action plans in place.

Pain relief

- Pain relief was not routinely administered within the service as patients attended for a short period and usually took analgesia before attendance. Nursing staff we spoke with told us consultants would normally prescribe relevant pain medication for patients under their care, or the resident medical officer would prescribe analgesia if necessary.
- Patients we spoke with had not required pain relief during their attendance at the outpatient department.
- We observed a consultation in outpatients between a patient and a doctor where the patient's experience of pain was discussed using a numeric pain rating scale of zero to three.
- Staff we spoke with told us a visual analogue scale (VAS) would be used for patients who were unable to express their pain.

Nutrition and hydration

- We noted a hot drinks machine available in the outpatient department waiting area for use by patients attending for appointments.
- Water dispensers were available in waiting areas in both the outpatient and physiotherapy department.
- Staff we spoke with told us that patients were able to have diet and fluids if needed, and snacks could be provided to diabetic patients.

Patient outcomes

- The service monitored the effectiveness of care and treatment and used the findings to improve them. They compared local results with those of other services to learn from them.
- The outpatient and physiotherapy departments contributed to the hospital's corporate audit programme. This included audits of patient health records, infection prevention and control, hand hygiene, medicines management and consent.
- The outpatient department participated in the national Patient Reported Outcome Measures (PROMS) and in the National Joint Registry (NJR). Results were monitored and discussed at the hospital's clinical governance and medical advisory committees monthly, as well as at a regional and corporate level. Outcomes were benchmarked against other comparable services and, where poor outcomes were identified, actions were in place to improve performance.

Competent staff

- Staff were competent and trained to carry out their roles, meet the needs of patients and were supported to undertake training to enhance their knowledge and skills.
- The service made sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and monitor the effectiveness of the service. Staff we spoke with confirmed they had completed all mandatory training and competency assessments.
- The outpatient manager and physiotherapy manager kept records of the mandatory training staff completed.
- Throughout our inspection, we found staff received training to support the delivery of care and individual's developmental needs. The outpatient manager and physiotherapy service lead had been supported to complete an institute of management and leadership course (ILM).
- All hospital staff were supported to complete additional training available at the BMI corporate academy. A number of health care assistant's we spoke with were completing an assistant practitioner course that would provide a foundation degree qualification. They told us that there were no restrictions on study leave or eLearning.
- Staff told us they had records of the training they received which described the level of competency they had achieved. All staff we spoke with had a competency file.
- Staff told us they were supported and encouraged to develop. They said they were supported by their supervisors and managers and received regular one-to-one meetings.
- Outpatient and physiotherapy staff told us they received an annual appraisal, in addition to six-month reviews. This process was used to identify any learning needs for the next year.
- Evidence showed that at the time of inspection, outpatient and physiotherapy departments were on target and almost all staff had received an appraisal. Data received from the hospital confirmed that 99% of physiotherapy staff have received an appraisal and 98% of outpatient staff have received an appraisal.

Multidisciplinary working

- Staff in different teams worked together as a team to benefit patients. Doctors, nurses and other healthcare professionals, such as the breast care specialist, supported each other to provide good care.
- Staff we spoke with felt they had good working relationships with other colleagues, including consultants. For example, physiotherapy staff told us they worked closely with pre-assessment colleagues, hand therapists, pain consultant and orthopaedic consultants so patients received a timely and streamlined service.
- There was a strong multi-disciplinary team (MDT) approach across all the areas we visited. Staff of all

disciplines, clinical and non-clinical, worked alongside each other throughout the hospital. We observed good collaborative working and communication amongst all members of the MDT. Staff reported that they worked well as a team.

- Managers and senior staff in both the outpatient and physiotherapy department held regular staff meetings. All members of the multidisciplinary team attended and staff reported that they were a good method to communicate important information to the team.

Seven day working

- The outpatient department offered appointments Monday to Friday, 8am to 9pm.We were told that Saturday clinics could be arranged to manage waiting lists if necessary.
- Staff confirmed that when the outpatient department was closed and patients had any queries, for example regarding wound management, the RMO would be called to advise. The RMO provided a 24 hour a day, seven days a week service on a rotational basis.
- The physiotherapy department was staffed Monday to Thursday, 8am – 7pm and 8am-5pm on Fridays. In addition, there was a weekend rota to provide support to inpatients.

Health promotion

- We noted there were various information leaflets available in the main waiting areas for both the outpatient and physiotherapy departments. This included, but was not limited to, 'Physiotherapy – a guide for patients', 'Getting you back to fitness', 'Weight loss surgery', 'The reassurance of fast results', and 'Infection prevention and control'.

Consent, Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS)

- There was a hospital policy to ensure that staff were meeting their responsibilities under the MCA and Deprivation of Liberty Safeguards (DoLS).Staff said they had had training in MCA and DoLS as part of their mandatory training.
- Data provided by the hospital showed 100% of staff were up to date with training in consent, mental capacity, including deprivation of liberty safeguards, in both outpatient and physiotherapy departments.
- Staff in outpatients and physiotherapy told us they rarely encountered patients living with dementia or who lacked capacity. However, they were able to describe the process they would follow if they suspected a patient lacked capacity, and knew who to contact for further support or advice on this. This was an improvement from our previous inspection.
- We noted there were contact details for the hospital safeguarding lead and the local safeguarding team on display in the staff offices, so staff would know who to contact if they had any concerns.
- Nursing, therapy and medical staff understood their roles and responsibilities regarding consent and were aware of how to obtain consent from patients.
- Patient records we reviewed contained evidence of appropriate consent, where required.
- Patients told us that staff were very good at explaining what was happening to them before asking for consent to carry out examinations or procedures. All patients we spoke with felt their care and treatment was fully explained, and that they were given enough time to ask questions if they were not clear about any aspect of their treatment. They described having treatment options explained so that they were informed to make their own decisions.

Are outpatients and diagnostic imaging services caring?

Good

Compassionate care

- We spoke with 16 patients during our inspection and all spoke highly of the care and compassion they were shown by all the staff they encountered during their time in the hospital.
- Feedback from patients confirmed that staff treated them well and with kindness. One patient described staff as "very outgoing, very approachable, everyone is really helpful and kind". Another patient described staff as "very nice, friendly and professional".

Good

Outpatients and diagnostic imaging

- We saw that the reception staff greeted patients warmly and ensured privacy and confidentiality was maintained at all times.Patients we spoke with confirmed their privacy and dignity was respected when speaking to the receptionist.
- Staff introduced themselves and took time to interact in a considerate and sensitive manner.
- We observed caring and positive interactions with patients during their consultations. Discussions and examinations took place in the consultation rooms to ensure privacy. Nursing and medical staff used curtains around the examination couch and patients were covered up when sensitive examinations took place.
- Staff were friendly and helpful and responded sympathetically to queries in a timely and appropriate way.
- The hospital obtained patient feedback through the Friends and Family Test (FFT), which allowed patients to state whether they would recommend the service and give feedback on their experiences. The 'Patient Satisfaction Survey Hospital Report' for May 2018, provided by the hospital, confirmed that of the 283 FFT respondents using outpatient services, 91.2% would be 'extremely likely' to recommend the service and 8.5% of patient were 'likely' to recommend the service.

Understanding and involvement of patients and those close to them

- Patients we spoke with said that they had received good information about their care and treatment and had been involved in decisions about their care.
- Patients attending the outpatient and physiotherapy department were offered chaperones for examinations. The hospital had a chaperone policy and we noted the service was advertised on the department walls.
- Patients we spoke with told us medical and nursing staff explained their care and they were offered choices and options about the timing of their treatment. Patients and relatives told us they felt able to ask questions and medical staff provided them with the information they needed to address any concerns.
- Staff recognised when patients needed additional support to help them understand and ask relevant questions about their care and treatment. Staff had telephone access to language interpreters if they were required, and interpreters could attend appointments when booked in advance.

Emotional support

- Staff throughout the department understood the need for emotional support. We spoke with patients and relatives who all felt that their emotional wellbeing was cared for. Patients we spoke with said that they had received good emotional support and felt that they been given ample time in which to ask questions.
- Patients we spoke with told us they knew who to contact if they had any worries about their care and said staff had supported them emotionally as well as physically.
- Staff told us they had time to spend with patients and their families to provide whatever emotional support they needed.

Are outpatients and diagnostic imaging services responsive?

Good

Service delivery to meet the needs of local people

- The outpatient and physiotherapy departments planned and developed services to meet the needs of the local population for both private and NHS patients.
- Patients attending the hospital outpatient department were a mix of privately funded (53%) and NHS funded (47%) patients.The local clinical commissioning group (CCG) set criteria within their contract for NHS patient's attendance at the hospital.This meant that local commissioners were involved in the planning of local services.
- The outpatient department was clearly signposted from the entrance of the hospital and was a short walk from the main reception on the ground floor. This meant that the department was easily accessible for all patients. The physiotherapy department was also clearly signposted.
- There was one waiting area for all outpatient clinics, which was on the ground floor in the main hospital

building. The physiotherapy waiting area was located a short distance away in the Cliftonville Unit. Both, the outpatients and physiotherapy departments had appropriate facilities to meet the needs of adult patients awaiting appointments. This included comfortable seating, access to bathrooms, drinks machines and reading material.

- Car parking facilities were available at no charge, which patients reported to be busy at times.
- Outpatient clinics were held from 8am to 9pm to facilitate flexible appointment times that were convenient to patients.Saturday morning clinics could be held depending on demand.
- The physiotherapy service had extended the department's opening times to enable patients to access the service during evenings, (until 7pm Monday to Thursdays), and at weekends for inpatients.

Meeting people's individual needs

- Patients with mobility difficulties had easy access to the waiting area and consulting rooms as both physiotherapy and outpatient departments were located on the ground floor. The corridors were wide and each reception had a low height desk, which meant there was easy access for wheelchair users.
- We saw that the hospital had installed hearing loops at all reception desks for patients with hearing difficulties. The service also had access to American Sign Language (ASL) interpreters for any patient requiring it across the hospital. At the time of our inspection, the physiotherapy service lead told us that they themselves and another member of staff were due to start a sign language course, so the service could be easily accessible to deaf patients.
- The hospital had access to a telephone interpretation service if a patient required assistance with translation.
- There were procedures in place to make sure patients who were self-funding were aware of fees payable. Staff told us they would provide quotes and costs, and ensured that patients understood the costs involved.
- General information leaflets relating to most services provided, including complaints, were also available in the waiting areas.
- Written information on medical conditions and procedures was available and accessible throughout the department.
- Refreshments were available to patients if required.
- Staff we spoke with told us patients who become unwell whilst waiting to be seen were brought to the attention of medical staff or resident medical officer.

Access and flow

- The hospital had a contractual target to meet 95% of patients on non-admitted pathways within 18 weeks of referral to treatment (RTT).Hospital data showed that between May 2017 and April 2018, at least 95% (figures ranged between 95.6% - 99.7%) of patients started non-admitted treatment within 18 weeks of their referral, which meant the hospital met the contractual target of 95%. However, during December 2017, 93.8% of patients started on non-admitted treatment within 18 weeks of their referral. The hospital reported that they had not received any fines in the last 12-month period.
- Patients we spoke with told us that they had not had any significant wait for their outpatient appointment. The outpatient manager told us the average wait for private patients to receive an appointment was between seven to 10 days. For NHS patients, the average time to receive an appointment would vary, although the maximum patients wait was six weeks, which was generally for an orthopaedic appointment.
- We noted the clinics to be running on time and patients did not have to wait long once they had arrived in the department.
- Staff told us a text message was sent to patients reminding them of their appointment.
- The hospital had very low 'did not attend' (DNA) rates. All patients who missed their appointment were followed up and offered a second appointment within 28 days. If they did not attend on the second appointment, the hospital would contact the referrer who would be notified of the non-attendance, and would need to re-refer the patient.

Learning from complaints and concerns

- The service treated concerns and complaints seriously, investigated them and learned lessons from the results, which were shared with staff.

Good

Outpatients and diagnostic imaging

- The hospital had a clear process in place for dealing with complaints. There was a complaints policy in place, which was under review at the time of our inspection. Staff we spoke with were aware of the complaints procedure and informed us that they tried to resolve any patient concerns immediately to prevent the concerns escalating to a complaint. Staff understood the principles of duty of candour and could describe them. We saw complaints leaflets, on how to make a complaint, were available to patients in the waiting areas.
- Patients we spoke with were aware of how to make a complaint, but told us that they were happy with the service they had received.
- The outpatient department received 40 complaints from July 2017 to June 2018. No complaints had been referred to Parliamentary and Health Service Ombudsman (PHSO) or the Independent Healthcare Sector Complaints Adjudication Service (ISCAS), or escalated to stage two or stage three of the complaints policy.
- Themes from complaints included poor communication, clinical care/treatment, and complaints about charges and invoicing. We saw that the hospital had responded to complaints in a timely manner, and appropriately investigated complaints and apologised to all patients involved.

Are outpatients and diagnostic imaging services well-led?

Good

Leadership

- Staff told us that they felt there was good leadership within the service and the organisation. There were named and experienced departmental leads for outpatients and physiotherapy services. Each lead was passionate about the service they led and worked well with the team of staff in their department.
- Staff within the outpatient and physiotherapy department spoke positively about their local leadership and told us they felt valued and respected.
- The hospital supported staff to develop leadership and management skills, with courses available for all levels of staff.
- Many staff had worked at the hospital for a long time and reported that their direct line managers were supportive and kept them informed of day to day running of the departments.

Vision and strategy

- The hospital had a clear vision, personalised from the BMI corporate vision, for what it wanted to achieve which was to “the best patient experience and best outcomes in the most cost-effective way”. The provider had a five-year vision from 2015 to 2020, with eight strategic objectives to drive positive change and further improve the quality of service provision. The hospital’s vision and strategy was cascaded to teams through departmental meetings, staff forums and notice boards.
- The outpatients’ service set up a five-year vision from 2015 in 2020, aligned with the hospital’s vision and strategy. All staff we spoke with were aware of the vision for the hospital and outpatient services, and understood their role in achieving it. During our last inspection, the strategy for outpatient services was not underpinned by detailed, realistic objectives and plans. Some staff had limited knowledge regarding the vision for the hospital. However, during this inspection, we found this had improved.

Culture

- Managers encouraged learning and a culture of openness and transparency. They operated an ‘open door policy’ and encouraged staff to raise concerns directly with them. We saw senior leaders were visible throughout the departments. Staff told us this was a normal daily occurrence. We observed positive, friendly and caring interactions between them and local staff.
- All staff we spoke with felt they could be open with colleagues and managers and felt they could raise concerns and would be listened to. Staff said any inappropriate behaviour would be dealt with immediately.
- All staff we spoke with were aware of the senior leadership team and said they were approachable, visible and supportive and leaders were positive, proud of the hospital and motivated staff.

Good

Outpatients and diagnostic imaging

Governance

- The service had clear governance systems in place. The hospital held meetings through which governance issues were addressed. The meetings included Medical Advisory Committee (MAC), Heads of Department (HoD) meeting, Senior Management Team (SMT) meeting, and Clinical Governance Committee meetings.
- The MAC met quarterly and the minutes of the meetings held in December 2017 and March 2018 were reviewed. The minutes showed key governance areas such incidents, practising privileges, and infection prevention and control were discussed.
- There was a systematic programme of internal audit for all departments across the hospital. This included audit of health records, infection prevention and control, hand hygiene, pain management, VTE, WHO checklist and consent. Physiotherapy also had a programme of audits, such as audit of treatment records, discharge procedures, and outpatient procedures. Audits were completed monthly, quarterly or annually according to the audit schedule and results were shared at relevant meetings. We saw that there was good compliance with completion of these audits and that there were action plans in place.

Managing risks, issues and performance

- The Heads of Department met monthly and the minutes showed items discussed included complaints, risks, information governance, audit results, new legislation/ policies and key departmental feedback. These meetings also shared staff experiences and information was shared back with staff in the departments.
- We found improvements in the hospital's governance and risk management arrangements had been made, since our last inspection in 2015. During the last inspection, we found the arrangements for governance did not always operate effectively. Risks and issues were not always dealt with appropriately or in a timely way. However, during this inspection, we found this had improved. The hospital had a corporate risk register which was managed through the electronic reporting system. The risk register was regularly reviewed and updated to ensure risks were monitored and appropriately managed. Heads of departments managed departmental risk registers which fed into the hospital's risk register. Risks documented on the outpatients and physiotherapy risk registers reflected what staff had told us. Governance and risk performance was discussed through the committee meeting structure.

Managing information

- Information needed to deliver effective care and treatment was available to relevant staff in a timely and accessible way.
- The outpatient services manager confirmed that consultants were able to access diagnostic results electronically. This prevented delays in potential decisions and enabled the consultant to review this information prior to seeing the patient.
- Computers were available on the outpatients and physiotherapy departments. All staff had secure, personal login details and had access to email and all hospital IT systems.

Engagement

- People who used outpatient and physiotherapy services were actively engaged and involved when planning services. Patients were regularly asked to complete satisfaction surveys on the quality of care and service provided. We saw there were boxes throughout the hospital to place completed forms. The hospital also gathered patient opinion from the friends and family test (FFT), BMI patient satisfaction survey, and patient led assessment of the care environment (PLACE). Departments used the results of the survey to improve the service. It was clear that the department recognised the value of public engagement.
- Staff told us that managers at all levels were approachable and that they felt comfortable to raise any concerns with them.
- Staff told us they had regular team meetings. Information was shared with staff in a variety of ways, such as face-to-face, email, newsletters/bulletins, and noticeboards. Staff in the outpatient department told us they have a 'communications book' to share information.

Learning, continuous improvement and innovation

- There was a culture of continuous staff development across the departments. We were told that a number of health care assistant staff had started their assistant

practitioner training and that the outpatients manager and physiotherapy lead had completed an institute of management and leadership (ILM) course. This demonstrated the hospital's commitment to continuous staff learning and improvement.

- During our last inspection, staff told us plans were in place to improve the examination rooms in line with infection prevention and control risks. At this inspection, we found all examination rooms we inspected were compliant with infection prevention and control measures.
- The physiotherapy lead clinical service manager told us they were recently given permission to install new gym equipment.
- The outpatient service manager told us mole mapping equipment was in place which enables the service to effectively monitor patients at risk of skin cancer.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

- The provider must ensure all staff have in date resuscitation training at the level appropriate for their role.
- The provider must ensure all relevant staff have training in the use of emergency equipment, appropriate to their role. This includes specifically defibrillators used in the service and the use of bag mask ventilation for emergencies.
- The provider must ensure all staff follow the hospitals medicine management policy.
- The provider must ensure they continue to assess, monitor and improve the quality and safety of services through the use of audit.

Action the provider SHOULD take to improve

- The provider should ensure that the records maintained by the cancer breast service are assessed and audited to provide the hospital an oversight of the information contained therein.
- The provider should ensure there are processes and audits in place regarding the breast care service so that the hospital and the medical advisory committee has oversight of the service.
- The provider should ensure there are processes in place for staff to complete complaints and report them appropriately.
- The provider should ensure that local risk registers are detailed, up to date, reviewed regularly, and reflect the risks within each service.
- The service should develop local standards for safety procedures for use in the operating theatres.
- The provider should ensure all emergency equipment is available at all times on the emergency resuscitation trolley.
- The provider should audit its compliance to NEWS2 and to sepsis screening.
- The provider should ensure all policies and standard operating procedures are up to date and reflect current evidence-based guidance.
- The provider should ensure there is a robust competency assessment process in place within theatres and in wards which ensures all staff have relevant training.
- The provider should ensure all equipment is safety tested, in line with local and national requirements.
- The provider should carry out an updated fire risk assessment.
- The service should ensure all staff follow the hospitals hand hygiene policy.
- The provider should ensure all preoperative assessments are carried out judiciously to avoid cancelling patients unnecessarily.
- The provider should ensure patients are not put at risk by being transported anywhere on a commode chair.
- The provider should ensure that all entries in patient's notes are signed and dated by consultants caring for children and young people.
- The provider should ensure all risks to children and young people are entered onto the hospital risk registers.
- The provider should ensure patient information for children and young people is presented in age appropriate formats.
- The provider should ensure there are sufficient nurses (child branch) to support children and young people receiving a local anaesthetic in day theatre.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment HCSA 2008 (Regulated Activities) Regulation 2014: Regulation 12 Safe care and treatment Not all staff had resuscitation training relevant to their role. In theatres, 80% of staff had ILS training and 83% of staff had BLS training. Not all staff could identify items on the emergency trolley and not all staff were aware of how to operate the bag mask ventilation system, required for use in an emergency. Not all patients were given all medication as prescribed. In four out of eight prescription charts there were omissions without a documented reason. Two instances of vials of propofol were unlabelled including one which was left unattended. One of eight prescription charts had an error in that ibuprofen was prescribed regularly to a patient and as an 'as required' drug (PRN).

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance HCSA 2008 (Regulated Activities) Regulation 2014: Regulation 17 Good governance.

This section is primarily information for the provider

Requirement notices

The provider did not ensure all services provided were assessed, monitored and improved through the use of audits.