BMI The Chaucer 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 Chaucer Hospital is operated by BMI Healthcare Limited. The hospital is registered for 60 beds, and these are split across two inpatient wards, one of which has four enhanced recovery beds with integral patient monitoring and telemetry. The hospital has two main theatres (1 with laminar flow) and a minor operations theatre based in outpatients. The hospital also has a dedicated Endoscopy Suite, 11 consulting rooms, a colposcopy suite, a Macmillan accredited Oncology unit, a physiotherapy department, Health Screening department and an HFEA licensed Assisted Conception Unit. The hospital has MRI, CT, ultrasound, X-ray and digital mammography within its imaging department. The hospital offers a wide range of surgical and medical procedures, including ENT, orthopaedics, gynaecology, oncology, general surgery, general medicine, gastroenterology, fertility services, ophthalmology, cosmetic surgery, urology, pain management.

We inspected this service using our comprehensive inspection methodology. We carried out the comprehensive announced of the inspection on 1 and 2 November 2016. With an unannounced inspection taking place on 11 November 2016.

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.

We rated this hospital as good overall.

- The senior management team, supported by the Heads of Departments, had a good knowledge of how services were being provided and were quick to address any shortcomings that were identified. Although relatively new in post the hospital executive director had made a significant impact on the hospital and staff felt that they had been a positive influence. They accepted full responsibility and ownership of the quality of care and treatment within their hospital and encouraged their staff to have a similar sense of pride in the hospital. Both the hospital director and the Director of nursing were able to talk to us in detail about all aspects of the services provided.
- The care delivered was planned and delivered in a way that promoted safety and ensured that peoples individual care needs were met. We saw patients had their individual risks identified, monitored and managed and that the quality of service provided was regularly monitored.
- The Executive Director was in overall charge of the hospital and all employed staff were line managed through her direct reports. She had eight heads of departments reporting directly to her including the Director of Nursing, quality and risk manager, imaging manager, pharmacy manager, physiotherapy manager, hospital services manager and materials manager.
- The Medical Advisory Committee (MAC) met bi-monthly and included representation from all specialities offered at the hospital. It was attended by the Executive Director and the director of nursing. A wide range of topics were discussed and action taken in response to any concerns raised. The minutes of the MAC meetings were distributed to all consultants.
- The MAC reviewed practising privileges every year. This included a review of patient outcomes, appraisals, General Medical Council (GMC) registrations and medical indemnity insurance. The hospital told us that 22 consultants had had their practising privileges removed; this was due mainly to no longer providing paediatric services at the hospital, along with retirement or relocation. One consultant had their practising privileges suspended this was due to failing to provide up to date documentation the hospital required to renew their practising privileges. This showed the hospital had a good procedure in place to make sure all consultants were experienced and fit to care for patients.
- Consultant revalidation was part of the requirement for maintaining their practising privileges. Consultants only performed operations they were used to performing at the acute NHS trust where they were

employed. This ensured they were competent and confident in undertaking operations and procedures. If a consultant wanted to carry out a new procedure, this had to be agreed as part of their practising privileges.

- The hospital used an agency that provided a Resident Medical Officer (RMO) onsite 24-hours a day, seven days a week, on a rotational basis. The RMO worked two weeks on, followed by two weeks off. The RMO undertook regular ward rounds to make sure the patients were safe. If the RMO was called out during a significant part of the night or was unwell, the RMO told us there were contingency plans in place to obtain cover. All staff and the RMO told us there were no concerns about the support they received from consultants and their availability.
- The hospital used the corporate BMI Healthcare Nursing Dependency and Skill Mix Planning Tool, to determine staffing levels. The nursing rota was entered into the system monthly and adjustments made 24 hours in advance based on patient numbers and dependency. This meant that the hospital ensured that staffing levels and mix were sufficient to provide safe care for patients.
- We saw a strong safety culture with policies and systems in place to allow staff to challenge practice they felt posed a risk. The hospital risk register 2016 was divided into categories such as patient safety, information management, financial, reputation, governance, operational, leadership and workforce, workforce health and safety, and facilities and infrastructure. The risk register detailed the risks, mitigations, actions, allocated key lead, and committee who had responsibility for ensuring existing risk controls and actions were completed for the identified risks.
- There were robust governance systems that were known and understood by staff and which were used to monitor the provision and to drive service improvements. The Clinical Governance Committee (CGC), met monthly and discussed complaints and incidents, patient safety issues such as safeguarding and infection control, risk register review. There was also a standing agenda item to review external and national guidance and new legislation, such as National Institute of Health and Care Excellence (NICE) guidance, such as NICE CG42, Dementia: supporting people with dementia and their carers in health and social care. This ensured the hospital implemented and maintained best practice, and any issues affecting safety and quality of patient care were known, disseminated managed and monitored.
- A clinical governance bulletin was produced across the BMI Healthcare organisation which supported the hospital monthly to manage risk. The bulletin identified changes in legislation relating to NICE publications and alerts regarding medicines and equipment. It also provided details of issues of best practice at other hospitals so that shared learning could be applied locally.
- There was a positive staff culture with many staff having worked at the hospital for a very long time. These core staff offered stability and continuity which was balanced by newer appointed staff who brought a fresh perspective and allowed for the introduction of new ways of working.
- The hospital was undergoing major renovation works at the time of our inspection. Despite this we found that corridors and patient areas were clean, and kept safe. Although we still found areas in need of renovation the Executive director was able to show us a plan of current works along with a plan of works going forward. The changes already made had improved the appearance and safety of the hospital, for example flooring that met with requirements for infection control.

We found areas of practice that required improvement in both surgery and in outpatients and diagnostic imaging services.

- All waste bins should be correctly labelled in line with in accordance with Health Technical Memorandum (HTM): Safe Management of Healthcare Waste, control of substances hazardous to health (COSHH), and health and safety at work regulations
- The procedure for cleaning of nasoendoscopes should be reviewed to ensure dirty instruments do not come into contact with clean areas.
- The hospital should ensure that language interpreters are only accessed via the formal translation service.
- Take action to ensure all staff have an annual performance appraisal.

Summary of findings

- Ensure that staff document consent in line with national guidance from the General Medical Council and Royal College of Surgeons.
- Ensure there is an accurate checklist is available for staff to use when checking equipment for the difficult intubation trolley.
- Ensure all medical equipment is up-to-date with service and safety checks.
- Ensure there are systems in place for making sure all medicines are within date.
- The provider should ensure that that appropriate balance checks of all Controlled Drugs (CDs) are carried out regularly.
- Take action to ensure all staff are compliant with safeguarding of vulnerable adults and safeguarding children training.
- Take action to ensure staff are aware of the mental capacity act, and deprivation of liberties, and how it applies to their role.
- Ensure dedicated hand hygiene sinks in patient bedrooms are included when carrying out refurbishment in accordance with the Department of Health's Health Building Note 00-09.
- Ensure carpets are removed from clinical areas and patient bedrooms in accordance with Department of Health's Health Building Note 00-09.

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 it move to a higher rating.

Professor Edward baker

Deputy Chief Inspector of Hospitals (South East)

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 very small proportion of hospital activity. The main service was surgery. Where arrangements were the same, we have reported findings in the surgery section. The hospital had an open and honest reporting culture and learned incidents. The incident reporting system was paper based. Staff had a good understanding of how to use the system and were able to describe examples of incidents they had reported. There were systems to keep people safe, these included systems to manage medicines, the risk of infection and the identification and management of risk. Staff understood their responsibilities in relation to safeguarding those in vulnerable circumstances. There were adequate number of staff at all times to meet the needs of patients who were competent and supported to do their jobs. Care was delivered in line with national guidance and patient outcomes were good when benchmarked. Patients were satisfied with their experience and were treated with dignity and respect. They were involved in their care and treatment. Patients could access care when they needed it and there were arrangements to ensure their individual needs were met and patients consented to their treatment. Complaints were well managed and lessons learnt to improve the service. Staff understood the vision, values and strategy of the hospital and demonstrated this in their work. There were robust governance arrangements which meant the leadership team could be assured of the quality and safety of the service. Staff felt supported by their leaders who were approachable and visible in the clinical areas. However: Although the hospital had systems in place for supporting staff with learning and development, in practice few staff working in endoscopy had received an annual appraisal due to capacity constraints.

Summary of findings

Surgery

Good

Patient safety at the hospital was monitored, incidents were reported and the learning from incidents was used to improve patient care. Staffing levels met the patients' needs and there was good multi-disciplinary team working. Medicines were mostly stored safely and the environment was clean and records were stored securely.
Patients received care and treatment according to national guidelines such as National Institute for Health and Clinical Excellence (NICE) and the Royal Colleges. Surgery services participated in national audits.
Patients spoke positively about their care, patients were treated with privacy and dignity.
The hospital was meeting national targets for referral to treatment times and processes were in place to support vulnerable patients. Complaints were dealt with efficiently.
Governance structures were good and there was effective teamwork with visible leadership within the services. Staff were positive about the culture within the surgical services and the level of support they received from their managers.
However:
Level 2 Safeguarding of vulnerable adults training compliance was below the BMI Target rate.
We saw one case where consent procedures had not been followed. However, the hospital was aware of this, had reported it as an incident and were investigating.
We found one difficult intubation tray with a completed weekly checklist to indicate that daily checks were made. However, we found the contents of the trolley did not match the checklist.
We found six pieces of medical equipment were out of service date The Quality and Risk manager was informed at the time of inspection; they immediately contacted the relevant companies, and ensured they had a date to service the equipment.
We completed a check of 10 stock medicines on Cornwallis ward and found one medicine, which had gone out of date the day before the inspection.
We found some theatre staff lacked awareness of the mental capacity act, and deprivation of liberties, and how it applies to their role.
We found some patient bedrooms did not have dedicated hand hygiene sinks.

Summary of findings

We found that some clinical areas still had carpet in situ.

Outpatients and diagnostic imaging

Good

People who used the services were protected from abuse and avoidable harm and staff were aware of the processes and reporting systems for recording incidents and safeguarding concerns. Staffing levels were sufficient to provide care in a safe way and staff appropriately responded to changing risks.
Hygiene and infection control practices were followed.
Patient records were held securely.
The care and treatment provided to people was evidence based and in line with relevant standards and legislation, including National Institute for Health and Care Excellence (NICE) and professional organisational guidelines.
Staff provided care and treatment to people who used the services in a caring and compassionate way and people were involved in decisions about their care.
The hospital planned the services to meet the needs of the local population. Waiting times for initial assessment, and treatment, following referral were low, and the services met the waiting time targets.
Staff treated people as individuals, and made appropriate adjustments as necessary.
There was a robust governance framework and strong management and leadership within the hospital. A comprehensive audit programme and a risk register were in place.
There was good staff engagement within the services and staff felt supported by the management team.
However
We found the procedure for cleaning of nasoendoscopes did not ensure that ensure dirty instruments did not come into contact with clean areas.
We found two waste bins that had not been labelled appropriately.
We found that although staff had access to translation services these were not always being accessed appropriately by staff.
We found that the diagnostic imaging department changing cubicles were not large enough to accommodate a wheelchair and no alternative changing area was available.

Summary of findings

Termination of pregnancy

We regulate this service but we do not currently have a legal duty to rate it. We highlight good practice and issues that service providers need to improve and take regulatory action as necessary.

BMI The Chaucer Hospital had performed two surgical Termination of pregnancy's (ToP) within the reporting period. Due to the low numbers of procedures, we were unable to discuss experiences with patients during this inspection. However we reviewed both patient records and were able to review hospital policy and procedures around ToP.

We found that the hospital followed current guidance for ToP. In the two records we looked at we saw that this guidance had been followed and that both patients had received safe care.

Summary of findings

Contents

Good

Location name here

Services we looked at

Medical care; Surgery; Termination of pregnancy; Diagnostic Imaging and Endoscopy Services; and Outpatient services.

Summary of this inspection

Background to BMI The Chaucer Hospital

BMI Chaucer Hospital is operated by BMI Healthcare Limited. It is a private hospital in Canterbury, Kent . The Chaucer Hospital is led by a senior management team that consists of the Executive Director and Director of Clinical Services, and a team of clinical and functional heads of each department. The Registered Manager had been in post for four months at the time of our inspection, and was also the Controlled Drugs Accountable Officer (CD AO) at this location.

Our inspection team

The team that inspected the service comprised four CQC inspectors, and specialist advisors with expertise in theatre management, nursing, and a radiographer. The inspection team was overseen by Vanessa Ward, Inspection manager.

How we carried out this inspection

We inspected this service using our comprehensive inspection methodology. We carried out the comprehensive announced of the inspection on 1 and 2 November 2016. With an unannounced inspection taking place on 11 November 2016.

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

Information about BMI The Chaucer Hospital

The hospital had 40 beds, split across two wards. Cornwallis has 25 beds, four of which were enhanced recovery rooms and used for a mixture of inpatients and day cases. Mountbatten ward had 12-day case beds and were not used for inpatients. All patient bedrooms were single rooms and have en-suite facilities. The hospital was open seven days a week to care for patients after their surgery that needed to stay in hospital overnight or at the weekend.

The theatre suite has two operating theatres, three recovery bays, and two anaesthetic rooms. One with laminar flow (a system that circulates filtered air to reduce the risk of airborne contamination). This is best practice for ventilation within operating theatres, and particularly important for joint surgery to reduce the risk of infection.

There are 11 consulting rooms and one minor operations room (also referred to as theatre four) in the outpatient's department. The physiotherapy department was located in its own dedicated area within outpatients. It had a large dedicated space that could be divided into consulting areas, with a gym and one separate treatment room for enhanced privacy.

The diagnostic imaging department hospital offered MRI, CT, ultrasound, X-ray and digital mammography.

Summary of this inspection

The hospital's endoscopy unit was attached to the Mountbatten ward. Endoscopy involves looking inside the body for medical reasons using an endoscope. An endoscope is an instrument used to examine the interior of a hollow organ or cavity of the body.

The oncology unit, Becket Suite, covers diagnostics, intravenous and oral chemotherapy instillations. Oncology is a branch of medicine that deals with the prevention, diagnosis and treatment of cancer. Treatment can include the use of chemotherapy, which is the treatment of disease by the use of chemical substances, especially by cytotoxic and other drugs.

During out inspection, we visited all clinical areas including theatres, both ward areas and the pre assessment clinic. We undertook an unannounced visit within ten working days of our announced inspection.

We spoke with twelve patients, 38 members of staff including, nurses, health care assistants, operating department practitioners, administrators, consultants and managers. We also received 22 'tell us about your care' comment cards which patients had completed prior to our inspection.

As part of our inspection, we looked at hospital policies and procedures, staff training records and audits. We looked at eight sets of surgical patient notes and two sets of notes for termination of pregnancy, four prescription charts and the environment and equipment. We also reviewed six inpatient medical records who were discharged as there were no medical patients in the hospital at the time of inspection.

Activity (July 2015 to June 2016)

Between July 2015 and June 2016, there were 6,833 inpatient and day case episodes at the hospital, with 6,301 procedures taking place. The most common procedure during the reporting period was phakoemulsification of lens, used to treat cataracts. Phakoemulsification of lens accounted for 925 of the procedures. Primary repair of inguinal hernia was the second most common surgical procedure and accounted for 146, procedures. Between July 2015 and June 2016, approximately 39% of patients were NHS funded, and the remaining 61% were privately insured and self-paying.

The hospital held a licence from the Department of Health to undertake surgical termination of pregnancy procedures. The service provided support, information, treatment, and aftercare women seeking termination of pregnancy. Surgical termination of pregnancies were carried were carried out as day cases on women within their first trimester, up to 14 weeks gestation. Between July 2015 and June 2016, two women had, had a surgical termination of pregnancy.

There were 34,886 outpatient total attendances in the reporting period (July 2015 to June 2016); of these 24% were NHS funded and 76% were other funded. The outpatient department saw both adults and children up to September 2016. After this date, only adults over the age of 18 were seen in the department.

Medical care services provided by the BMI Chaucer hospital are medical inpatient care, end of life care, endoscopy and oncology day care. In the period July 2015 to June 2016 inpatient attendances were 1,202.

The majority of patients seen for palliative and end of life care are patients with a primary diagnosis of cancer. The hospital reported three deaths between July 2015 and June 2016; two deaths were recognised as end of life care patients under the care of the palliative care team and one was an oncology patient.

There are 180 doctors and dentists employed or practicing under rules and privileges for the provider of which 180 have had their registration validated in In the reporting period (July 15 to June 16). During this period 22 Consultants have had their practising privileges removed due to retirement, relocation or as a result of the hospital no longer providing paediatric services. One

Summary of this inspection

consultant had had their practising privileges suspended due to lack of up to date certification. The provider told us that they will have their practising privileges removed if their certification is not forthcoming.

BMI The Chaucer Hospital employed 39.4 registered nurses, and 22.5 Operating department practitioners (OPD) and care assistants. The accountable officer for controlled drugs (CDs) was the registered manager.

Track Record on Safety

Never Events

In the reporting period (July 15 to June 16) there have been 0 Never Events. Never Events are a type of serious incident that are wholly preventable, where 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. [It is particularly important to understand how the provider has learned from this/these incident(s) and what is being done to reduce risk of reoccurrence.

Clinical Incidents

In the reporting period (July 15 to June 16) there were 270 clinical incidents. Of these incidents 216 were categorised as no harm, 44 were categorised as low harm, 11 were categorised as moderate, 0 were categorised as severe and 0 were categorised as a death.

In the reporting period (July 15 to June 16) there were 188 clinical incidents and 48 non-clinical incidents within Surgery or Inpatients

In the reporting period (July 15 to June 16) there were 34 clinical incidents and 50 non-clinical incidents within Other Services.

In the reporting period (July 15 to June 16) there were 48 clinical incidents and six non-clinical incidents within Outpatients and Diagnostic Imaging

Serious injuries

In the reporting period (July 15 to June 16) there were two serious injuries.

Mortality

In the reporting period (July 15 to June 16) there were three inpatient deaths; of these deaths 0 were unexpected.

Meticillin-resistant Staphylococcus aureus (MRSA)

In the reporting period (July 15 to June 16) there were 0 incidences of hospital acquired MRSA.

Meticillin-sensitive Staphylococcus aureus (MSSA)

In the reporting period (July 15 to June 16) there were 0 incidences of hospital acquired MSSA.

Clostridium difficile (C.diff)

Summary of this inspection

In the reporting period (July 15 to June 16) there were 0 incidences of hospital acquired C.diff.

E-Coli

In the reporting period (July 15 to June 16) there were 0 incidences of hospital acquired E-Coli.

Hip Surgical Site Infections (SSIs) – Hip replacement primary

In the reporting period (July 15 to June 16) there were two SSIs resulting from hip operations giving a rate of 1.82 per 100 surgeries.

Knee Surgical Site Infections (SSIs) – Knee replacement primary

In the reporting period (July 15 to June 16) there were two SSIs resulting from knee operations giving a rate of 0.79 per 100 surgeries.

In the reporting period (July 15 to June 16) the provider received 26 complaints. No complaints have been referred to the Ombudsman or ISCAS (Independent Healthcare Sector Complaints Adjudication Service) in the same reporting period. The assessed rate of complaints (per 100 inpatient and day case attendances) is lower than the rate of other independent acute hospitals we hold this type of data for.

Services provided at the hospital under service level agreement:

- Laser protection service
- 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

Incidents were reported, investigated and learning evidenced. Reports were communicated to all staff.

Patients were cared for in a visibly clean environment that was well maintained. There were arrangements to prevent the spread of infection and compliance with these was monitored. There were no outbreaks of serious infection reported.

The hospital was undergoing an extensive renovation programme at the time of our inspection which was improving areas such as flooring to make them easy to clean for the purposes of infection control. This had not been completed and there were still areas of the hospital that required updating and a rolling programme in place to address these areas.

There were processes for assessing and responding to patient risk. The service had enough staff with the skills and experience to care for the number of patients and their level of need. The majority of staff had completed the provider's mandatory training programme. Staff were aware of their responsibilities with regard to the protection of people in vulnerable circumstances.

There were adequate supplies of appropriate equipment that was properly maintained to deliver care and treatment and staff were competent in its use. Staff demonstrated good medicines storage, management and administration. Although there was room for improvement in the recording of patient own controlled medications.

Are services effective?

Good

We found care and treatment reflected current national guidance. There were formal systems in place for collecting comparative data regarding patient outcomes.

Staff worked with other health professionals in and out of the hospital to provide services for patients. Patients were cared for by staff who had undergone specialist training for the role and who had their competency reviewed.

There were arrangements that enabled patients to access advice and support seven days a week, 24 hours per day. There was comprehensive assessment of patient needs. This included clinical needs, physical health, nutrition and hydration needs. Patients received adequate pain relief.

Summary of this inspection

Patients provided informed, written consent before commencing their treatment. However, we found one example where consent had not been obtained following BMI policy. Where patients lacked capacity to make decisions, most staff were able to explain what steps to take to ensure relevant legal requirements were met, although staff in theatres were not always able to describe their responsibilities around this legislation.

There was a proactive audit programme that included national, corporate, hospital and departmental audits. Results were shared throughout the hospital and collated to identify themes.

Are services caring?

Good

Staff provided sensitive, caring and individualised personal care to patients. Staff supported patients to cope emotionally with their care and treatment as needed.

Patients commented positively about the care provided from all staff they interacted with. Staff treated patients courteously and with respect. Patients felt well informed and involved in their procedures and care, including their care after discharge.

Patients and their relatives were involved in their care and were given adequate information about their diagnosis and treatment. Families were encouraged to participate in the personal care of their relatives with support from staff.

We observed patients treated with compassion, care and dignity. Patient feedback was positive and staff demonstrated commitment to continuous improvement.

Are services responsive?

Good

There were a variety of mechanisms to provide psychological support to patients and their supporters. This range of service meant that each patient could access a service that was relevant to their particular needs. For example those with spiritual needs, those requiring bariatric equipment, patients whose first language was not English, or support for people living with dementia or learning disabilities. However we did find in the outpatients department that staff did not always access translation services appropriately.

The services were delivered in a way that met the needs of the local population and allowed patients to access care and treatment when they needed it. Waiting times, delays and cancellations were minimal and well managed. Patients told us staff were responsive to their needs.

Complaints management was a priority in the hospital. The process was transparent and open with learning communicated across the hospital.

Summary of this inspection

Are services well-led?

Good

There were clear organisational structures and roles and responsibilities. The senior management team were highly visible and accessible across the hospital. Staff described an open culture and said managers were approachable at all times.

Staff spoke highly about their departmental managers and the support they provided to them and patients. All staff said managers supported them to report concerns and their managers would act on them. They told us their managers regularly updated them on issues that affected the separate departments and the whole hospital.

There were good governance, risk and quality systems and processes that staff understood. The committee structure supported this with reports disseminated and discussed appropriately. Staff from all departments had a clear ambition for their services and were aware of the vision of their departments.

Staff asked patients to complete satisfaction surveys on the quality of care and service provided. Departments used the results of the survey to improve services. The hospital had a risk register which was reviewed at the governance committee meetings.

The management team had an understanding of the Workforce Race Equality Standard (WRES) as there is a national requirement to produce key data relating to race quality in the workplace. BMI had started to collect data nationally which they currently held, for example the numbers of staff from black and ethnic minority groups. The management team was in the process of implementing reporting processes to capture the data to enable them to fully comply with WRES reporting requirements.

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	Good	Good	Good	Good	Good	Good
Outpatients and diagnostic imaging	Good	Not rated	Good	Requires improvement	Good	Good
Termination of pregnancy	N/A	N/A	N/A	N/A	N/A	N/A
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

We rate safe as good.

Incidents

- In the reporting period July 2015 to June 2016, there were no never events related to medical care services. 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.
- In the reporting period July 2015 to June 2016, there were no serious injuries related to medical care services reported to the Strategic Executive Information System (STEIS).
- The hospital reported three deaths between July 2015 and June 2016; two deaths were related to end of life care and one was an oncology patient. The hospital carried out a review of the deaths, all of which concluded that these were unavoidable. However, during the review, the hospital identified areas for improvement such as symptom management and the need to utilise experts within the field of end of life care. An end of life care (EOLC) strategy was developed and palliative care training for staff was arranged. Staff continued multidisciplinary working with hospice consultants and the hospital had plans to review the EOLC pathway for the care of EOLC patients.
- An up to date corporate incident reporting policy was in place. The incident reporting system was paper based. Staff had a good understanding of how to use the system and were able to describe examples of incidents they had reported. Staff were able to describe examples of changes in practice following an incident. We saw evidence of incidents discussed at the clinical governance meetings and learning disseminated at ward meetings.
- Data received from the hospital showed between July 2015 and June 2016 there had been 270 clinical incidents reported across the hospital, and 188 incidents (70%) occurred within surgery and inpatients. For example, a patient with a latex allergy had not been identified at pre admission, but had been identified on admission. There were no trends identified for this service. The rate of clinical incidents for the hospital was higher than the rate of other independent acute hospitals we hold this type of data for in the same reporting period. The high rate of incident reporting and low rate of severe of death incidents indicated that the hospital had an open and honest reporting culture and learned from low harm and near miss incidents.
- There were 104 non-clinical incidents reported by the hospital between July 2015 and June 2016, of which 46% (48 incidents) occurred in surgery or inpatients. The information provided by the hospital was not separated by medical or surgical incidents. The rate of non-clinical incidents for the hospital was higher than the rate of other independent acute hospitals we hold this type of data for in the same reporting period.
- Staff were able to describe the basis of duty of candour. This relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of 'certain notifiable safety incidents' and provide reasonable support to that

person. Staff gave us an example where an incorrect medication was administered to a patient. Even though the patient did not experience significant harm, staff apologised and explained to the patient and relative what had gone wrong.

Clinical Quality Dashboard or equivalent (how does the service monitor safety and use results)

- The NHS safety thermometer is a local improvement tool for measuring, monitoring, and analysing patient harms and harm-free care. The NHS safety thermometer allowed the proportion of patients who were kept 'harm-free' from venous thromboembolisms (VTE's), pressure ulcers, falls and catheter associated urine infections to be measured on a monthly basis.
- Patients identified at risk were placed on an appropriate care plan and were monitored more closely by staff. For example, if a patient was at risk of developing pressure ulcers the hospital would provide a special mattress for them, which would help stop pressure ulcers occurring.
- Between July 2015 and June 2016, staff reported 100% of inpatient VTE screening rates. There was no reported incident of hospital acquired VTE or pulmonary embolism in this period for medical care.

Cleanliness, infection control and hygiene

- To maintain registration with CQC, healthcare establishments must demonstrate compliance with infection prevention criteria as detailed in The Health and Social Care Act 2008: code of practice on the prevention and control of infections and related guidance (Department of Health 2015). We saw information provided by the hospital which demonstrated detailed activities carried out yearly known as 'Infection Prevention and Control Annual Work Programme'. Activities carried out included having systems and policies in place to ensure the hospital met with infection, prevention and control of infection requirements.
- Patient-led assessments of the care environment (PLACE) are a system for assessing the quality of the patient environment; patients' representatives go into hospitals as part of teams to assess how the environment supports patients' privacy and dignity, food, cleanliness, patients living with dementia or disability and general building maintenance. The PLACE assessment for cleanliness for the period February to June 2016 was 85%, which was lower than the England national average of 98%. The assessment of cleanliness covers areas such as patient equipment, baths, showers, toilets, floors and other fixtures and fittings. The hospital had a refurbishment plan to the overall site and works were carried out during this inspection. The hospital infection control lead was also involved in the the refurbishment plan.
- During the inspection, all the areas we visited looked visibly clean and tidy. We found equipment was visibly clean throughout the department, and staff had a good understanding of responsibilities in relation to cleaning and infection control. Staff used 'I am clean' labels on equipment, which indicated the date the equipment had been cleaned. All equipment we saw during inspection had a label.
- We saw completed cleaning checklists for the oncology unit (August 2016 to October 2016), the endoscopy suite (October 2016) and Cornwallis Ward (September 2016 to October 2016). However, staff had not signed the cleaning schedule for the office on the ward on five days in September and three days in October.
- Some of the patient bedrooms on Cornwallis Ward had carpets. Carpets in clinical areas prevent effective cleaning and removal of body fluid spillages. The Department of Health's HBN 00-09 states, "Carpets should not be used in clinical areas". However, we saw carpets in patient bedrooms were visibly clean and free from stains. We also saw regular deep cleans of carpets had taken place. At the time of inspection, we saw that the hospital current programme of works included carpet replacement which was phased for completion until the year 2020. However, we saw regular deep cleans of carpets had taken place and a scheduled deep clean programme until March 2017. Flooring in the oncology unit and endoscopy suite was compliant with HBN 00-09.
- Staff were compliant with the corporate February 2016 'Standard Infection Control Precautions Policy' and the policy was in date. The policy included areas such as hand hygiene and the use of personal protective equipment such as gloves and aprons. In the event of spillages of blood and body fluids, the policy stated a step by step process. This meant that staff were able to follow clear processes.

- We saw personal protective equipment and hand-sanitising gel was available in all patients' bedrooms. None of the patients we saw required using hand-sanitising gel at the time of inspection. We saw nurses carried small personal bottles of hand sanitising gel attached to their uniforms and used the gel at the time of inspection. Posters were displayed in ward offices which explained the '5 moments for hand hygiene'. However we did not see these posters on display in patient bedrooms as the hospital was undergoing a programme of refurbishment at the time of inspection, therefore posters had been removed.
- On Cornwallis Ward, we did not see dedicated clinical hand wash basins in patient bedrooms. Staff and visitors used the hand hygiene basins in the bedrooms' en-suite bathrooms or the handwashing facilities in the sluice. This did not comply with HBN 00-09: infection control in the built environment, which states "healthcare providers should have policies in place ensuring that clinical wash-hand basins are not used for other purposes". The corporate May 2016 'Infection Prevention and Control, Hand Hygiene Policy (including training)', states, "Basins in patients' bathrooms/ensuites must never be used for handwashing by clinical staff as these sinks carry high levels of bacterial contamination due to their design and general usage". It also states, "single bed or ensuite room should have one sink per room and a separate patient's washbasin".
- The hospital told us they are aware of the lack of dedicated clinical hand wash basins in patient bedrooms, and we saw the installation of new hand washbasins was included in their programme of works, which at the time of inspection was in progress. However, due to the build layout of the bedrooms, they will be unable to install a dedicated clinical hand hygiene basin in the patients' bedrooms.
- We saw staff separated waste into different coloured bags to signify the different categories of waste. This was in accordance with Health Technical Memorandum (HTM): Safe Management of Healthcare Waste, control of substances hazardous to health (COSHH), and health and safety at work regulations.
- We saw sharps bins were available in treatment and clinical areas where sharps were used and was compliant with health and safety sharps regulations 2013, 5 (1) d. The regulation requires staff to place secure containers and instructions for safe disposal of medical sharps close to the work area. Staff fully completed labels on sharps bins, which ensured traceability of each container.
- The specialised ventilation revalidation results were reviewed against performance criteria as defined by HTM 03-01 2007. The hospital showed us the recorded results together with the maintenance records provided for endoscopy which indicated the presence of suitable maintenance regimes being employed.
- Staff in the endoscopy suite took monthly environmental mycobacterium samples. The most recent annual test showed low mycobacterium counts therefore the chamber was not currently being used for sterile scopes until another test showed a negative result.
- In the endoscopy suite, we saw there were adequate systems to ensure that endoscopes were safely decontaminated. We saw staff used a tracking and tracing scanning system for endoscopes. There was a traceability book for each washer and the system tracked the endoscopes through each stage of the decontamination process and enabled patient identification. Staff placed traceability stickers in patient records as well as the drying cabinet storage record.
- We saw a colour coding system for storing endoscopes; clean endoscopes were stored in a green container and dirty endoscopes stored in red containers.
- Some chemotherapy drugs are harmful to patients and staff. We saw the oncology unit, had kits readily available to deal with chemotherapy spills and staff were aware of how to use them.
- Staff prepared chemotherapy in an aseptic pharmacy department that guarded against the risk of infection being introduced when the chemotherapy was administered. This ensured that oncology patients were kept safe from decontamination caused by harmful bacteria, viruses, or other microorganisms; surgically sterile or sterilized.
- There was a corporate policy in place for management of the deceased, which included guidance for the

management of a patient's body following their death with a suspected or confirmed infection. Staff we spoke with were aware of the procedures to follow as per the policy.

Environment and equipment

- The oncology unit had six single pods, which were used as both consulting and counselling room as the pods had blinds on windows and doors could be closed when privacy was needed. The 'Health Building Note 02-01: Cancer treatment facilities' recommends a mixture of open-plan and individual treatment spaces, but states that the overall size of the treatment suite will depend on patient throughput.
- Each pod had its own television and wireless internet access. Patients could control the temperature in their pod (patients receiving chemotherapy can be very sensitive to temperature) and all pods had black out blinds for patients receiving treatment sensitive to light.
- Staff checked and recorded the temperature of the clinical room daily when the oncology unit was open.
- There was a resuscitation trolley on each ward and the endoscopy suite. The oncology unit shared a trolley with Mountbatten ward, however staff advised this did not affect access. The resuscitation trolleys were secure and we saw records of equipment and consumables checks were up to date. Staff ensured all trolleys were fully stocked with equipment needed in a resuscitation emergency. All consumables were in date. Staff checked the trolley on Cornwallis Ward daily. The trolley on the Mountbatten ward was checked on the days the ward was open and records clearly stated 'closed' on the days the ward was not open.
- Both medical and surgical patients used Cornwallis Ward. It had 25 beds used for both inpatient and day cases. Each bed had an individual bedroom with its own bathroom.
- There were no patients requiring end of life care (EOLC) admitted to the hospital at the time of the inspection. Staff told us there were no issues around securing the necessary equipment for EOLC patients, for example pressure relieving mattresses to prevent the development of pressure sores. We saw a variety of equipment readily available on the oncology unit.
- Staff told us syringe drivers were available. The syringe driver is a portable battery operated device to help reduce symptoms by delivering a steady flow of injected medication continuously under the skin. It is useful way of delivering medication for an end of life care patient when they are unable to take medication orally.
- We saw portable appliance testing (PAT) stickers on electrical equipment, which showed electrical equipment had been tested and was safe to use. This complied with the Medicines and Healthcare Regulatory products Regulatory Agency (MHRA) "Managing Medical Devices" April 2015.
- On Cornwallis ward, we noted that six pieces of equipment were due for service between May and August 2016, and was therefore two to five months out of date. This was raised with the quality and risk manager at the time of the inspection who took appropriate and immediate action. Equipment we checked on the oncology unit and endoscopy suite was within the date of service.
- The Patient Led Assessment of the Care Environment (PLACE) for the period of February to June 2016 showed the hospital scored 75% for condition, appearance, and maintenance of the environment, which was lower than the England average 93%. The assessment for condition, appearance, and maintenance covers areas such as decoration, the condition of fixtures and fittings, tidiness, signage, lighting (including access to natural light), linen, access to car parking, waste management, and the external appearance of buildings and maintenance of grounds. However, the hospital were undergoing a programme of refurbishment works at the time of inspection.

Medicines

- There was an up to date corporate policy on the safe management of medicines. We saw evidence of 10 pharmacy standard operating procedures on Cornwallis Ward which was developed specific to the hospital.
- Compliance with the hospitals mandatory medicines management training was 93%, which was better than the hospital target of 90%.
- The pharmacy department carried out a number of audits related to medicines. These were carried out quarterly and included the medicines management

audit, controlled drug (CD) audits, pharmacy intervention audits and audit of time taken to dispense a prescription. The audits demonstrated 100% compliance. The six-monthly missed doses audit carried out in August 2016 showed five missed doses for one patient. However, no further action was required as the doses missed was intentional.

- On Cornwallis Ward and the oncology unit, staff securely stored medicines in a clinical room with keypad access and cupboards in the room were locked. Keys for those cupboards were kept in a coded key safe or were in the possession of a nurse.
- Medicines on Cornwallis Ward and the oncology unit were kept in temperature-controlled rooms and we saw evidence of ambient temperature records being kept. Medicines requiring refrigeration were stored in the pharmacy department.
- We completed a random check of 10 stock medicines on Cornwallis Ward and found one medicine which was out of date. This meant the safety and effectiveness of medicines on the ward could not be assured. We brought this to the attention of the nurse in charge.
- We observed appropriate storage and record keeping of controlled drugs on Cornwallis Ward and the endoscopy unit as per the Misuse of Drugs Regulations, 2001. We saw evidence of daily balance checks and three monthly pharmacy audits in the stock controlled drugs (CD) register on Cornwallis Ward.
- We checked the stock balance of two CDs in the cupboard on Cornwallis Ward and found these were correct as per the CD register. All CDs we checked were in date. However, we noted that there was a balance of 28 tablets of a CD in the register of patients own drugs dated January 2016 but there were no tablets for this patient in the cupboard. We highlighted this to the nurse in charge who discussed this with pharmacy and requested the patient's notes. The discharge letter stated the medication had been given to the patient and was signed by the nurse. On our follow up inspection, we saw evidence of an incident form completed with an investigation underway. We saw a copy of the pharmacy CD audit from April 2016 and did not see evidence of patient's own CDs audited.
- Emergency drug packs for arrest, anaphylaxis and deteriorating patients were available and standardised across the service. Pharmacy staff kept records of locations and expiry dates of the emergency drug packs.
- Staff had access to appropriate resources related to medicines such as the British National Formulary 72 and online access to an intravenous medicines guide.
- We reviewed six prescription charts for patients currently on Cornwallis Ward or recent discharges. All prescriptions were signed and dated, allergies were documented and where medicines were omitted there was a documented reason.
- We reviewed two chemotherapy prescription sheets on the oncology unit and saw they were clear with copies of relevant protocols securely attached to the prescription. The hospital had started a roll out of electronic prescribing for chemotherapy patients. At the time of inspection, patients on selected regimens had electronic prescriptions. We saw a prescription on a hand held equipment which had clear instructions and links to relevant protocols and procedures. Pharmacy staff and chemotherapy nurses said that although the system had some teething problems, these had been resolved and staff were happy using the system.
- A member of the pharmacy team visited the ward daily to facilitate patient discharge, complete clinical reviews of inpatient prescriptions, check patient's own medication to determine suitability of use and support the multidisciplinary team with clinical decisions regarding patient's medication.
- The pharmacy department included one pharmacy manager, two full time pharmacists, three part time pharmacy technicians and a pharmacy assistant. A bank pharmacist who covered annual leave and occasional Saturdays supported the department.
- A pharmacist attended a multidisciplinary team meeting on Cornwallis Ward at 8:30am; other attendees include nurses, business support and physiotherapists. Issues such as patients on high-risk medicines such as insulin or oral anticoagulants (medicines to prevent blood clots), those on compliance aids, admissions and discharges were highlighted to the pharmacist at this time. This meant the pharmacy team could prioritise patients based on risk and reduce the risk of medication errors and delayed discharges.

- Staff kept a maximum of five private outpatient prescriptions in a locked medicines cupboard on Cornwallis Ward which met the current demand. We saw a log, which showed when a prescription had been issued, to whom and what for. This was in line with NHS Protect, security of prescription forms guidance 2013.
- Pharmacy staff told us they provided patients with a medication record card if a need was identified, for example if the patient had trouble remembering to take their medicines.
- The pharmacy department supplied patients' with supporting information with their medication. For example, they supplied leaflets regarding unlicensed medicine advice, safe and effective use of antibiotics and alert cards for novel oral anticoagulants to appropriate patients.
- On the oncology unit, staff gave chemotherapy drugs directly into a patient's vein. A complication of this is a leakage of the drug from the vein in to the surrounding tissue. Staff kept an emergency pack of medicines in the clinical room in the event a patient had an anaphylactic reaction or a patient suffered extravasation. The pharmacy department prepared the packs, maintained a log of expiry dates and replaced the pack once it was used or an item expired.
- The hospital did not use dose banding for chemotherapy. Dose banding is a national system introduced by NHS England to reduce variation and wastage in chemotherapy. A pharmacist told us that patients received individually calculated doses of medicines.
- Chemotherapy drugs were delivered to the oncology unit in a sealed box. These medicines were not stored away as staff used them almost immediately upon delivery which meant that these medicines were used straight after preparation. A nurse checked the medicines before transferring them to the patient's room, and the medicines were checked by two registered nurses before administration.
- Data provided by the hospital showed from April 2016 to July 2016 there were five incidents reported related to medicines. Two related to dispensing of medicines, one to a communication error, one administration error and one recording error in theatres. All incidents outlined any remedial or other action taken following the incident. Although the number of reported medicines related incidents were low in numbers and risks, they were discussed at clinical governance meetings, which were attended by the pharmacy manager.

Records

- The hospital used a variety of information technology systems that held patient data. Management required all staff to be compliant with information security and data protection with all services around patients. We saw 95% of hospital staff completed mandatory e-learning modules for information governance, which was better than the hospital target of 90%.
- An audit showed that 100% of adults who were admitted as inpatients were VTE risk assessed from July 2015 to June 2016.Staff had completed VTE risk assessments in all patient records we reviewed.
- The hospital completed a medical records audit in July 2016 to monitor clinical documentation and their compliance with policies and national guidelines. The audit showed compliance ranged from 91% to 93% in areas such as; notes were secured within the file, patient and GP details were present in the records, fully completed consent forms, allergies noted, all entries were dated, timed and signed. The findings of the audit were presented to the clinical governance committee and medical advisory committee. Heads of departments disseminated results during team meetings. We reviewed six medical records and all of these showed 100% compliance.
- Staff in the endoscopy suite placed traceability stickers for endoscopes in patient records. There was also a record of storage in the drying cabinet.
- Oncology patients carried record books, which indicated the chemotherapy type and frequency as well as the patient's most recent blood test results.
- The hospital used a personalised EOLC plan for EOLC patients. The care plan was to be used in conjunction with other risk assessments. For example, pain management and pain scale, 'do not attempt cardio-pulmonary resuscitation' (DNACPR) form and National Early Warning System (NEWS) chart.
- The hospital had a medical records department on site. Staff tracked notes so their location was known. During

our inspection, we requested notes for review and found these were located promptly. The hospital therefore ensured staff had quick access to patients' medical information.

- We saw care pathway records for oncology patients were stored in the cancer nurse specialist's office; this office was locked when not in use. Consultant notes for oncology patients were kept off site in a nearby office, there was a system in place where notes for patients to be seen in clinic were transferred to the hospital on the morning of the appointment and retrieved the following day. This meant that a full patient record was available at the time of the patient appointment.

Safeguarding

- There had been no safeguarding referrals made to the CQC from July 2015 to June 2016.
- There were corporate policies in place for safeguarding adults and children and these were accessible to staff. We saw a flow chart of how to raise a safeguarding concern in Cornwallis Ward for staff to refer to.
- Staff received mandatory training in the safeguarding of adults and children, as part of their induction followed by safeguarding refresher training undertaken every two years.
- Safeguarding of vulnerable adults training was undertaken every two years for levels one and two. Data indicated, by August 2016, 92% of required staff had completed level one, which was better than the BMI Healthcare target of 90%. However, 82%, of required staff had completed level two, which was worse than the BMI healthcare target. This meant the hospital did not have assurance all staff had the necessary up-to-date training to keep patients safe.
- Safeguarding of children training was undertaken every two years for levels one and two. Data indicated, by August 2016, 95% of required staff had completed level one, which was better than the BMI Healthcare target of 90%, however, 79% of required staff had completed level two, which was worse than the BMI Healthcare target.
- Staff had a good understanding of what a safeguarding concern might be and how to escalate a concern. They knew who the safeguarding lead was.
- The Director of Clinical Services was the hospital safeguarding lead and trained to level 3, who had access to the BMI regional safeguarding lead trained to level 4. This was in line with the 'Intercollegiate document, safeguarding children and young people: role and competences for health care staff, March 2014'.

Mandatory training

- We saw the mandatory training records for nursing staff.
- The hospital target for mandatory training completion was 90% (including bank staff). Overall completion rates for the hospital as of 30 September 2016 were 98%. Endoscopy staff completion rates were 92%, oncology staff 99%, ward staff 94% and ward administrative staff 97%.
- Management tailored the mandatory training programme to the requirements of each staff job role. Staff completed on-line training that included a knowledge check and required updating annually. Staff told us they had no problems completing on-line training and this was done during work time. Staff were also allocated time to complete mandatory training.
- The compliance manager emailed weekly reminders to line managers in order to monitor mandatory training. Staff were incentivised to complete mandatory training, as they were not eligible for a pay rise unless all mandatory training had been completed.

Assessing and responding to patient risk

- We looked at six records of medical inpatients and saw a range of risk assessments were used which used nationally recognised and validated tools. These included assessments for risk of pressure damage and malnutrition. We saw assessments were reviewed against score charts and there were clear escalation process as required by the hospitals care bundles. Other risk assessments included those concerned with falls, manual handling and the use of bed rails.
- Staff assessed the risks of VTE for each patient and appropriate prophylactic measures were in place because of this, for example the use of anti-coagulant medication. Staff reported 100% of inpatient VTE screening rates for the period July 2015 to June 2016. There was one incident of hospital acquired VTE or pulmonary embolism in a surgical patient in this period.

Good

Medical care

- Guidance from NICE CG50 Acutely Ill Patients in Hospital, recommends the use of an early warning scoring system to identify patients whose condition may be deteriorating. The hospital used the National Early Warning System (NEWS) and we saw this was routinely used for inpatients where appropriate.
- Staff did not use NEWS scoring in the endoscopy unit, as patients were not in unit long enough for this to be of effective use.
- We saw there was adequate resuscitation equipment and it was easily accessible. Staff knew where the equipment was located.
- The hospital employed two resident medical officers (RMOs) via an agency who were available on site 24 hours a day, seven days a week. The RMO was available to assist nursing staff and consultants by completing any necessary medical tests and writing prescriptions required by the lead consultant. The RMO gave us an example of a patient who had become unwell during the night, and had to transfer to the local NHS hospital.RMO provided medical cover 24 hours a day, seven days a week. The RMO was able to give us examples of managing complex patients out of hours and said that consultants were happy to be contacted for advice if needed.
- Consultants were responsible for their own patients. It was a requirement of the corporate practising privileges policy, that consultants remained available (both by phone and, if required, in person) or arranged appropriate alternative named cover, via a buddy system if they were unavailable, when they had inpatients in the hospital.
- A senior nurse was available at the hospital as a contact point for both staff and patients, including to help resolve patient queries and to accept out of hours admissions. They were contactable via bleep or telephone.
- On discharge, staff provided patients in the oncology unit with telephone contact details for a 24-hour advice line. Triage log forms showed staff had documented when advice had been given to patients. This was filed in patient records.
- Staff told us that they would ring for an ambulance if patients required transfer to the local NHS trust. We saw a service level agreement for this and included the direct transfer of critically ill patients to the intensive care unit.
- For EOLC patients, care plans showed agreed plans to reduce intervention where the progression of illness was evident. After this, care was based on ensuring the person remained as comfortable as possible at all times.
- Patients had personalised EOLC care plans that used the Modified Richmond Agitation – Sedation Scale (m-RASS). This scoring system is a tool for measuring consciousness and delirium and assisted staff to administer the appropriate medication and support.

Nursing staffing

- Staffing levels were calculated using a corporate nursing allocation tool. The nursing rota was completed monthly and adjustments made 24 hours in advance based on patient numbers and dependency.
- Unqualified staff members including health care assistants and reception staff supported clinical staff.
- As of 1 July 2016, the hospital had 20 whole time equivalent (WTE) inpatient nursing staff employed and 7.8 WTE health care assistants (HCAs) for inpatients. The inpatient departments had a ratio of nurse to health care assistant of 2.6:1.
- There was one WTE nurse vacancy due to maternity leave.
- Nursing staff we spoke with told us they considered there was sufficient nursing staff to meet the needs of patients.
- From July 2015 to June 2016, the use of bank staff in inpatient departments was higher than the average of other independent acute hospitals we hold this type of data for in the reporting period, except for in January 2016 when the rate was lower than the average. There were no agency nurses working in inpatient departments in the last three months of the reporting period.
- For the same reporting period, there was no bank and agency used for inpatient HCAs, except for four months when the rates were similar to the average of other independent acute hospitals.

Good

Medical care

- Agency staff had not been used on the inpatient wards for over a year. Bank staff worked at the hospital regularly and were familiar with policies and procedures. This provided continuity of care for patients and ensured these staff could work safely as they were familiar with the systems and processes of the hospital.
- The oncology service employed a manager, two specialist oncology sisters, two chemotherapy nurses and two development nurses.
- Two chemotherapy nurses staffed the oncology unit at all times. We observed nurses contact the ward to liaise with ward staff to cover breaks for staff in the unit during the day.
- Two registered nurses and two health care assistants staffed the endoscopy unit.
- End of life care was the responsibility of all staff and there were no designated nursing staff for the role.

Medical staffing

• The hospitals inpatient wards were shared with surgical patients. The medical staffing arrangements are reported on under the surgery service within this report.

• Nursing staff in the oncology unit could contact the RMO on the ward if medical advice was needed.

Are medical care services effective?

Good

We rated effective as good.

Evidence-based care and treatment (medical care specific only)

- We saw relevant and current evidence based guidance, standards, best practice and legislation were identified and used to develop how services, care and treatment were delivered. For example National Institute for Health and Care Excellence (NICE) guidance CG161: falls in older people assessing risk and prevention and European Oncology Nursing Society (EONS) extravasation guidelines.
- There were policies in place describing the management of neutropenic sepsis, which were compliant with NICE guideline CG151 (neutropenic sepsis: prevention and management in people with cancer).
- The endoscopy unit did not have Joint Advisory Group (JAG) accreditation at the time of inspection. The service had registered with JAG and had completed an endoscopy global rating scale (GRS) self-assessment. GRS is a quality improvement system designed to provide a framework for continuous improvement for endoscopy services to achieve and maintain accreditation. JAG had yet not formally reviewed the hospital and hospital management said they were looking at two years until accreditation.
- The hospital had an audit programme throughout all clinical departments. Audits were completed and reported to the departments and through to the clinical governance meetings. Audits included hand hygiene, WHO checklist, pain and medicine management and patient health records.
- The hospital took part in national audits, for example the NHS safety thermometer, VTE, NCEPOD (The National Confidential Enquiry into Patient Outcome and Death) reviews clinical practice and identifies potentially remedial factors.
- The hospital had responded to the withdrawal of the Liverpool Care Pathway (LCP) and the publication of 'One Chance to Get it Right'. The hospital had a personalised EOLC plan for patients who were recognised to have a life limiting condition and were expected to die within seven days. At the time of inspection, no patients were on this care plan.

Pain relief (medical care specific only)

- There was a pain assessment scale within the National Early Warning Score (NEWS) chart used within the hospital. We reviewed eight sets of NEWS charts, all of which had been completed correctly.
- Pain score and assessment prompts were included in the 'Nursing Intentional Rounding' form used by staff, to ensure their patients were safe and comfortable. Staff made hourly intentional rounds for all inpatients and day patients. Patients told us nurses routinely asked them about their pain levels part of these rounds.
- We spoke with two oncology patients, who told us staff met their pain management needs. There were no medical patients admitted at the hospital at the time of the inspection.

- Nurses on the oncology unit told us they could contact the RMO to prescribe additional pain relief for a patient if it was required.
- The pharmacy team supported pain management at ward level by providing advice and support to patients and clinical teams. Staff included details of medications given on discharge in a letter to the patient's GP. This ensured that GPs were kept informed.

Nutrition and hydration

- Staff screened all patients for malnutrition and the risk of malnutrition on admission, using the Malnutrition Universal Screening Tool (MUST). We reviewed six medical records, all of which had been completed correctly.
- Patients on the oncology unit had access to a food and drinks menu, which they could order from at any time during their treatment.
- Nutrition and hydration was included in the 'patient needs' prompt on the 'nursing intentional rounding' form used by staff, to ensure their patients were safe and comfortable. Intentional rounds were undertaken hourly for all inpatients and day patients. Patients told us nurses routinely offered them drinks as part of these rounds.

Patient outcomes (medical care specific only)

- The hospital told us they audited patient outcomes through the participation in national audit programmes. A corporate quality dashboard was produced which enable each hospital to monitor outcomes such as unplanned readmissions, transfers out and infection rates. Staff sought advice from corporate medical director and/or director of clinical services when outcomes showed a negative trend.
- The hospital reported no re-admission rates related to medical care between July 2015 and June 2016. This meant that patients who were discharged from the hospital were not required to be re-admitted.
- Results on patient outcomes were compared with other locations within the region and across the corporate group through the corporate clinical dashboard. This used data from the incident and risk-reporting database. This allowed the hospital to review both their own data and compare this with hospitals of a similar size within the corporate group.
- Staff reported three deaths between July 2015 and June 2016. Two deaths were related to EOLC and one an oncology patient.

Competent staff

- There was a corporate policy in place for granting and maintaining consultant practicing privileges. The MAC was responsible for granting and reviewing practising privileges for medical staff and we saw evidence of this being done in the MAC meeting minutes.
- In the reporting period July 2015 to June 2016, 22 practising privileges were removed due to retirement, relocation or because of the hospital no longer providing paediatric services. In the same period, one consultant was suspended due to lack of up to date certification.
- The hospital had systems in place for supporting staff with learning and development, however in practice, few staff working in endoscopy had received an annual appraisal due to capacity constraints. As of 27 October 2016, the appraisal rate for staff in endoscopy was 17%, oncology 89%, ward staff 82% and ward administrative staff 100%. Overall, the appraisal rate for the hospital was 70%. We did not see an action plan but were told that staff who had not had an appraisal were on target to have one completed by the hospital appraisal timescale. Lack of appraisals for endoscopy staff may have meant the service did not address any potential staff performance issues.
- Staff we spoke to told us they had a yearly or twice yearly appraisal. They felt it was useful and managers discussed performance and opportunities for training and progression.
- Nurses we spoke to said they felt supported by their managers in regards to maintaining their registration with the Nursing and Midwifery Council (NMC). They told us that the ward manager had recently carried out training and support sessions related to revalidation for both Cornwallis and Mountbatten Wards.
- Staff told us they had could access training and gave us examples of training they had recently completed in addition to mandatory training. For example, a

chemotherapy nurse told she had recently completed a two-day systemic anticancer therapy course and a ward HCA told us she had recently completed a bereavement-counselling course.

- Bank staff had access to the same on-line training modules as permanent hospital staff.
- We saw competency certificates for ward, oncology and endoscopy staff. Examples of competencies included pain management, cannulation, and administration of chemotherapy and operation of specific equipment.
- Minutes of the July 2016, clinical governance meeting stated that EOLC e-learning modules would be available to nursing staff. An implementation date was not documented. The hospital was currently collating names for a study day available via the local hospice for nurses (October 2016) and HCAs (April 2017), the attendees would act as champions and cascade the information to their teams.

Multidisciplinary working

- A multidisciplinary team meeting took place daily on Cornwallis Ward at 8:30am; attendees included nurses, business support, pharmacists and physiotherapists.
- We saw evidence of input from allied health professionals, for example physiotherapists, dieticians and speech and language therapists in patient records. Staff we spoke with told us they had good access to these teams in the hospital.
- We observed good multidisciplinary team working between the RMO, nursing staff, pharmacy staff and oncology staff during our inspection.
- The hospital had a good working relationship with the local hospice and staff were able to access consultant support for advice on managing EOLC patients.
- Nursing staff and the resident medical officer (RMO) described a good working relationship with pharmacy staff. We observed friendly and professional interactions between the pharmacist and nursing staff on the wards and the cancer nurse specialists.

Seven-day services

- The resident medical officer (RMO) provided medical cover 24 hours a day seven days a week.
- Consultants were responsible for their own patients and it was a requirement of corporate practising privileges policy, that consultants remain available (both by phone and, if required, in person) or arrange appropriate alternative named cover, via a buddy system if they will be unavailable, at all times when they had inpatients in the hospital.
- There was always a senior nurse available at the hospital as a contact point for both staff and patients, including to help resolve patient queries and to accept out of hours admissions.
- Patients' in the oncology unit were provided with a telephone number enabling them to have access to support and advice 24 hours a day seven days a week.
- Either a pharmacist or pharmacy technician (with phone access to a pharmacist) provided an on-call service 24 hours a day seven days a week.
- Hospital staff had access to support from the local hospice 24 hours a day seven days a week.

Access to information (medical care only)

- We saw a range of information was available for patients. This included information published by recognised organisations such as Macmillan, as well as signposting to services such as complementary therapy providers.
- Endoscopy patients and inpatients received a letter on discharge. This included details of the procedure or treatments, changes to medication, findings and details of any follow up. Staff sent a copy of this letter to the patients GP and a copy was kept at the hospital in the patients' medical records. This meant there was a continuity of service and all medical teams were kept informed.
- We saw three records of medical patients recently discharged from the hospital. All were completed with appropriate assessments, signatures, allergies were noted and all observations were documented and dated.
- The hospital had an adult risk assessment document in place. This was used during the pre-assessment of each patient. It allowed for standardised assessment and documentation, there was guidance on the frequency of each assessment tool, unless clinical judgement or the

patients' condition determines otherwise. Its contents included Malnutrition Universal Screening Tool (MUST), pressure ulcer, moving and handling, falls, intravenous site and bed rail risk assessment.

- The hospital had a medical records department on site. Staff we spoke with told us that medical records were easy to access and NHS medical records will always be returned to the belonging NHS Trust as soon as they were no longer required. Staff tracked notes so their location was known.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards (medical care patients and staff only)

- The corporate policy for safeguarding adults incorporated the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS). The policy had clear guidance that included the MCA 2005 legislation and set out procedures that staff should follow if a person lacked capacity. The policy included the process for consent, documentation, responsibilities regarding the consent process.
- Staff we spoke with could describe their responsibilities to ensure patients consented when they had capacity to do so or that decisions were taken in a patients best interests when they lacked capacity.
- Patients signed their consent for chemotherapy agreements and we saw these in patients' records. We saw recorded evidence that staff outlined the expected benefits and risks of treatment so patients could make an informed decision.
- The hospital carried out a quarterly audit of completion of consent forms and documentation in patient records. Audit results showed 94% compliance with the standards during the June 2016 audit.
- Staff understood the 'do not attempt cardio-pulmonary resuscitation' (DNACPR) decision making process and described decisions with patients and families. At the time of inspection, there were no patients who had a DNACPR in place.

Are medical care services caring?

Good

We rated caring as good.

Compassionate care

- The patient-led assessments of the care environment (PLACE) assessment for privacy, dignity and wellbeing between February and June 2016 was 70%, which was below the England national average of 83%. However, we saw staff treating patients in a kind and considerate manner. We saw staff knock and wait before entering patient's rooms on the wards. Patients told us staff always treated them with dignity and respect. Comment cards received from patients stated, "Treated with the utmost dignity and respect, and am always taken care of in a way which exceeds my expectations" and "deals with patients in a friendly and dignified manner."
- We observed staff on Cornwallis Ward introducing themselves to patients and their relatives.
- We saw staff respond quickly to patient's call bells, which had been activated on Cornwallis Ward.
- Staff asked all patients to complete a patient satisfaction questionnaire that incorporated questions of all aspects of their care and experience. The hospital measured national survey information, for example the Friends and Family Test (FFT), and used all patient feedback to guide investment plans, treatments offered and the overall patient experience.
- The hospital FFT scores for NHS patients from January to June 2016 were above 98%, which was similar to the England average, except in May 2016 when it was lower at 96%. The FFT response rate at the hospital was in line with the national average (40%), except in June 2016 where there was a response rate of 30%.
- We saw 17 responses on comment cards from patients who attended Becket suite, the oncology unit. Comments included, "Excellent 5 star treatment", "Very good communication from staff, always remember who I am and my needs, very reassuring", "Always listening and addressing concerns promptly" and "Staff are very attentive and caring at a difficult time of treatment."

Understanding and involvement of patients and those close to them

Good

Medical care

- Staff discussed side effects of treatment with patients in a kind and considerate manner.
- Patients received full explanations and details about the procedures they were to have. We saw leaflets and booklets contained this information.
- Patients we spoke with told us they were given information about the costs of treatment and the various methods of payment.
- Oncology patients could ring a dedicated number if they felt unwell at home. They carried a record book with details of what to do if they experienced feeling unwell. This was in line with the Manual for Cancer Services: Department of Health, 2004.
- We spoke with two oncology patients who attended the oncology unit. They told us staff were caring and professional. They felt involved in their care and were given adequate information about their diagnosis and treatment. Staff gave patients time to ask questions and answered questions in a way patients could understand.
- Staff told us that relatives were encouraged to participate in the care of patients when this was appropriate. For example, relatives assisting with mouth care and personal care. However, we did not observe this, as there were no medical or end of life care patients on the ward during inspection.
- Patients undergoing an endoscopic procedure attended a pre-assessment clinic to receive a full explanation as well as medicines necessary for them to have their procedure at this appointment.
- The hospital did not conduct any local bereavement surveys. However, patient information leaflets were available that were produced by charities, the hospital and the local authority. Leaflets included 'Coping with dying', 'Hospice information' and 'Registering a death'. They included information on practical issues when someone dies and information on registering a death with contact details of the local registry office. Ward staff contacted relatives after the death of a close one to offer any support required over the telephone or in person. Staff told us they would make every effort to send a staff representative to attend a patient's funeral.

Emotional support

- The oncology nurses provided specialist palliative support to patients, their relatives and staff. They were contactable seven days a week. The hospital also worked closely with the clinical nurse specialist from the local hospice who provided specialist palliative support to patients, their relatives and staff. The palliative care team were contactable seven days a week.
- Bereavement support was not specifically provided by the hospital. Relatives were signposted to relevant outside agencies that could support them. A patient told us they had been provided with information on who to contact if they required emotional support.
- The chaplain provided pastoral care, which included practical, emotional and spiritual support. The chaplain visited the hospital two days every week and on request. Staff offered to put patients in touch with a minister of their faith if requested.
- Staff told us debriefing sessions were encouraged for staff. Staff involved in a difficult case were encouraged to talk about their experiences and support each other.
- We saw staff interacting with patients in a supportive manner and provide empathy and reassurance.
- Two oncology patients told us they could relax when they were having treatment. They gave examples of having treatment in a single pod, were able to listen to music, use the hospital Wi-Fi access to use smart devices and watch movies.
- The oncology unit had six individual rooms where patients could have treatment as well as private conversations with their relatives and staff.

Are medical care services responsive?

Good

We rated responsive as good.

Service planning and delivery to meet the needs of local people

- Patients including those requiring end of life care received holistic care. Inpatient wards offered en-suite single rooms with televisions and internet facilities for patients to use. There was limited space in patient rooms to accommodate an extra chair for relatives who wanted to stay overnight. However, relatives could stay overnight in a separate single room if this was available. Staff told us that not many relatives requested to stay overnight, however the hospital were able to accommodate all relatives previously.

- Friends and family were able to visit the hospital from 2pm to 8pm daily. Outside these hours; visiting was by agreement with nursing staff and patients. There were unlimited visiting times for end of life care patients and there was access to a separate lounge where patients and relatives could reflect and enjoy time together.
- The endoscopy unit was open daily Monday to Friday when sufficient patient numbers permitted. We were told that occasionally the unit would open until 6pm to accommodate for later sessions.
- The oncology unit was open Monday to Friday from 8am to 9pm and were flexible with opening outside those hours when required. This gave patients a choice in the time or day of the week they had their treatment. Patients had access to telephone advice 24 hours a day, seven days a week.
- The hospital had a pharmacy which provided both inpatient and outpatient services. The pharmacy was open from 9am to 5pm Monday to Friday and 9am to 1pm on Saturday. We saw leaflets offering a free and confidential medicines helpline to patients so they could contact the pharmacy department after their hospital visit. The helpline was available from Monday to Friday 9am to 5pm and Saturday 9am to 12.30pm.
- A pharmacist or pharmacy technician provided an on-call service (with phone access to a pharmacist) 24 hours a day seven days a week. There were appropriate processes in place for staff to obtain medication from the pharmacy department out of hours.
- Food and drink facilities were available for patients and visitors at the hospital restaurant. The restaurant was closed due to refurbishment during inspection. However, temporary arrangements were made available for patients and visitors. Hot and cold drinks were available at any time on request.
- An outsourced company provided catering at the hospital. The PLACE assessment between February and June 2016 showed the hospital had a score of 94% for food, organisational food and ward food. This was higher than the England average of 91% for food and organisation food and 92% for ward food.
- The hospital provided three meals a day for inpatients. Choice could be seen on menus, there was also a 'chef's specials' menu available which provided additional choices for patients. A member of catering staff spoke with patients daily to discuss any individual needs.
- Catering staff were aware of the side effects from treatments and recognised the importance of patient to eat something they chose and to their liking. We saw the catering department also provided a 'home comforts menu', which had choice such as scrambled egg and rice pudding.
- One physiotherapist was trained in acupuncture and provided this as a therapy service on the oncology unit and was available on request. Staff told us that consent for the service was documented in the patient's care records.
- Oncology patients received their treatment in an individual room. Two patients we spoke with said this provided them privacy. However, they also felt "Isolated" in the rooms and would have liked the opportunity to talk with other oncology patients during treatment.

Access and flow

- Staff initially saw the majority of inpatients in outpatients and were admitted if required. All patients who were admitted were pre-assessed either face to face or by telephone. Staff conducted an interview via telephone for patients undergoing a minor procedure. Therefore, the hospital was responsive to sharing the patient pathways and ensured that all relevant information was given to the patients.
- The oncology unit provided an average of 100 episodes of chemotherapy sessions per month, and this capacity met the current demand.
- Oncology patients accessed treatment through their insurance companies or privately. Patients received a pre-assessment clinic appointment where a doctor decided on the treatment regime, with a nurse in attendance. This determined how many days a week the patient attended for treatment.
- There were no waiting lists for oncology at this hospital. Patients reported that they did not have to wait long for chemotherapy treatment and they could choose a time and date that suited them best.
- The hospital accepted patients for end of life care both inside and outside normal working hours. Palliative care consultants were available, on call, to receive referrals at all times. We were told referrals were received with or without a cancer diagnosis. Data on the percentage of patients who were referred with a cancer and non-cancer diagnosis were not collected. Therefore, we were unable to establish the mix of patients requiring

end of life care. This would ensure that EOLC patients were treated equally regardless of their diagnosis. Staff told us that the majority of end of life care patients were oncology patients.

- The hospital did not have an end of life care alert system to alert staff to a new admission. However, the oncology team usually knew patients who were admitted to the hospital for end of life care and the admission was often expected. This provision was adequate for a hospital of this size.
- Patients who were admitted for end of life care and did not have a cancer diagnosis were flagged up daily through the huddle meetings and referrals were made to the local hospice palliative care team This meant that patients received specialist end of life care.
- Systems were in place to facilitate the rapid discharge of patients to their preferred place of care. Staff assessed patient's needs and arranged for appropriate equipment to be in place when patients were discharged.
- We were told most of the patients stayed in their preferred place of care and patients were discharged within 48 hours if equipment was required. However, there was no data available to confirm the percentage of patients that received their preferred place of care and how rapid the discharge was.
- Care pathways directed staff to consider all aspects of discharge planning for inpatients. We saw sections such as take home medication, follow up appointment dates and key contact details had been completed which meant patients were protected from the risks associated with poorly planned discharge from the hospital.
- Nurses on the wards referred a patient to the community team if a patient required additional assistance when they returned home. For example, medication, palliative care and wound care.
- Staff in the endoscopy unit sent a copy of discharge letters to GPs on the same day as the procedure. They used the NHS secure email system in keeping with the hospital information governance best practice.
- Staff reported an incident regarding a patient who was transferred out to another facility in July 2016. The patient had deteriorated during the post-operative period and required further treatment in emergency and critical care. The incident was investigated and showed findings, root cause and lessons learned.

Meeting people's individual needs

- We saw leaflets offering a free and confidential medicines helpline to patients so they could contact the pharmacy department after their hospital visit. The helpline was available from Monday to Friday 9am to 5pm and Saturday 9am to 12:30pm.
- Staff gave patients pain information leaflets at pre assessment and on discharge to take home which provided information on how to manage pain following discharge from hospital.
- Oncology patients had access to a range of leaflets explaining their condition and treatment. Most of these were produced by recognised national charities. No leaflets were displayed in other languages. However, the manager told us these could be obtained from the charity if required.
- Patients attending the oncology unit had access to a range of complementary therapies such as aromatherapy, reflexology and acupuncture. We did not see any therapies provided during inspection but patients we spoke with valued them and felt they gained therapeutic benefit. We saw the August 2016 oncology meeting minutes that showed a physiotherapist had completed an acupuncture course and was commencing an acupuncture course specific to oncology. The hospital supported staff and gave them protected time to complete courses. This gave the patients an option as complementary therapy.
- We saw a range of information was available for patients. These included post-operative pain advice booklets, cancer pain management and information published by charities regarding the different types of cancer, coping with the diagnosis, treatment and the future.
- The oncology unit was awarded the Macmillan Quality Environment Mark (MQEM) in 2014, which is valid for three years. This stipulates units must be welcoming and accessible to all; they are respectful of people's privacy and dignity; they are supportive to user's comfort and well-being and listen to the voice of the user.
- The hospital also ran a support group "Chaucer Chatters" for oncology patients, their relatives and friends. The group met monthly in the hospital restaurant where everyone was welcome and refreshments were provided. A variety of topics were discussed such as the different types of cancers,

treatments and the resources available. This gave patients, relatives and friends the opportunity to gain knowledge and enabled them to share experiences and gain mutual strength. We saw the group's 2017 programme, which was scheduled through to December and included topics such as living with cancer, hair and make-up, complementary therapies, musical evening and a Christmas party. Group comment cards showed overwhelmingly positive feedback such as "Chaucer Chatters social group enables me to meet up with other people in a similar situation and chat in an informal social setting", "Excellent", "A great initiative to meet up other cancer patients and be able to discuss any worries openly", and "Learn useful stuff along the way."

- The hospital provided a welcome letter to patients admitted to the wards. The letter explained the process of admission, facilities on the ward and hospital and provision of meals. It also explained the staff handover arrangements on the wards and medication rounds.
- The hospital provided pastoral care to patients requiring spiritual support regardless of their religious denomination. Staff were aware of how to contact the service.
- In the event of the death of a patient, the hospital had a service level agreement with a local undertaker. Staff were able to contact the undertaker at any time who then collected the patient from the ward. If a relative wanted the patient to be moved to a different location, this could be arranged with the funeral directors.
- Staff explained to us how deceased patients were cared for after death. After a death had occurred, families were able to stay at the hospital for as long as they required. Staff gave relatives the choice of whether to help with after death care or whether they left this to nursing staff. The RMO verified death in front of the relatives and prepared the medical certificate detailing cause of death. Staff made this available to families before they left the hospital.
- Cornwallis Ward had a 'Death of the Patient' resource folder that was accessible to all staff in the hospital. It contained blank medical certificates, cremation forms and guidance, local funeral director contact details, register office information, BMI policy for the management of the deceased, after death patient check list, pastoral care information and a logbook.
- Staff told us how they accessed professional translation services for people who needed them. This was arranged at pre-assessment and the same translator followed the patient through the hospital, from admission to discharge. However, staff advised us translators were rarely needed. This supported patients to build trust with the translator and ensured effective communication.
- Staff told us they could access leaflets containing information about endoscopic procedures in other languages if required.
- We asked staff about arrangements to support people living with a learning disability or dementia. Staff identified the needs of these patients at the pre assessment appointment. The hospital had a dementia strategy and staff told us there were facilities for carers to stay overnight when required.
- PLACE assessment between February and June 2016 showed the hospital scored 81% for dementia, which was just higher than the England average of 80%. Dementia was included in PLACE assessments for the first time in 2015, and focused on key issues such as, flooring, decoration (for example contrasting colours on walls), signage, along with seating and availability of handrails, which can prove helpful to people living with dementia. The hospital had a dementia strategy to ensure they met the needs of people living with dementia.
- Staff assessed patient's weight before admission and arranged the availability of appropriate equipment when required. The hospital had equipment that could cater for bariatric patients up to a certain weight. Equipment was suitable for patients with a BMI of less than 40. They had a wider chair, appropriate beds and an adapted wheelchair.

Learning from complaints and concerns

- The hospital recognised there might be occasions when the service provided fell short of the standards to which they aspired and the expectations of the patient were not met. Staff encouraged patients who had concerns about any aspect of the service to contact the hospital in order that these could be addressed. These issues were managed through the complaints procedure.
- We saw a patient information guide on Cornwallis Ward that included a section on the formal complaints procedure. The BMI leaflets 'Please tell us' were located throughout the hospital and contained information on how to raise any concerns. Staff gave patients the opportunity to complete the hospital's patient survey questionnaire.

Good

Medical care

- There were 15 complaints on the hospital complaints log between March and September 2016. Three of these were related to medical wards and included complaints related to temperature of the patient's room, incorrect pricing and a lost consent form for a patient who was in the waiting room for three hours. The hospital investigated all three complaints and all had concluded promptly within a week to three weeks. This met with the hospital complaints policy of 20 days.
- CQC directly received one complaint about the hospital in the reporting period July 2015 and June 2016. There were no complaints referred to the NHS Ombudsman or Independent Healthcare Sector Complaints Adjudication Service (ISCAS) between July 2015 and June 2016.
- Staff told us that due to the size of the hospital it was normal practice for complaints to be discussed as they were received. These were then reviewed in the daily morning meeting. The executive director, director of clinical services and hospital heads of departments attended this. They told us this ensured a transparent approach that allowed early identification of issues for onward cascade. Complaints were discussed at clinical governance meetings, the medical advisory committee and ward meetings. This showed learning was shared across the hospital and disseminated to all appropriate staff.
- Oncology patients we spoke with said they knew how to complain but had not felt the need to as the care and treatment was of a very high standard.
- Staff at all levels were encouraged and empowered to address any concerns whilst the patient was on site and resolve any issues as soon as possible.
- The responsibility for all complaints rested with the executive director who decided which head of department and/or consultants needed to be involved in the investigation. The executive director, director of clinical services or the quality and risk manager were allocated to investigate complaints, depending on what the complaint involved. An acknowledgement was sent to the complainant immediately upon receipt of the complaint, which explained the investigation process and timescales.
- The BMI Healthcare complaints policy set out the relevant timeframes associated with the complaint response process. An initial acknowledgement was required within two working days and a full response within 20 working days. If a complaint was escalated to a further stage, the complainant was given contact information for the health ombudsman. Private and NHS patients were signposted to ISCAS and the NHS Ombudsman respectively.
- Management monitored investigations to ensure timescales were adhered to and responses provided within 20 working days. If a response could not be provided within this timeframe, a holding letter was sent to keep complainants fully informed of the progress of their complaint. We saw the records of complaints investigations. Staff retained all complaint information in a paper file. Electronic copies were stored on the hospital information management system.

Are medical care services well-led?

Good

We rated well-led as good.

Leadership and culture of service

- There was a clear management structure which staff were aware of. This meant leadership and management responsibilities and accountabilities were explicit and clearly understood.
- The management structure for medical care service at the hospital was the executive director and the director of clinical services who were responsible for the ward manager and ward sisters. Heads of departments oversaw the running of their respective areas and reported to the executive director and director of clinical services.
- All staff we spoke with told us that the senior team at the hospital were visible and approachable. All staff knew who the senior team were. All staff told us they had seen change and improvement since the executive director came into post and were very positive about working at the hospital. One comment we received in respect of the senior team was, "the culture has changed and I am now able to confidently do my job". Another member of staff said they felt "they were able to grow within the hospital".
- Nursing staff on Cornwallis Ward and the oncology suite spoke highly of their direct line manager and felt able to raise issues with them.

- Staff described an open reporting culture with an emphasis on learning. A member of staff said they felt able to report on themselves, for example a medication error.
- There were no whistleblowing concerns reported to CQC in the last 12 months.
- All staff we spoke with described good team working within all clinical areas in the hospital.
- Ward staff told us that they all worked well together. Several of the staff had been there over 20 years. Staff told us they regularly socialised together. Staff felt supported and felt there was a work and life balance.

Vision and strategy for this core service

- All BMI hospitals worked to an overarching BMI Healthcare strategy.
- The hospital had a vision and clinical strategy that was made up of five key themes. These were to deliver high quality patient outcomes; to provide best patient care; to ensure patients have a premium experience; to work closely with their consultants and to be proud of their care.
- Staff we spoke with demonstrated clear understanding that the patient was at the heart of what they do and worked together to achieve this.
- Staff from the oncology, endoscopy and inpatient wards had clear ambitions for the services they provided and were aware of the visions of the departments. The vision was to provide the highest standard of care and ensure patient experiences were as comfortable as possible.
- The endoscopy team were working towards Joint Advisory Group (JAG) accreditation. Information provided by the hospital showed they would achieve this in two years' time. This was supported by the hospital action plan for JAG accreditation.
- An action plan was in place with education in end of life care as a focus. Two nurses were due to complete palliative care courses provided by the local hospice and upon completion would become end of life care champions in the hospital. As champions, their role would be to review any improvements to end of life care, provide specialist palliative care and be a point of contact for end of life care patients and relatives.
- There was a BMI Healthcare corporate policy for the management of the deceased, which had been ratified by the cancer clinical steering group.

Governance, risk management and quality measurement (medical care level only)

- A corporate governance strategy provided a framework for local governance procedures. The medical care service governance processes were the same throughout the hospital. We have reported about the governance processes under this section of the surgery service within this report.
- The hospital had a clinical governance committee (CGC) which met monthly. The committee governed all inpatient governance, risk management and quality measurements for medical care. The group linked with the hospital Medical Advisory Committee (MAC) who met bi-monthly.
- There were a variety of monthly meetings that discussed risk, incidents and complaints. These included the senior management team and heads of department meetings. Management disseminated information from these meetings at ward meetings. In turn, information from departmental meetings was fed up to the heads of department. This ensured there was good communication throughout the hospital and staff were aware of specific incidents and causes for concern. We saw examples of minutes that demonstrated departmental and other meetings fed into the CGC such as ward meetings, medicine management group and resuscitation committee. Management discussed clinical quality and governance at the bi-monthly MAC. Attendance at these meetings included the executive director, director of clinical services and a GP.
- Cornwallis Ward had a clinical governance folder that contained recent minutes from the clinical governance committee, complaints log and incident reports. We saw evidence that staff had signed that they had read the folder.
- Staff attended monthly ward meetings. We saw minutes that demonstrated good attendance. Staff told us the meetings were useful and the minutes were circulated by email. This meant that staff unable to attend had access to discussions and information.
- There was 100% completion rate of validation of registration for doctors working at the hospital under practicing privileges in the reporting period July 2015 to June 2016.
- The hospital management and the MAC, managed consultant contracts, known as practicing privileges, jointly. We saw evidence of discussion of new

applications and outcomes in the September 2016 MAC minutes. There was also evidence of consultants suspended when they had not provided the required documentation requested by the hospital management and reinstated once they had, and consultants removed due retirement or the hospital no longer provided children's services.

- There was a hospital risk register on the hospital intranet in respect of the whole organisation. The executive director monitored the register in respect of this location.
- The hospital risk register 2016 was divided into categories such as patient safety, information management, financial, reputation, governance, operational, leadership and workforce, workforce health and safety, and facilities and infrastructure. The risk register detailed the risks, mitigations, actions, allocated key lead and committee who had responsibility for ensuring existing risk controls and actions were completed for the identified risks.
- The hospital risk register was for the whole hospital and this had clearly stated a clinical or non-clinical area and a department of the hospital within each risk description. This meant that staff in each department were able to identify which area a risk is related to. Staff we spoke with were able to tell us what was on the risk register.
- The risk register was reviewed monthly at 2016 CGC meetings as a standard item to ensure that identified risks were on the register and if any risks had changed they were re-categorised. We saw this in the CGC meeting minutes from April to July 2016.

Public and staff engagement

- The hospital monitored patient satisfaction in all areas of its service delivery. This was achieved through obtaining patient feedback and views through the forms they placed on the wards and the oncology unit. An external provider provided the analysis of this information and this was arranged through the corporate teams. The hospital received a corporate monthly report, which showed response rates, rating within categories and ranking against all BMI hospitals. It also included all the freehand patient comments.
- The hospital continually reviewed the patient satisfaction scores and dealt with areas for improvement.
- The hospital encouraged social interaction for staff through a range of events organised specific to the hospital. For example, the Pin Awards, staff recognition awards and a free of charge lunch to all staff on their birthdays.

Innovation, improvement and sustainability

- The senior management team was constantly seeking extra funding from corporate to make extensive refurbishments to the hospital. All staff we spoke with felt motivated to be working in a newly refurbished environment.
- Staff were encouraged to be innovative. For example, a chemotherapy nurse initiated and led a hospital run support group for oncology patients, relatives and friends called the "Chaucer Chatters".

Good

Surgery

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

Are surgery services safe?

Good

We rated safe as Good

Incidents

- The hospital followed their corporate 'Incident Policy, including Serious Incidents' (dated February 2016).
- All staff we spoke with had a good understanding of the reporting system and knew where the forms were kept. All incidents, accidents, and near misses were reported using a paper based system. Staff were able to give us examples of the type of incidents they reported.
- The hospital did not report any 'never events' between July 2015 and June 2016. 'Never events' are serious largely preventable patient safety incidents that should not occur if a unit has implemented preventable measures. The occurrence of a 'never event' could indicate unsafe practices.
- Between July 2015 to June 2016 there had been two serious incidents reported that required investigation. Serious incidents were investigated using the corporate root cause analysis (RCA) template. We saw evidence demonstrating the RCA resulted in learning points. For example following a patient falling from the operating table, we saw actions had been recommended such as patients walking themselves to theatre, rather than taken on a trolley, and ensuring patients are positioned centrally on the operating theatre. We observed these taking place during our inspection.
- The hospital reported three deaths in the period between July 2015 and June 2016, however, none of these deaths related to patients who had, had surgery.
- Incidents were reviewed by and investigated by an appropriate manager (depending on where the incident took place). The designated investigator would also to look for improvements to the service. They were also investigated through a process of root cause analysis (RCA), with outcomes and lessons learned shared with staff. We saw five RCA investigation reports, which had been completed, with recommendations and action plans, which confirmed the process.
- Data received from the hospital showed between July 2015 and June 2016 there had been 270 clinical incidents reported across the hospital, and 188 incidents (70%) occurred within surgery and inpatients. For example, a patient with a latex allergy had not been identified at pre admission, but had been identified on admission. The theatre was alerted on the patient's admission and they made sure the correct precautions were in place, by making sure the patient could be swapped with another patient to be first on the theatre list. This ensured safe surgery for the patient.
- Staff told us they received feedback directly if they were involved in an incident or at their team meetings where incidents and complaints were discussed. We saw ward and theatre team meeting minutes, which confirmed incidents were a standing agenda item.
- Staff also told us they received feedback on incidents via, 'closing the loop', which were weekly review meetings of all incidents that had occurred. These meetings are able to identify trends of themes from incidents, for example, we saw three investigations into

incidents that happed on the same theatre list, it was identified a contributing factor to all these occurred due to a member of staff arriving late. We saw there were recommendations and action plans, which confirmed the process.

- Theatre staff had a morning brief, which ensured all staff had up to date information about risks and concerns.
- All incidents and adverse events were discussed at the bi-monthly Medical Advisory Committee (MAC), and the monthly Clinical Governance Committee (CGC), and Senior Management Team (SMT) meetings. We saw the minutes of the MAC, CGC and SMT confirmed this.
- The hospital did not carry out specific morbidity and mortality review meetings, due to the low numbers of patients treated and the resulting low numbers of patients who would fall into this category. The Chair of the MAC told us, all patient complications were reviewed by the MAC.
- Staff described the principle and application of duty of candour, Regulation 20 of the Health and Social Care Act 2008, which related 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 saw three examples where the hospital had followed the duty of candour within complaint responses.

Clinical Quality Dashboard or equivalent

- The NHS safety thermometer is a local improvement tool for measuring, monitoring, and analysing patient harms and harm-free care. The NHS safety thermometer allowed the proportion of patients who were kept 'harm-free' from venous thromboembolisms (VTE's), pressure ulcers, falls and catheter associated urine infections to be measured on a monthly basis.
- Patients identified at risk were placed on an appropriate care plan and were monitored more closely by staff. For example, if a patient was at risk of developing pressure ulcers the hospital would provide a special mattress for them, which would help stop pressure ulcers occurring.
- The hospital reported one case of hospital acquired venous thromboembolism (VTE) between July 2015 and June 2016, and a screening compliance rate of 100% for the reporting. We looked at eight sets of medical records, which showed all patients had been risk assessed for VTE, and if appropriate action taken if required. We saw the root cause analysis investigation report, which had been completed for reported case of VTE, with recommendations and action plan. Action plans were monitored and had been completed within the required timescales.

Cleanliness, infection control, and hygiene

- Staff followed their corporate 'Standard Infection Control Precautions Policy' (dated February 2016), which included hand hygiene, use of personal protective equipment such as gloves and aprons, and spillage of body fluids.
- The infection prevention control meeting met quarterly and discussed incidents, surgical site infections, and root cause analysis, outbreaks of infection, infection control training, and feedback from audits or reports. We saw the minutes of the infection prevention control meetings held in April and July 2016.
- The 'Infection Prevention and Control Annual Work Programme' for 2015 to 2016, detailed activities to ensure the hospital met the requirements of the Department of Health: Code of Practice on the prevention and control of infections and related guidance. This programme of work was mapped to the compliance criteria within the code of practice and included systems to manage and monitor the prevention and control of infection, maintain a clean and appropriate environment, ensure appropriate use of antimicrobials and ensure all staff were fully involved in the process of preventing and controlling infection.
- We saw that waste was separated in different coloured bags to identify the different categories of waste. This was in accordance with Health Technical Memorandum (HTM): Safe Management of Healthcare Waste, control of substances hazardous to health (COSHH), and health and safety at work regulations.
- The hospital had two operating theatres one of which had laminar flow theatre ventilation (a system that circulates filtered air to reduce the risk of airborne contamination), which was best practice for ventilation within operating theatres, and particularly important for joint surgery to reduce the risk of infection.

Good

Surgery

- We found equipment was visibly clean throughout the department, and staff had a good understanding of responsibilities in relation to cleaning and infection control. All equipment we saw had 'I am clean' labels on them, which indicated the date the equipment had been clean and was safe to use.
- We saw personal protective equipment, was available in all patient bedrooms. Personal protective equipment is protective clothing such as aprons, gloves, goggles, or other garments or equipment designed to protect the wearer's body from injury or infection.
- Hand sanitising gel was available in all patients' bedrooms. In addition, we saw nurses carried small personal bottles of hand sanitising gel attached to their uniforms. Posters were displayed in ward offices which explained the '5 moments for hand hygiene', we did not see these posters on display in patient bedrooms, however the hospital was undergoing a programme of refurbishment and posters had been removed.
- There were no dedicated hand wash basins in patient bedrooms, staff and visitors used the basin in the bedrooms ensuite bathroom or the hand washing facilities in the sluice. This is not in accordance with the Department of Health's (DoH) Health Building Note (HBN) 00-09: infection control in the built environment, which states ' The corporate 'Infection Prevention and Control, Hand Hygiene Policy (including training)' (dated May 2016), states 'Basins in patients' bathrooms/ en-suites must never be used for hand washing by clinical staff ', and goes on to say so.
- The hospital told us they are aware of the lack of dedicated hand washbasins in patient bedrooms, and we saw the installation of new hand wash basins was included in their programme of works, which was in progress. However due to the arrangement of the rooms; they would be unable to have a dedicated hand hygiene basin in all patient's rooms. This meant the hospital did not comply with their corporate policy, and HBN 00-09.
- We observed staff following the local policy and procedure when scrubbing, gowning, and gloving prior to surgical interventions. When a procedure had commenced movement in and out of theatres was restricted. This minimised the infection risk.
- At the pre-operative assessment stage, staff screened high-risk patients for Meticillin-resistant Staphylococcus aureus (MRSA), such as orthopaedic surgery, those who had been in hospital previously and patients who had previously tested positive for the bacteria. This was in line with Department of Health: Implementation of modified admission MRSA screening guidance for the NHS (2014). MRSA is a type of bacterial infection and is resistant to many types of antibiotics.
- If a patient was identified as carrying MRSA, they received treatment in the five days leading up to their surgery. The scheduling of theatre lists allowed for patients who had infection to be last on the theatre list. However, although it may be considered desirable to place a patient who had been identified as having MRSA, at the end of a procedure list, in mechanically filtered environments such as operating theatre suites, the number of air exchanges should render this unnecessary. Good infection control practices, which should be in place between all patients, should reduce the risk of cross-infection. Patients identified with MRSA could be isolated in their rooms to prevent cross infection risks.
- Hospital data showed that between July 2015 and June 2016 there had been a total of 17 surgical site infection (SSI) following surgery at the hospital, for primary hip or knee arthroplasty, other orthopaedic and trauma, breast and gynaecological procedures, upper gastrointestinal, colorectal, and urological surgery.
- The rate for primary hip or knee arthroplasty, other orthopaedic and trauma, breast and gynaecological procedures were higher than the rate of other independent hospitals we hold this type of data for. We saw two root cause analysis investigation reports, which had been completed, with recommendations and action plan. Action plans were monitored and had been completed within the required timescales.
- The rate of infections for upper gastrointestinal, colorectal, and urological procedures was lower than the rate of other independent hospitals we hold this type of data for.
- There were no reported SSI resulting from the revision of hip or knee arthroplasty, spinal, cardiothoracic, cranial, or vascular procedures, between July 2015 and June 2016.

- All SSI were discussed at the monthly clinical governance meeting and the quarterly infection prevention control meeting. We saw evidence of this in the minutes.
- Patient-led assessments of the care environment (PLACE) are a system for assessing the quality of the patient environment; patients' representatives go into hospitals as part of teams to assess how the environment supports patients' privacy and dignity, food, cleanliness, patients living with dementia or disability and general building maintenance. The PLACE assessment for cleanliness for the period February to June 2016 was 85%, which was worse than the England national average of 98%. The assessment of cleanliness covers areas such as patient equipment, baths, showers, toilets, floors and other fixtures and fittings. The cleaning of the hospital was undertaken by an outside company. However, during our inspection, we found the hospital to be clean. The patients we spoke with also told us they were pleased with the cleanliness in the hospital.

Environment and equipment

- The ward and theatre areas were visibly clean, well maintained, and free from clutter. The ward comprised of single bedrooms with en-suite bathroom facilities, suction and piped oxygen, and emergency call facilities.
- None of the staff we spoke with had concerns about equipment availability. If any equipment required repair, they reported it and it was fixed quickly. Staff were aware of the process for reporting faulty equipment.
- We saw three resuscitation trolleys in the theatre and on the wards. All trolleys were locked. Records showed the trolleys were checked daily. All drawers had the correct consumables and medicines in accordance with the checklist. We saw consumables were in date and the trolleys were clean and dust free. The automatic defibrillator worked and suction equipment was in order. This meant staff had access to equipment in the event of a medical emergency.
- Storage facilities within the hospital for supplies and equipment were well organised and tidy, this meant equipment was easy to locate. All disposable items we saw were in date for example, syringes and wound dressings.
- Some of the patient bedrooms on both Cornwallis and Mountbatten ward had carpets. Carpets in the clinical areas prevent effective cleaning and removal of body fluid spillages. The Department of Health's HBN 00-09 says, "carpets should not be used in clinical areas". However, we saw carpets in the patient bedrooms were visibly clean and free from stains. We also saw regular deep cleans of carpets had taken place. At the time of inspection, we saw that carpet replacement was included in the hospital's current programme of works.
- The Association of Anaesthetists of Great Britain and Ireland safety guidelines Safe Management of Anaesthetic Related Equipment (2009) were being adhered to. There was a logbook with each anaesthetic machine to record the daily pre-session check and these had been completed. This gave assurances that safety checks had been undertaken and equipment was safe to use.
- There was a difficult intubation tray, which contained equipment to be used when a patient's airway was difficult to manage. There was a completed weekly checklist to indicate that daily checks were made. However, we found the contents of the trolley did not match the checklist. This was bought to the attention of the theatre manager, who stated they would revise the list. This meant staff could not be confident the correct equipment was available, if they had to use the difficult intubation trolley.
- Single use sterile instruments were stored appropriately and were within their expiry dates. The theatres' equipment store had sufficient storage space and items such as surgical procedure packs, implants and consumable items were appropriately stored in a tidy and organised manner.
- Theatre Sterile Supply Unit (TSSU) services have been taken off-site to a corporate hub to ensure compliance with regulatory requirements for decontamination, Health Technical Memorandum (HTM) 01-01: management and decontamination of surgical instruments (medical devices) used in acute care.
- Water supplies were maintained at safe temperatures and there was regular testing and operation of systems to minimise the risk of Legionella bacteria. During our inspection, we saw copies of the records for flushing of water outlets and weekly, monthly, and annual checks.

This is in line with requirement of Health and Safety Executive (HSE) L8; and Health Technical memorandum HTM04-01 A and B: guidance on the control of legionella.

- The Patient Led Assessment of the Care Environment (PLACE) for the period of February to June 2016, which showed the hospital, scored 75%, for condition, appearance, and maintenance, which was worse than the England average 93%. The assessment for condition, appearance, and maintenance covers areas such as decoration, the condition of fixtures and fittings, tidiness, signage, lighting (including access to natural light), linen, access to car parking, waste management, and the external appearance of buildings and maintenance of grounds. However, during our inspection we saw there was a programme of works in place for redecoration. Patients and relatives spoke enthusiastically about the redecoration that had already been undertaken, one relative told us, they had visited the hospital on other occasions, and the decoration had "made an improvement".
- We saw portable appliance testing (PAT) stickers on electrical equipment, which showed electrical equipment, had been tested and was safe to use. This meant the hospital had assurance that all pieces of medical equipment were tested for electrical safety.
- We looked at 10 pieces of medical equipment on both Cornwallis and Mountbatten ward, including a bladder scanner, and three blood pressure machines. We found six pieces of medical equipment were out of service date The Quality and Risk manager was informed at the time of inspection; they immediately contacted the relevant companies, and ensured they had a date to service the equipment.
- We saw staff had competency documents to show they were trained in the use of medical equipment, this meant the hospital ensured staff were safe and competent to use medical equipment on patients.

Medicines

- Staff followed their corporate 'Safe Management of Medicines Policy' (dated August 2014), which included, roles and responsibilities, storage of medicines in hospital departments, dispensing, controlled drugs and preparation of medicines. We also saw 10 pharmacy standard operating procedures on Cornwallis ward specific to the hospital.
- The pharmacy department carried out a number of audits related to medicines. These included the quarterly medicines management audit, missed doses audit, quarterly controlled drug (CD) audit, pharmacy intervention audit and audit of time taken to dispense a prescription. We saw recommendations from the audits were monitored and had been completed within required timescales.
- On both Cornwallis and Mountbatten ward, we saw medicines were kept in clinical room with keypad access and cupboards in the room were locked. Keys for those cupboards were kept in a coded key safe or were in the possession of a nurse. This was in line with standards for good medicines management and prevented unauthorised access to medicines.
- Medicines on Cornwallis and Mountbatten ward were kept in temperature-controlled rooms and we saw evidence of ambient temperature records being kept, and completed. Medicines requiring refrigeration were stored in the pharmacy department This provided assurances that staff stored refrigerated drugs within the correct temperature range to maintain their function and safety.
- In theatres, we saw that appropriate medicines were stored in dedicated medicines fridges. We saw records, which showed daily checks were undertaken. We also saw recommended actions to be taken if the fridge temperatures were not in the correct range.
- We completed a check of 10 stock medicines on Cornwallis ward and found one medicine, which had gone out of date the day before the inspection. This meant the safety and effectiveness of medicines on the ward could not be assured. We bought this to the attention of the nurse in charge.
- There was a clear process for the wards and theatres to order controlled drugs (CDs). We observed appropriate storage and record keeping of controlled drugs (CD's) on Cornwallis ward and in theatres as per the Misuse of Drugs Regulations, 2001. We saw evidence of daily

balance checks and three monthly pharmacy audits in the stock CD register; however, it was not clear if these had been completed in the register of patient's own CD's.

- We checked the stock balance of two CD's in the cupboard on Cornwallis ward and found these were correct as per the CD register; all CD's we checked were in date. However, we noted that there was a balance of 28 tablets of a CD in the register of patients own drugs dated January 2016 but there were no tablets for this patient in the cupboard. We highlighted this to the nurse in charge who discussed this with pharmacy and requested the patient's notes. The discharge letter stated the medication had been given to the patient and was signed by the nurse. The nurse told us she would complete an incident form. We saw a copy of the pharmacy CD audit from April 2016 and did not see evidence of patient's own CD's audited. This meant there was not a robust process to ensure patients' own medications were monitored and accurate records kept.
- Emergency drug packs for cardiac arrest, anaphylaxis (allergic reaction), and deteriorating patients were available and standardised across the service. This meant staff were familiar with them as they were the same throughout the hospital. Records of locations and expiry dates were kept in pharmacy.
- Staff had access to appropriate information related to medicines such as the British National Formulary 72 and online access to an intravenous medicines guide.
- We reviewed four prescription charts for patients currently on Cornwallis ward or recent discharges, all prescriptions were signed and dated, allergies were documented, and medicines omitted had a reason for omission documented. We saw evidence of pharmacy endorsements on the prescription charts.
- There was a limited selection of over labelled medication available on Cornwallis Ward for discharges outside of pharmacy opening hours. Two registered nurses would check the medication dispensed before giving it to the patient.
- A maximum of five private outpatient prescriptions were kept in a locked medicines cupboard on Cornwallis Ward. We saw a log, which indicated when a prescription had been issued, to whom and what for. This is in line with NHS Protect, security of prescription forms guidance 2013.
- A member of the pharmacy team visited the ward daily to facilitate patient discharge, complete a clinical review of the inpatient prescriptions, check patient's own medication to determine suitability of use and support the multidisciplinary team with clinical decisions regarding patient's medication.
- The pharmacy department included one pharmacy manager, two full time pharmacists, three part time pharmacy technicians, and a pharmacy assistant. A bank pharmacist who covered annual leave and occasional Saturdays supported the department. The executive director managed the pharmacy manager who managed the remaining pharmacy staff.
- A pharmacist attended a multidisciplinary team meeting on Cornwallis Ward at 8:30am; other attendees included nurses, business support, and physiotherapists. Issues such as patients on high-risk medicines such as insulin or oral anticoagulants (medicines to prevent blood clots), those on compliance aids, admissions and discharges were highlighted to the pharmacist at this time. This meant the pharmacy team could prioritise patients based on risk and reduce the risk of medication errors and delayed discharges.
- The pharmacy department supplied patients' with supporting information with their medication. For example, they supplied leaflets regarding unlicensed medicine advice, safe and effective use of antibiotics and alert cards for oral anticoagulants to appropriate patients.

Records

- Staff followed their corporate 'Policy for the Retention of Records (including guidance for ALL business documentation and healthcare records)', which included record keeping, maintenance and closure and confidentiality.
- Patient medical records were paper based. At the time of inspection, we saw patient personal information and

medical records were managed safely and securely, in line with the Data Protection Act. When not in use patients notes were kept in a locked cupboard behind the nurse's station.

- Patient records were well maintained and completed with clear dates, times and designation of the person completing the documentation. We reviewed eight sets of medical records. The records were written legibly and assessments were complete. Each patient had an appropriate care pathway in place dependent upon the procedure they had. Evidence was available to show discharges were planned. There were pathways for specific operations for example total hip and knee replacements. These pathways followed the patient's journey from pre assessment through to discharge. Records were multidisciplinary which meant all relevant information was in one place. In addition, they highlighted particular risks that were relevant to the procedure.
- Medical records showed where staff had completed patient risk assessments. These included risk assessments for falls, malnutrition, and pressure ulcers. All risk assessments completed followed national guidance. For example, all patients were risk assessed on admission for their risk of venousthomboemolsim (VTE), and this was in line with the National Institute for Health and Care Excellence (NICE) QS3 – statement one.
- Medical records were held securely on site, in multiple locations at the hospital. There was an archive facility for patients medical records, which would be stored on site, for newer records once the patient has been discharged the notes were transferred off site to a secure location to be scanned. The hospital was in the process of sending all medical records, for scanning. There was a tracker system in place, which we saw; this meant staff knew where the medical records were at all times.

Safeguarding

- There was an up to date corporate ''Safeguarding Adults Policy Incorporating Mental Capacity and Deprivation of Liberties and PREVENT For England and Wales' (dated May 2015) and 'Safeguarding Children Policy' (dated March 2016) with defined responsibilities at national, regional and hospital level
- We saw that there were posters displayed in each department for example, 'What to do if you're worried an adult is being abused'. These posters contained flow charts and actions to be taken and who to contact in the event of adult or child safeguarding issues arising.
- Staff received mandatory training in the safeguarding of adults and children, as part of their induction followed by safeguarding refresher training undertaken every two years.
- Safeguarding of vulnerable adults training was undertaken every two years for levels one and two. Data indicated, by August 2016, 92% of required staff had completed level one, which was better than the BMI Healthcare target of 90%. However, 82% of required staff had completed level two, which was worse than the BMI healthcare target. This meant the hospital did not have assurance all staff had the necessary up-to-date training to keep patients safe.
- Safeguarding of children training was undertaken every two years for levels one and two. Data indicated, by August 2016, 95% of required staff had completed level one, which was better than the BMI Healthcare target of 90%, however, 79% of required staff had completed level two, which was worse than the BMI Healthcare target. However, from August 2016 the hospital no longer provided surgical services to children.
- The director of clinical services was the hospital safeguarding lead and trained to level 3, who had access to the BMI regional safeguarding lead trained to level 4. This was in line with the 'intercollegiate document, safeguarding children and young people: role and competences for health care staff, March 2014'. Most staff knew who the lead was for safeguarding.
- The staff in pre assessment and on the ward demonstrated an understanding of their safeguarding responsibilities and an understanding of safeguarding procedures. However, not all staff we spoke with in theatre were clear on what a safeguarding concern was, but were able to describe how they would act upon and escalate any concerns they had.
- There had been no safeguarding concerns reported to CQC between July 2015 and June 2016.

Mandatory training

- Mandatory training for all staff groups was comprehensive with many modules accessed through an on line learning system. Mandatory training modules included fire safety in a hospital environment, information governance, Protecting people at risk of radicalisation (PREVENT) and safety, health and the environment. Other training was role specific for example patient moving and handling, medical gas training, and acute illness management.
- We saw records, which showed 90% of theatre staff and 94% of inpatient ward staff had completed their mandatory training, which was equal or better than the BMI corporate target of 90%.
- The resident medical officers (RMO) were required to undertake their mandatory and statutory training with the agency that supplied them as part of their contract.
- Consultants had to complete mandatory training with the trust they worked for as part of their appraisal process.

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

- Pre assessment of patients was in accordance with British Association of Day-care Surgery (BADS). Staff explained that during pre-assessment they checked the patient's understanding of the treatment they were being admitted for, discussed discharge arrangements, and completed a range of risk assessments such screening all patients over 70 for dementia. During the pre-admission appointment any special needs were identified and recorded such as dietary or mobility needs.
- The unit did not have any level two or three critical care beds. To mitigate this risk, the unit only operated on patients pre-assessed as grade one or two under The American Society of Anaesthesiologists (ASA) grading system. Grade one patients were normal healthy patients, and grade two patients had mild disease, for example well controlled mild asthma.
- As part of the preoperative assessment process, patients completed a pre-assessment medical questionnaire. These were reviewed at pre-assessment appointments to assess suitability of patients for surgery and carry out health assessments such as electrocardiogram (ECG). The pre assessment team told us they felt supported by and worked closely with the consultant anaesthetists, and were given advice if they identified any concerns about a patient's condition or fitness for surgery.
- As part of the questionnaire all female patients of child-bearing age were asked the date of their last menstrual period (LMP), to check their pregnancy status. On admission to the ward, female patients had an additional pregnancy test performed. This was in line with the National Patient Safety Agency 2010 Rapid Response Report, which highlights the 'unreliability of LMP as a sole indicator of potential pregnancy'.
- Risks to patients were assessed and monitored at pre assessment, and then checked again prior to treatment. These included risks relating to morbidity, medical history, pressure ulcer risk, and venous thromboembolism (VTE). Rates for screening VTE were reported as 100%, between July 2015 and June 2016. During our inspection, we looked at eight sets of medical records, which showed risk assessments had been completed correctly.
- The hospital used the National Early Warning Score (NEWS), and escalation flow charts. NEWS is a simple scoring system for physiological measurements, such as blood pressure and pulse, for patient monitoring. If a patient's score increased, staff were alerted to the fact and a response would be prompted. The response varied from increasing the frequency of the patient's observations, to urgent review by the patient's consultant. Observation of the eight sets of medical records showed these assessments were undertaken. .
- The hospital used intentional rounding by nursing staff, which was completed throughout the patients stay. This meant patients were visited in their rooms hourly to check, for example, if call bells and a drink were in reach, if the patient had pain or had any other requests. We saw eight intentional rounding charts, which showed these had been completed correctly.
- There were alarm systems to alert medical and nursing staff when immediate assistance was required in the case of an emergency.
- There was a service level agreement with a local NHS trust, between July 2015 and June 2016, there had been ten cases of unplanned transfer. The rate of emergency patient transfers to an acute hospital had remained

consistent, and was 'not high' when compared to other similar hospitals we hold data for. Staff we spoke with were familiar with the escalation process and where necessary, patients were transferred by ambulance.

- The hospital employed two resident medical officers (RMO's) via an agency who were available on site 24 hours a day, seven days a week. The RMO was available to assist nursing staff and consultants by completing any necessary medical tests and writing prescriptions required by the lead consultant. The RMO gave us an example of a patient who had become unwell during the night, and had to transfer to the local NHS hospital.
- The practising privileges agreement required the designated consultant to be contactable at all times when they had inpatients within the hospital. They needed to be available to attend within an appropriate timescale according to the level of risk of surgical emergency. This included making suitable arrangements with another approved practitioner to provide cover in the event they were not available, for example whilst on holiday.
- We observed theatre staff carrying out the World Health Organisation (WHO) 'five steps to safer surgery' checklist for procedures. The WHO checklist is a national core set of safety checks for use in any operating theatre environment. The checklist consists of five steps to safer surgery. These are team briefing, sign in (before anaesthesia), time out (before surgery starts), and sign out (before any member of staff left the theatre).
- Staff regularly audited the use and completion of the WHO surgical checklist. We saw observational audit of the checklist gained 100%. During our inspection, we observed two theatre teams undertake the WHO checklist correctly, and saw eight sets of notes, which showed the WHO had been completed fully.

Nursing and support staffing

- The hospital used the corporate staffing levels. The nursing rota was entered into the system monthly and adjustments made 24 hours in advance based on patient numbers and dependency.
- The hospital mainly undertook elective surgery, which meant the number of nursing, and care staff hours needed on any particular day could be calculated and booked in advance. Employed staff worked their contracted hours flexibly to cover the rota and any gaps were filled by bank or agency nursing staff or by overtime.
- Staff we spoke with told us they had enough staff on duty at all times to deliver good individualised care to all patients even though they could sometimes be very busy.
- Clinical staff were supported by other staff members including health care assistants and reception staff.
- As of 01 July 2016, there was 20 whole time equivalent (WTE) inpatient nursing staff employed and 7.8 WTE health care assistants (HCAs) for inpatients. The inpatient departments had a ratio of nurse to health care assistant of 2.6:1.
- There was one WTE nurse vacancy currently on maternity leave.
- Data from the hospital showed between July 2015 to June 2016, the use of bank and nurses in inpatient departments was higher than the average of other independent acute hospitals we hold this type of data for in the reporting period, except for in January 2016 when the rate was lower than the average. There were no agency nurses working in inpatient departments in the last three months of the reporting period.
- For the same reporting period, there was no bank and agency used for inpatient HCAs, except for four months when the rates were similar to the average of other independent acute hospitals.
- Staff told us that agency staff had not been used on the inpatient wards for over a year and bank staff used worked at the hospital regularly and were familiar with policies and procedures. This provided continuity of care for patients and ensured these staff could work safely as they were familiar with the systems and processes of the hospital.
- Handover between shifts was undertaken in a small office on the ward to ensure privacy of confidential information.
- The hospital told us, and staff confirmed there was always a senior nurse on call cover out of hours, with support of a duty manager at all times.

Good

Surgery

- The resident medical officer, we spoke with, had a high level of confidence in the skills and experience of the nursing staff.
- We found the hospital complied with recommendations of the Association for Perioperative Practice (AfPP) for the numbers of staff on duty during a standard operating list. This consisted of two registered nurses, an operating department practitioner, a healthcare assistant, a consultant, and an anaesthetist.

Surgical staffing

- All patients were admitted under the care of a named consultant. There were 180 consultants who had been granted practising privileges at the hospital. Practising privileges is a term used when doctors have been granted the right to practise in 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 medical and dental practitioners' (dated November 2015), which included granting and maintaining practising privileges, and roles and responsibilities. The executive director and 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 privileges.
- Operating theatres were generally in use between 8.30am and 8pm Monday to Friday, and 8.30am to 4pm on Saturdays. If a patient was required to return to theatre out of hours due to complications from surgery, there was an on call system in place to notify staff. The Resident Medical Officer (RMO) knew how to contact a patient's consultant, or the on call anaesthetist. We saw the on call list for the hospital displayed in the nursing offices.
- Consultants were responsible for the care and treatment of their patients at all times. Consultants were accessible by telephone 24 hours a day. Consultants would visit their patients at weekends and out of hours if required. It was a requirement of BMI Healthcare's practising privileges policy, that consultants remained available (both by phone and if required, in person) or arranged appropriate alternative named cover if they would be unavailable at any time when they had inpatients in the hospital. We saw a duty rota of consultants and their contact details clearly displayed in the ward office, alternatively these were available at reception. Staff told us they never had trouble contacting consultants, if needed.
- The hospital used an agency that provided a RMO onsite 24-hours a day, seven days a week, on a rotational basis. The RMO worked two weeks on, followed by two weeks off. The RMO undertook regular ward rounds to make sure the patients were safe. If the RMO was called out during a significant part of the night or was unwell, the RMO told us there were contingency plans in place to obtain cover.
- All staff and the RMO told us there were no concerns about the support they received from consultants and their availability.
- The RMO had a formal handover when they changed shifts. The RMO told us there was good communication around the patients with specific needs, however we were unable to observe a handover as there was no change over during our visit. The RMO also informed us they attended the evening nursing handover, in order to ensure they were aware of any potential patients who may require further input overnight.

Emergency awareness and training

- The hospital had a 'Business Continuity Policy' (dated February 2016), which included roles and responsibilities, training, risk assessment and recording and reporting. There was also a 'Bomb Threat Policy' (dated June 2015), which outlined the actions to be taken in the event of a bomb threat being received.
- Scenario based training was held regularly this ensured staff responded appropriately to emergency situations. For example, staff told us these included, basic airway management (a way of and resuscitation of a patient. The hospital also provided monthly-unannounced resuscitation training, most recently was 28 September 2016, and we saw evidence of this.

Are surgery services effective?

Good

We rated effective as good

Good

Surgery

Evidence-based care and treatment

- Care and treatment was delivered to patient in line with the National Institute for Health and Care Excellence (NICE) and the Royal Colleges guidelines, for instance the Royal College of Anaesthetists. For example, the use of the national early warning system (NEWS) was used to assess and respond to any change in a patient's condition. This was in line with NICE guidance CG50.
- Staff assessed patients for the risk of venous thromboembolism (VTE) and took steps to minimise the risk where appropriate, in line with the venous thromboembolism: reducing the risk for patient in hospital NICE guidelines CG92.
- NICE guidance CG65 for hypothermia: prevention and management in adults having surgery was followed, the patients temperature was monitored within an hour of going to theatre, in the anaesthetic room and then every 30 mins if the operation takes longer than 30 mins. This is important as keeping patients warm lowers the risk of complications following surgery.
- The hospital followed NICE guidance for preventing and treating surgical site infections (SSI) NICE guidelines CG74. Following discharge, the hospital had implemented a follow up call for all hip and knee patients as part of their 30-day Surgical Site Infection (SSI) audit.
- We saw NICE guidelines NCG45 for preoperative tests were being adhered to, by the pre assessment nurse.
- We saw the hospital had recently implemented NICE guidelines CG42, Dementia: supporting people with dementia and their carer's in health and social care.
- The hospital provided data to the National Joint Registry (NJR). The NJR collected information on all hip, knee, ankle, elbow, and shoulder replacement operations to monitor the performance of joint replacement implants.
- Consultants confirmed that BMI surgical procedures were in line with best practice and were always followed. We saw evidence of this in the monthly Clinical Governance Committee meetings and the bi-monthly Medical Advisory Committee meetings, which highlighted latest NICE guidance.
- The hospital also provided breast surgery. The hospital, as part of the BMI Healthcare group had signed up to contribute information for inclusion in the national Breast and Cosmetic Implant Registry (BCIR). Similar to the NJR, the purpose of the BCIR was to monitor the performance of implants, specifically breast implants. National implementation of the BCIR was due to take place in September 2016, but due to problems with the website, this had been delayed. However, the hospital showed us a local register they kept in preparation for transfer of records to the BCIR once this was launched. This was in line with best practice guidance.
- Staff told us the service referred all cosmetic breast surgery patients to the breast care nurse pre-surgery, for counselling. This was in line with the Royal College of Surgeons (RCS).
- Comprehensive care pathways were in place for patients undergoing local and general anaesthesia. This included quality indicators of anaesthesia, management of pain and recommendations for the management, post discharge complications. This meant there was a standard system in place for each patient.

Pain relief

- There was a pain assessment scale within the National Early Warning Score (NEWS) chart used within the hospital. We reviewed eight sets of NEWS charts, which showed these had been completed correctly.
- Pain score and assessment prompts were included in the 'Nursing Intentional Rounding' form used by staff, to ensure their patients were safe and comfortable. Intentional rounds were undertaken hourly for all inpatients and day patients. Patients told us nurses routinely asked them about their pain levels part of these rounds.
- We spoke with five patients, who told us their pain management needs were met. One patient told us staff had explained about their pain management, including what to expect when they were discharged.
- Patients were given pain information leaflets at pre assessment and on discharge to take home which provided information on how to manage pain following discharge from hospital.

Nutrition and hydration

- Staff screened all patients for malnutrition and the risk of malnutrition on admission, using the Malnutrition Universal Screening Tool (MUST). MUST was documented within the integrated care pathway records. We reviewed eight sets of medical records, which showed these had been completed correctly.
- Nutrition and hydration was included in the 'patient needs' prompt on the 'nursing intentional rounding' form used by staff, to ensure their patients were safe and comfortable. Intentional rounds were undertaken hourly for all inpatients and day patients. Patients told us nurses routinely offered them drinks as part of these rounds.
- The hospitals 'post-operative nausea and vomiting care plan' contained clear escalation guidelines for symptom management for patients following surgery. The guidelines were clearly set out and presented in an easy to follow manner. Staff told us the guideline was easy to follow and use. We reviewed four care plans, which showed these had been completed correctly.
- Staff followed guidance on fasting prior to surgery, which was based on the recommendations of the Royal College of Anaesthetists, which states that food can be eaten up to six hours and clear fluids consumed up to two hours before surgery. Information regarding fasting was provided to patients in their pre admission pack stating that they needed to fast for six hours before surgery. We saw patients admissions were at different times to ensure compliance with this guidance. This ensured that patients were without food and water for the minimum amount of time. Additionally, staff told us, there was good communication between theatres and the ward, if the theatre lists were delayed, they would inform the ward so they could ensure patients were able to continue taking in clear fluids, as per guidelines.

Patient outcomes

- There were five cases of unplanned readmission within 28 days of discharge in the reporting period between July 2015 and June 2016. The Care Quality Commission (CQC) had assessed the proportion of unplanned readmissions to be 'not high' when compared to other independent acute hospitals we hold this data for.
- Under a service level agreement with the local NHS trust, ten patients had been transferred out to an NHS hospital between July 2015 and June 2016 because of post-operative complications. However, the proportion of unplanned transfers was found to be 'not high' when compared to other independent acute hospitals we hold this data for.
- The hospital provided data to the national Patient Reportable Outcome Measures (PROMs). All NHS patients having hip or knee replacements, varicose vein surgery or groin hernia surgery were invited to fill in PROMs questionnaires. The PROM questionnaire asks patients about their health and quality of life before they have an operation, and about their health and effectiveness of the operation afterwards.
- The hospital provided PROMs data for primary knee replacement (EQ-5D, EQ-VAS, and Oxford knee score) and primary hip replacement (EQ-5D, EQ-VAS and Oxford hip score). The EQ-5D profile asked patients to report on their health based on self-assessed levels of problems ('no', 'some' 'extreme'). The EQ-VAS questionnaire asked patients to describe their overall health on a scale that ranged from 'worst possible' to 'best possible' health.
- The hospital's PROMs data showed ten out of ten patients reported health improvements under the Oxford Knee Score criteria following primary knee replacement between April 2014 and March 2015. This was the most recent data available at the time of inspection.
- For primary knee replacements 100% felt their health had improved under the criteria EQ-5D. Under the EQ-VAS for nine out of the 10 patients during the same reporting period, 78% reported as improved and 11% as worsened.
- The hospital's PROMs data showed 16 out of 16 patients reported health improvements under the Oxford Hip Score criteria following primary hip replacement between April 2014 and March 2015. Eighty-six percent of the patients felt their health improved following surgery, and 7% as worsened under the EQ-5D criteria. Under the EQ-VAS 69% for the 16 patients during the same reporting period, reported as improved and 25% as worsened.

- Due to the small numbers of patients involved, these findings cannot be compared to national data. The PROMs programme required at least 30 patients in each category to calculate the average health adjusted scores and compare these outcomes to other hospitals.
- The hospital contributed data to the Private Healthcare Information Network (PHIN) to collate outcome data across the independent sector that was comparable with the NHS. The hospital told us it also compared patient outcome data with all hospitals across the BMI Healthcare group, such as returns to theatre, transfers out, unplanned readmission and infection rates, using the corporate dashboard.

Competent staff

- The hospital had systems in place for supporting staff with learning and development, however in practice; few staff working in surgery had received an annual appraisal due to capacity constraints. Lack of appraisals for theatre staff may have meant the service did not address any potential staff performance issues.
- Staff who had, had an appraisal told us they were undertaken yearly. They felt it was useful and managers discussed performance and opportunities for training and progression.
- All nursing and theatre staff completed competency assessments to ensure they had the skills and knowledge to carry out the roles they were employed to do. Competency assessments were completed before staff could undertake the specific procedure.
- One-hundred percent of nurses and operating department practitioners (ODP's), who worked within surgical services for six months or more, had recorded validation of professional registration. This meant the hospital conducted annual checks to ensure all the nurses were registered with the Nursing and Midwifery Council (NMC) and ODP's were registered with Health and Care Professionals Council (HCPC).
- Nurses we spoke with said they felt supported by their managers for maintaining registration with the NMC. They told us that the ward manager had recently carried out training and support sessions related to revalidation.
- Both RMO's were trained in advanced life support and would lead the response team in the event of any unexpected patient risks or emergencies until a consultant and ambulance arrived.
- Applications for practising privileges from consultants were reviewed and granted or declined by the executive director; the Medical Advisory Committee (MAC) endorsed these. This involved checking their suitability to work at the hospital, checks on their qualification, references, immunisation, and indemnity insurance. The hospital only granted practising privileges for procedures or techniques that were part of the consultant's normal NHS practice. The hospital would consider making an exception to this rule if a consultant provided evidence of adequate training and competency.
- The MAC reviewed practising privileges every year. This included a review of patient outcomes, appraisals, General Medical Council (GMC) registrations and medical indemnity insurance. The hospital told us that 22 consultants had had their practising privileges removed; this was due mainly to no longer providing paediatric services at the hospital, along with retirement or relocation. One consultant had their practising privileges suspended this was due to failing to provide up to date documentation the hospital required to renew their practising privileges. This showed the hospital had a good procedure in place to make sure all consultants were experienced and fit to care for patients.
- Consultant revalidation was part of the requirement for maintaining their practising privileges. Consultants only performed operations they were used to performing at the acute NHS trust where they were employed. This ensured they were competent and confident in undertaking operations and procedures. If a consultant wanted to carry out a new procedure, this had to be agreed as part of their practising privileges.
- Forty-eight consultants with practising privileges had not treated patients at the hospital between July 2015 and June 2016. We spoke to the Executive Director, who told us these were consultant anaesthetists and did not directly look after patients, but still had practising privileges at the hospital.

- Between July 2015 and June 2016, eight consultants had undertaken advanced life support (ALS) training, 119 out of 137 had completed basic life support (BLS) training. Twenty-three out of 28 required staff had undertaken the illness management (AIM) training
- The resident medical officer (RMO) completed training and appraisals through their employing locum agency. They also had a BMI consultant mentor who they could meet with to discuss and monitor progress with their development goals for the year. The RMO explained they have not yet met with their mentor, as at the time of inspection, they had only recently started.

Multidisciplinary working

- Throughout our inspection, we saw evidence of good multidisciplinary working in all areas. We observed positive interaction and respectful communications between professionals.
- Nursing staff and the RMO described a good working relationship with pharmacy staff. We observed a good working relationship between the pharmacist and nursing staff on the wards.
- Our review of eight patient records, talking with 21members of staff and five patients, confirmed there were effective multidisciplinary working practices, which involved nurses, doctors, physiotherapists, and pharmacy. Staff told us they felt supported by and that their contribution to overall patient care was valued. Staff told us they worked hard as a team to ensure patient care was safe.
- The preoperative assessment nurses liaised with anaesthetists and surgeons to coordinate preoperative investigations, including confirming what assessments were needed and following up the communication once, results were known.
- Theatre staff had a daily morning brief, which ensured all staff had up to date information about issues with scheduling or cancellations, risks or concerns.
- The multidisciplinary theatre team met every other month; we saw minutes from two of the recent meetings.
- We saw physiotherapy staff on the ward going to see patients and witnessed effective communication between physiotherapy staff and nurses. We also spoke with patients who told us about specific exercises a physiotherapist had given them to aid their post-surgery recovery.
- The hospital had service level agreements in place to access the services of local NHS hospitals. This included microbiology services, dietetic support, and the agreement for the local acute hospital to retrieve critically ill patients for intensive care treatment.
- A nurse from the ward would attend a daily meeting every morning, this allowed them to assess the number of patients planned to ensure the ward filled all the shifts. It also allowed for escalation of concerns or shortfalls in staffing. All departments of the hospital were represented at this meeting.

Seven-day services

- Theatre lists were undertaken Monday to Friday from 8.30am to 8pm, and Saturday from 8.30am to 4pm. The interim theatre manager and director of clinical services managed the theatre schedule. There was an on call theatre team rota in place for staff to attend quickly if a theatre was needed on a Sunday or out-of-hours.
- We saw rotas in place for key hospital staff, and anaesthetists, to ensure patients had timely access to services. However, staff told us they rarely needed to come into work whilst on call, as very few patients needed to return to theatre. The hospital had six unplanned returns to theatre between July 2015 and June 2016. We were told there was a service level agreement with the local NHS trust, to be able to transfer patient who require intensive care support (special departments of a hospital or healthcare facility that provides intensive care support to critically ill patients).
- The hospital was open seven days a week 24-hours a day to care for patients after surgery that needed to stay in hospital overnight and the weekend.
- The pre assessment clinics ran in Monday to Friday 8am to 5.30pm. There were no clinics run on Saturdays, but staff told us they were flexible with their times and would come in early or stay late to reflect patient's needs.

- The hospital had a pharmacy which provided both inpatient and outpatients services. The pharmacy was open from 9:00am to 5:00pm Monday to Friday and 9:00am to 1:00pm on Saturday.
- Either a pharmacist or pharmacy technician (with phone access to a pharmacist) provided an on-call service 24 hours a day seven days a week. There were appropriate processes in place for staff to obtain medication from the pharmacy department out of hours.
- The required Standard Operating Procedure set by the Department of Health says that women should have access to a 24-hour advice line, which specialises in post termination of pregnancy care. The consultant who undertakes the surgical termination of pregnancy provided the patient with a direct telephone number so they could contact them if they felt they need further support. Additionally the hospital provided the patient with a contact telephone number for the ward on discharge.
- The diagnostic imaging department provided 24- hour a day, seven days a week service for urgent examination request, via an on call system. This allowed staff to access diagnostic services in a time way to support clinical decision-making.
- The physiotherapy department provided inpatient services twice a day Monday to Friday 8am to 8pm, and once a day at the weekend.

Access to information

- There were comprehensive pathway records available to staff that contained all of the information staff needed to deliver effective care and treatment. These included risk assessments for venous thromboembolism (VTE), falls, nutrition, pressure ulcer assessment, and medical notes. We reviewed eight sets of notes, which showed these had been completed correctly.
- Patients were required to complete comprehensive pre-admission medial questionnaires prior to surgery, which included their past medical history and their current medications. Dependent upon a patient's history, patients may receive a nurse-led telephone clinical assessment, invited to undertake a physical face-to-face meeting with a member of pre-assessment staff where a number of investigations could take place or an anaesthetic referral. This would provide healthcare professionals information of the patient's current health status.
- Discharge letters were sent to patients general practitioners (GP's) on the day of discharge with details of the treatment or procedure completed, follow up arrangements and medicines provided.
- We reviewed the discharge arrangements and saw these were stated as soon as possible. This meant patients felt fully informed for all parts of their operation and recovery. Preoperative assessment staff told us they spoke to patients at length about their procedure and gave them information to take away, such as 'your guide to pain control', and 'infection prevention and control'. If a patient required a urinary catheter after surgery (a tube inserted into your bladder), the nurses gave them a 'guide for patients', which explained why the catheter was needed, and how it would be managed.
- We saw five discharge letters, which included admission details, clinical assessment, and medication on discharge, all five were fully completed. One copy would be given to the patient, another sent to the patient's general practitioner, and the third copy would be retained in their notes. This ensured continuity of care for the patients once discharged.
- Test results, including x-rays, were held electronically. The consultants and RMO had access to these as required.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- There was access to guidance and policies for staff to refer to about Mental Capacity Act (MCA) and Deprivation of liberty safeguards (DoLs). The hospital followed their corporate 'Consent Policy (June 2016), which included responsibilities and duties, training, key principles and assisting with decision-making.
- Patient Led Assessment of the Care Environment (PLACE) for February to June 2016 showed the hospital scored 81% for dementia, which was better than the England average of 80%. The PLACE assessment for Dementia was included for the first time in 2015, and

focuses on key issues such as, flooring, decoration (for example contrasting colours on walls), signage, along with seating and availability of handrails, which can prove helpful to people living with dementia.

- Safeguarding of vulnerable adults training was undertaken every two years for levels one and two, and included training in the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLs). The level of training undertaken was dependant on the role staff were performing.
- Staff we spoke with on the ward and preoperative assessment were clear about their responsibilities in relation to gaining consent from people, including those who lacked capacity to consent to their care and treatment.
- However, theatre staff had limited knowledge of the Mental Capacity Act (MCA), mental capacity assessments, or Deprivation of Liberty Safeguards (DoLs). When questioned staff could not provide appropriate examples of when a DoLs application may be needed and there was confusion between the differences of safeguarding requirements and that of the MCA. This meant the hospital did not have assurance all staff had the necessary up-to-date training to keep patients safe.
- During our inspection, we were told about a patient who had been at the hospital recently and had not signed their consent form prior to arriving at theatre. The corporate consent policy stated, 'for day case and inpatients a consent form properly completed and signed by the responsible clinician and the patient must be available in the notes prior to the patient leaving their room for surgery or other invasive procedure for which written consent is required.' We saw an investigation into this incident has been commenced and was on going.
- We saw eight sets of notes during our inspection. We saw evidence of staff following the consent policy and seeking consent from patients prior to procedure and on the day of the procedure. This meant staff were working in line with the General Medical Council guidance for consent and the hospital policy, which meant patients were involved and understood the reason for the procedure.
- Patients we spoke with told us they were given as much information as they required from their consultant prior to their operation, to enable them to give informed consent to the procedure. Any risks with regard to the operation or procedure had been explained to them.
- The BMI Chaucer followed their corporate 'Adult Resuscitation Policy' (dated March 2015) and 'Children Resuscitation Policy' (dated April 2015), which clearly identified the process for decisions relating to do not attempt cardiopulmonary resuscitation (DNACPR) orders. At the time of inspection, there were no patients with a DNACPR order in place. Patients resuscitation status was assessed and documented pre and during their admission.

Are surgery services caring?

Good

We rated caring as Good

Compassionate care

- Staff treated patients with kindness, dignity, and respect. Staff interacted with patients in a positive, professional, and informative manner. This was in line with National Institute for Health and Care Excellence (NICE) QS15.
- We spoke with five surgical patients on the wards. All patients we spoke with said the care they received was of a very good standard. One patient told us "my whole experience has been brilliant". Another patient said, "Staff are all really warm, and caring".
- We observed many positive interactions between staff and patients during our inspection. We witnessed staff approach people rather than waiting for requests for assistance. Most staff introduced themselves with "my name is". A patient told us, "all staff treated with me with respect". Patients told us staff were "helpful", "genuine", "caring" and "kind".
- We saw patients being treated as individuals and staff spoke with patients in a kind and sensitive manner.

Good

Surgery

- We saw chaperones were available. The hospital followed their corporate "Provision of Chaperones during Examination, Treatment and Care", (dated September 2015), which outlined roles and responsibilities, training and best practice guidance.
- We did not see posters on display informing patients of the availability of a chaperone. Staff told us, patients were given the opportunity to accept or decline a chaperone during their stay. Patients we spoke with told us they were aware they could ask for a member of staff to be with them if they wished.
- The NHS Family and Friends Test is a satisfaction survey that measures patient's satisfaction with the care they have received. Data for all patients between January to June 2016 showed the hospital had consistently high scores (greater than 96%) and the response rate varied between 30% and 54%. The response rates for this period were the same as or better than the average England response rate for NHS patients, except for May and June 2016, when it was below the average response rate. This showed that most patients were positive about recommending the hospital to their friends and family.
- We received four comment cards from patients who had recently had surgery at the hospital. All were very positive about care and treatment they received. Comments included "the nursing staff have been excellent", "all staff were friendly, and kind", "I was taken very good care of".

Understanding and involvement of patients and those close to them

- We saw eight sets of patient medical records and saw they included pre admission and pre-operative assessments that took into account individual patient preferences.
- We saw staff introduce themselves to patients, explain their role and the examination that was about to be performed.
- Discharge planning was discussed pre operatively to ensure appropriate post-operative caring arrangements were in place. We saw examples of written information that was given to patients to take home.
- Staff sent detailed information about the surgery patients were booked in for with the admission letter, which included admission date and time and length of stay. We saw examples of this information and it was in clear, simple language.
- All patients we spoke with told us their care was discussed in detail with them. Patients told us they were given time and were able to ask questions, and felt full informed and included in the decisions that were made about their care. One patient told us "I felt like I was included at all times, and given all the information I needed". Another told us "I felt like I could ask any anything, and that was ok".
- Clear and concise information was given to patients prior to their admission. They told the reception staff treated them with kindness and respect.
- The costs of treatment were discussed patients, including what was covered within the cost including tests, investigations and follow up visits, should they be required. Information related to different payment methods was available on the hospital web site, as well as via the hospital.
- Call bells were accessible for patients on the ward to enable them to call for assistance if required. We spoke with five patients who told us, nursing staff answered the call bells promptly.

Emotional support

- Patients told us they felt able to approach staff if they felt they needed any aspect of support.
- All patients' bedrooms were private and could be used to deliver any bad news, which may adversely affect a patient's future. Nurses told us that if a patient were going to receive 'bad' news from a consultant, then they would make sure that there was a nurse present as well to provide additional support.

Are surgery services responsive?

Good

We rated responsive as good

Service planning and delivery to meet the needs of local people

Good

Surgery

- The hospital worked with the local Clinical Commissioning Group (CCG) in planning services for NHS patients. Operating sessions were made up of a mix of patients who had selected the hospital through Choose and Book and private patients.
- All admissions for surgery were elective procedures; due to the surgery being elective service, planning was straightforward as the workload was foreseeable.
- As part of the preoperative assessment process, patient completed a pre-admission medical questionnaire, which would help identify patients with certain medical conditions or who may need further assessment. Dependent upon a patient's history, patients may receive either a Nurse-led clinical assessment, be invited to attend a face-to-face assessment where a number of investigations may take place, or be referred for an Anaesthetic review.
- Patients arrived at different times to enable staff to manage admissions and to reduce the patients waiting times for patients.
- The hospital did not provide surgical services for children.
- We saw that patients were given a copy of the letters sent to their GP outlining the treatment provided including prescribed medicines to take home and any follow up arrangements.

Access and flow

- There were 6,833 overnight and day-case patients admitted to the hospital between July 2015 and June 2016.
- Between July 2015 and June 2016, approximately 39% of all patients were NHS funded; the remaining 61% were private insured or self-paying patients.
- The NHS patients either were referred to the hospital via their general practitioners (GP), via the 'choose and book' system, or were referred directly to the hospital form the local NHS trust.
- During our inspection the theatre lists ran on time. The inspection did not highlight any concerns relating to the admission, transfer, or discharge of patients form the ward or theatres. The patients we spoke with did not have any concerns in relation to their admission, waiting times, or discharge arrangements.
- Theatre staff, consultants, and anaesthetists had an on call rota arrangement to manage any unexpected returns to theatre including weekends and overnight. This meant staff were available to ensure patients had timely access to services.
- There were 6,841 visits to the operating theatre between July 2015 and June 2016. Hospital data showed between July 2015 and June 2016, there had been 18 surgical procedures cancelled on the day of surgery for a non-clinical reason, which showed that a small number of operations were cancelled at the hospital. All patients were offered another appointment within 28 days of cancellation.
- Staff confirmed patients identified as high risk, such as diabetic patients, were usually scheduled for surgery at the beginning of the theatre list in case they developed complications during their procedure. The matron showed us how the pre assessment staff communicated any high-risk patients that had been identified, such as patients who were diabetic or may be living with dementia.
- Referral to treatment (RTT), under the NHS Constitution, patients in England says patients 'have the right to access certain services commissioned by NHS bodies within maximum waiting times, or for the NHS to take all reasonable steps to offer a range of suitable alternative providers if this is not possible'. The NHS Constitution sets out that patient's should wait no longer than 18 weeks from GP referral to treatment.
- Referral to treatment waiting times (RTT) for NHS-funded patients having inpatient surgery at the hospital, on average was 90% of patients received treatment within 18 weeks of referral. This was equal to the national target of 90%
- The hospital met the RTT target for patients admitted for treatment within 18 weeks of referral for August and September 2015, January 2016 and March to June 2016, for the reporting period. The worst month in this period was December 2015 where 81% of patients received treatment within 18 weeks of referral. The best month was May 2016, where 96% of patients received treatment within 18 weeks of referral. Although NHS England stopped the national target in June 2015, the hospital continued to monitor and treat patients in line with the target.

Good

Surgery

- Admission times were varied and we saw that reception staff greeted patients and showed them to their rooms. Staff were responsive and attended the patient promptly.
- At discharge, nurses gave patients a direct telephone number to the ward in their discharge pack. Patients could call this number and speak to a nurse, if they had any concerns.
- On arrival at the hospital, patients booked in at reception and this was reflected on the computer system so staff working on the ward knew when patients arrived. When the ward staff were ready to admit the patient was escorted to the ward by the receptionist, and taken into the bedroom.
- Pre-admission checks and assessments were undertaken, when complete the patient changed and waited for their procedure in the waiting room. Staff then escorted patients to the theatre for their procedures. The majority of patients walked to theatre rather than going on a trolley or wheelchair. Immediately after surgery, staff cared for patients in the recovery room.
- Once patients were stable and pain-free, staff took them back to the ward area to continue recovering. Patients had a responsible adult to collect, escort and stay with them for 24 hours. We saw in the patients care plan there was a section that must be completed with the nominated adult's name and contact details. This ensured staff were aware who to contact when the patient was fit for discharge and who would stay with them for 24 hours.

Meeting people's individual needs

- All admissions were pre-planned so staff could assess patients' needs before treatment. This allowed staff to plan patients' care to meet their specific requirements, including cultural, linguistic, or physical needs.
- A pre assessment phone call or meeting was held with the patient before the planned surgery date and any issues concerning discharge planning or other patient's needs were discussed at this stage.
- Intentional rounding by care staff was completed throughout the patients stay. This meant patients were visited in their rooms hourly to check for example, if call bells and a drink were in reach, if the patient had pain or had any other requests.
- The environment and provision of single rooms with television and en-suite bathroom facilities met individual patient's expectations of private healthcare facilities.
- Patients had access to a variety of information leaflets in the hospital. All information leaflets were in English, however staff told us they could access written patient information in other languages through an electronic system and obtained when required.
- An interpreting service for patients who did not speak English was available and staff knew how to access it.
- Vulnerable adults and patient's specific needs such as patients living with learning disabilities and dementia were identified at the pre-operative assessment stage and appropriate steps were taken to ensure they were appropriately cared for. Steps included screening all adult patients over 70 for dementia, or ensuring patients, where required, were accompanied by a relative or carer for their admission.
- The Patient Led Assessment of the Care Environment (PLACE) for February to June 2016 showed the hospital scored 81% for dementia, which was better than the England Average of 80%.
- The PLACE assessment for the period of February to June 2016 showed the hospital scored 80% for disability, which was lower than the England average of 81%. The place assessment for Disability was included for the first time in 2016, and focuses on key issues of access including wheelchair, mobility (e.g. handrails), signage and provision of such things as visual/ audible appointment alert systems, hearing loops, which can prove helpful to people living with disability.
- The hospital was accessible to patients with a physical disability, as it was all on one floor. We saw there were wheel chairs in the front entrance for patients to use, along with wheelchair accessible toilets. The bathrooms

in patient's rooms were easy access showers with no steps, there were also handrails and stools in the showers to provide extra support and stability when showering.

- There were leaflets available that explained payment options, and procedure of who to contact if there are any questions, or queries. Staff told us they would provide quotes and costs, and ensure that patients understood what the costs involved. The hospital website also clearly described the different payment options available.
- Relatives were able to stay overnight if this was required; they would be given bedding, and were able to sleep in the chair at the bedside, or in a separate room nearby.
- We were told there were service level agreements for specialist nurses for specific patient groups were available, such as urology or breast care.
- Pharmacy staff told us that they would provide patients with a medication record card if they identified a need for this. For example if the patient had trouble remembering to take their medicines.
- We saw leaflets offering a free and confidential medicines helpline to patients so they could contact the pharmacy department after their hospital visit. The helpline was available from Monday to Friday 9:00am to 5:00pm and Saturday 9:00am to 12:30pm.
- The hospital provided three meals a day for inpatients. Choice could be seen on menus, there was also a 'chef's specials' menu available which provided additional choices for patients. A member of catering staff spoke with patients daily to discuss any individual needs.
- Catering staff were aware of the side effects from surgery and treatments and recognised the importance of patient to eat something they chose and to their liking. We saw the catering department also provided a 'home comforts menu', which had choice such as scrambled egg and rice pudding. One patient told us they had been offered alternatives to the menu due to finding it difficult to swallow following surgery.
- The hospital took part in the Patient Led Assessment of the Care Environment (PLACE) audit February to June 2016, which showed the hospital, scored the same or better than the England average for food, organisation food and ward food. The assessment for food and hydration covers organisation questions looking at the catering services provided such as choice of food, 24-hour availability, mealtime, and access to menus. It also includes an assessment of food services at ward level, looking at areas such as the taste and temperature of food.
- We spoke with five patients who all spoke positively about the quality of the food offered; they told us they were offered a choice of food and drink. One patient told us the choice of food was "excellent", another patient told us the food was "good".
- Part of the pre assessment medical questionnaire included dietary requirements, which asked patients if they had any special dietary requirements, which meant individual patient needs were met. We spoke to one patient who had a dietary requirement, who told us the hospital catered for their needs, on this admission and previous admissions.
- Day patients were routinely offered a choice of sandwiches, soups, salads and jacket potato, or could be provided with specific requests for food that were not on the menu.

Learning from complaints and concerns

- The hospital received 26 complaints between July 2015 and June 2016. No complaints had been referred to Parliamentary and Health Service Ombudsman (PHSO) or the Independent Sector Complaints Adjudication Service (ISACS). The Care Quality Commission (CQC) had assessed the level of complaints to be lower than the rate of other independent hospitals we hold this type of data for.
- The hospital had a clear process in place for dealing with complaints, including and up to date 'Complaints Policy' (dated October 2015). Staff we spoke to were aware of the complaints procedure. We saw complaints leaflets were available and saw the hospital website had a section detailing how to make a complaint.
- Complaints were discussed with all members of staff with any learning points identified. We saw complaints were a standing agenda item in the minutes of the Clinical Governance Committee, Medical Advisory Committee and the Senior Management Team meetings. This meant that the hospital learnt form complaints and improved services where appropriate.

Good

Surgery

- A senior manager had overall responsibility for responding to all written complaints. The hospital acknowledged complaints within 48 hours of receiving the complaint with an aim to have the complaint reviewed and completed within 20 days. There was an expectation that complaints would be resolved within 20 days. If they could not, a letter was sent to the complainant explaining why. During inspection we reviewed three of the complaints relating to surgery and saw they had been answered within the specified timeframe
- We saw a patient information guide on was available on both the wards, that included a section on the formal complaints procedure. The BMI leaflets 'Please tell us' were located throughout the hospital and contained information on how to raise any concerns. Staff gave patients the opportunity to complete the hospital's patient survey questionnaire.

Are surgery services well-led?

Good

We rated well-led as Good

Leadership / culture of service related to this core service

- The overall lead for the service was the director of nursing, who was also the director of clinical services. A clinical nurse manager led the surgery inpatient ward. The theatre manger had recently left and there was currently in interim theatre manager in place, who was on site for two days a week, at other times the director of clinical services, would assist with day-to-day issues.
- Many staff had worked at the hospital for a long time, and said they enjoyed working there. Staff spoke positively about their relationships with their immediate mangers. Staff felt they could be open with colleagues and managers and felt they could raise concerns and would be listened to.
- Staff said senior managers were available, visible within the surgical services, and approachable. For example the executive director and director of clinical services, undertook daily walkabouts to speak to staff and resound to concerns. They operated an 'open door policy' and encouraged staff to raise concerns directly with them.
- Staff we met were all welcoming, friendly, and helpful, morale was good, and staff told us they felt 'proud' to work at the hospital. There was a good team spirit and atmosphere, and staff told us they felt part of a 'big family'. Staff spoke positively about the service they provided for the patients.
- There was a flexibility and willingness among all the teams and staff we met. Staff worked well together, and positive working relationships existed between the multidisciplinary teams.
- There was an open culture in the hospital with non-medical staff feeling able to speak with medical staff on an equal basis.
- There had been low rates of sickness in the reporting period July 2015 to June 2016, for all staff groups. Sickness rates for theatre nurses were lower than the average of other independent acute hospitals we hold this type of data for, except for in November 2015, February and March 2016 when the rates were higher than the average.
- Sickness rates for theatre operating department practitioners and health care assistants were lower than the average of other independent acute hospitals we hold this type of data for in the same reporting period, except for in August 2015 when the rate was higher than the average.
- Sickness rates for inpatient nurses were lower than the average of other independent acute hospitals we hold this type of data for in the reporting period, except for in August and September 2015, April and June 2016 when the rates were higher than the average.
- Sickness rates for inpatient health care assistants were lower than the average of other independent acute hospitals we hold this type of data for in the same reporting period, except for in July and September 2015 and January 2016 when the rates were higher than the average.

Vision and strategy for this this core service

- The BMI Chaucer hospital vision was 'serious about health, passionate about care'. This was underpinned by five strategic priorities, which included, 'to deliver high quality patient outcomes', to provide the best patient care', 'to ensure patients have a premium experience', 'to work closely with our consultants' and 'to be proud of ourselves'.
- Most staff were able to explain the values, and what they meant to them. We saw the values were displayed on notice boards. Staff were proud of the job they did and felt empowered to deliver a caring service by being supported by strong hospital leadership.

Governance, risk management and quality measurement

- The hospital had clear governance in place. The hospital held meetings through which governance issues were addressed. The meetings included Medical Advisory Committee (MAC), Senior Management Team (SMT), Infection Control and Health Safety and Environment meeting.
- The hospital followed their corporate 'Clinical Governance Policy' (due for review June 2016), which included clinical governance leadership and monitoring and compliance.
- The Clinical Governance Committee (CGC), met monthly and discussed complaints and incidents, patient safety issues such as safeguarding and infection control, risk register review. There was also a standing agenda item to review external and national guidance and new legislation, such as National Institute of Health and Care Excellence (NICE) guidance, such as NICE CG42, Dementia: supporting people with dementia and their carers in health and social care. This ensured the hospital implemented and maintained best practice, and any issues affecting safety and quality of patient care were known, disseminated managed and monitored. During our inspection we saw the minutes of the CGC held in April, May, June, and July 2016.
- The MAC met bi-monthly and the minutes of the meetings held in November 2015, January, March, and May 2016 were reviewed. The minutes showed key governance areas such as complaint and incidents, quality assurance, and feedback from the CGC were discussed.
- The SMT met monthly and the minutes of the meetings held in March, April, May and June 2016 were reviewed. The minutes showed items discussed included complaints, incidents, patient feedback, and key departmental feedback.
- Agendas and minutes showed audits and learning from complaints, infection control issues, good practice, and risk management were discussed.
- We saw action plans were monitored and staff implemented elements of action plans where appropriate. For example, we saw a root cause analysis (RCA) investigation and action plan following the emergency transfer of a patient following surgery to the local NHS hospital. We saw actions arising from the investigation were completed within the required timescales.
- Staff told us they had access to policies and procedures and felt they were kept up to date and informed by the management team. Staff told us they received a monthly newsletter 'Nolan's News', which kept them updated about events happening at the hospital, such as refurbishment and long service award dinners.
- There was a hospital risk register on the hospital intranet in respect of the whole organisation. The executive director monitored the register in respect of this location.
- The hospital risk register 2016 was divided into categories such as patient safety, information management, financial, reputation, governance, operational, leadership and workforce, workforce health and safety, and facilities and infrastructure. The risk register detailed the risks, mitigations, actions, allocated key lead, and committee who had responsibility for ensuring existing risk controls and actions were completed for the identified risks.
- The hospital risk register was for the whole hospital and this had clearly stated clinical or non-clinical departments of the hospital within each risk description. This meant that staff in all areas and departments were able to identify which area a risk is related to. Staff we spoke with were able to tell us what was on the risk register.

- The risk register was reviewed monthly at 2016 CGC meetings as a standard item to ensure that identified risks were on the register and if any risks had changed they were re-categorised. We saw this in the CGC meeting minutes from April to July 2016.

Public and staff engagement (local and service level if this is the main core service)

- The hospital gathered patient opinion using patient surveys offered to all patients during their stay, friends and family test (FFT) and patient led assessment of the care environment (PLACE) which was carried out annually.
- The hospital actively encouraged patients to participate in the BMI patient survey. We saw patients being offered a form to complete and there were boxes throughout the hospital to place completed forms. Patients also received follow up calls within 48 hours following discharge, which provided patients with an opportunity to feed back on their experience.
- The hospital held staff forums, where staff from all departments could attend to discuss any issue or concern and share ideas and learning. We saw that 'Nolan's News's' was started following a suggestion at a recent staff forum.
- There were various staff recognition schemes, including service recognition awards for staff who had worked at the hospital for five, ten, 15, 20 and 25 years. One member of staff told us they received a card and gift voucher, as a result of willingness to work additional hours at short notice, this made the member of staff feel valued.

Innovation, improvement and sustainability (local and service level if this is the main core service)

- The executive director told us they had put in a business case with corporate BMI Healthcare to upgrade the air ventilation system in theatre two, to an ultra-clean, laminar flow system. This would mean they would be able to undertake orthopaedic operations in both theatres. At the time of inspection, they were waiting for approval.
- The hospital was currently undergoing a programme of refurbishment, and there was a plan in place to upgrade all patients' rooms. This included removing carpets and installing laminate flooring, and up grading sinks to clinical hand washes basins. All staff and patients we spoke with felt motivated to be working or being cared for in a newly refurbished environment.
- Staff told us they were encouraged to make improvements through innovative thinking, and included when developing services. Staff felt listened to and acknowledged when making a suggestion or recommendation for service improvement.

Good

Outpatients and diagnostic imaging

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

Are outpatients and diagnostic imaging services safe?

Good

We rated safe as good.

Incidents

- There were no 'never events' reported by the hospital between July 2015 and June 2016. 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 July 2015 to June 2016, 48 clinical incidents occurred in the outpatient and diagnostic imaging departments which was 18% of all clinical incidents reported hospital wide. Six non-clinical incidents were reported by the department which accounted for 6% of nonclinical incidents reported hospital wide.
- The rate of clinical incidents was lower than the rate of other independent hospitals we hold data for, and the number of non-clinical incidents was higher than other independent hospitals we hold data for. We spoke to both clinical and non-clinical staff who had a clear understanding of the incident reporting process, which was paper based. Staff told us that if they were not sure about whether to report an incident, they could approach their respective managers for advice and support.
- The hospital reported no ionising radiation (medical exposure) regulations (IRMER), 2000 incidents to the CQC in the last 12 months. A radiation protection adviser based at a local NHS hospital was available for advice if required.
- We saw that the diagnostic imaging department had reported 12 incidents since January 2016. These were all categorised as low or no harm. We saw minutes of the diagnostic imaging team meetings which indicated incidents were discussed.
- Staff had a good awareness of duty of candour but could not describe any recent examples of where this had been used within the outpatient or diagnostic imaging departments. '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.'

Cleanliness, infection control and hygiene

- Most of the areas we visited in the outpatients department were visibly clean and tidy and there were good infection control practices in place. Consulting rooms in the outpatient department had recently had carpets replaced with laminated flooring and continuous coving, bringing it in line with Department of Health's Health Building Note (HBN) 00-09: infection control in the built environment. However, the outpatient waiting area was carpeted and could not be as easily cleaned when spills occurred. There were visible stains and a worn appearance. HBN 00-09: infection control in the built environment states; 'Spillage can occur in all clinical areas, corridors and entrances' and 'in areas of frequent spillage or heavy traffic, they can quickly become unsightly'. However, we

saw that there were quarterly deep cleaning of the carpets and the hospital was also undergoing a carpet replacement programme, with the outpatient waiting area being scheduled for replacement in November 2016.

- Not all staff had training in using the spill kits in the event of a spillage and we saw a risk assessment for this which did not have any controls in place and a review date of January 2017. This meant that spillage could occur and not be cleaned appropriately.
- The room housing the dental x-ray equipment was also carpeted. This was also due to be replaced as part of the carpet replacement plan but it was unclear on the schedule when this flooring was due for replacement. The hospital's Patient Led Assessment of the Clinical Environment (PLACE) score from February 2016 to June 2016 was 85%, which was worse than the national average of 98%.
- Equipment was cleaned between each patient use and a green sticker placed on it to indicate this. We saw equipment with these stickers on it, which indicated it had been cleaned and was ready for use.
- We saw rotas detailing named staff who were responsible for cleaning allocated consulting rooms in outpatients and these indicated that rooms had been cleaned. These clearly stated when the room was unable to cleaned – for example during re-decorating.
- However, in the X ray room we saw that the control panel had a layer of dust and the glass screen appeared smeared. We raised this with the imaging manager who advised that the cleaner was possibly using the wrong cleaning product on the screen. This accounted for the smeared appearance and she advised that this would be raised with the cleaning team. They told us the dust could have possibly come from the vents above the control panel, as the room had not been used since the previous week, and in line with the cleaning rota for this room, high and low level dusting and dusting of the vents was completed weekly.
- The hospital followed their corporate 'Standard Infection Control Precautions Policy' (dated February 2016), which included hand hygiene, use of personal protective equipment (PPE) such as gloves and aprons, and spillage of body fluids. Staff we saw were bare below their elbows and we saw PPE was available to staff although none was required at the time of our inspection.
- We saw hand hygiene audits from the outpatient department for January, February and March 2016, these audits demonstrated that all staff performed hand hygiene, but not all staff were always bare below the elbows, which was followed up with reminders from the observers on the majority of occasions. All staff that we saw during our inspection were bare below the elbows.
- We spoke to staff regarding challenging other members of staff if they were not bare below the elbows or did not perform hand hygiene. Most staff felt confident to challenge but some newer members of staff felt less confident in doing so. However, they were confident they could approach their senior team or line manager if there was a concern regarding this for support and guidance.
- We saw that waste was separated in different coloured bags to signify the different categories of waste in most of the rooms we saw. This was in accordance with Health Technical Memorandum (HTM): Safe Management of Healthcare Waste, control of substances hazardous to health (COSHH), and health and safety at work regulations. However, in consulting room nine, we saw two pedal operated bins that were not labelled. One had a yellow (offensive) waste bag inside while the other had a white bag inside. This indicated that they were intended for clinical waste but had not been appropriately labelled.
- The majority of the consulting rooms in outpatients had recently had sinks replaced in order to become compliant with HBN 00:10 Part C Sanitary ware. However, there were a number of non-compliant sinks that remained in consulting room 10, the clean and dirty utility rooms and four areas of the diagnostic imaging department. The hospital were aware of the non-compliance, and a replacement sink programme was in place with dates up to February 2018.
- Some areas of outpatients used nasoendoscopes (a flexible tube used to examine the roof of the mouth and throat, by being passed through the nostril). Staff walked us through the process of cleaning the nasoendoscopes. There was a system of transporting the used nasoendoscopes in a covered, solid walled, leak proof container in line with health and safety executive standards for nasoendoscope reprocessing units. They were taken from the consulting rooms directly to the area where they could be decontaminated using a three step cleaning system. However, the room used to decontaminate the

nasoendoscopes was the clean area, meaning that dirty equipment could contaminate the clean area. This was raised with the departmental sister who advised us she would review this process.

- At our unannounced inspection, the outpatient manager confirmed that the process has not been updated since the inspection but they were reviewing the best option to put in place and understand that they are in the process of acquiring appropriate equipment (trolley tray) before change can take place. This meant there was still a risk of contamination.
- As part of the three step cleaning process, a bar code sticker is placed in the patient notes and on the scope decontamination register to ensure traceability and we saw records to demonstrate this was being carried out.
- We saw sharps bins were available in the treatment areas and consulting rooms. This demonstrated compliance with the health and safety regulation 2013 (The Sharps Regulations), 5 (1) d. This required staff to place secure containers and instructions for safe disposal of medical sharps close to the work area. We saw labels on sharps containers had been fully completed ensuring traceability of each container.
- The infection prevention control committee met quarterly and discussed incidents, surgical site infections, and root cause analysis, outbreaks of infection, infection control training, and feedback from audits or reports. We saw the minutes of the infection prevention control meetings held in April and July 2016, which confirmed this was occurring.

Environment and equipment

- The outpatient service had nine individual consulting rooms, a minor operations treatment room (also referred to as theatre four) and an outpatient waiting area.
- The consulting rooms we saw were equipped with a treatment couch and trolley for carrying clinical equipment on and contained disposable curtains that had been changed within the last 6 months.
- The hospitals PLACE scores from February 2016 to June 2016 were worse than the England average for condition, maintenance and appearance scoring 75% with the average being 93%.
- We checked emergency trolleys containing resuscitation equipment. The trolley situated in the outpatient department was tamper proof and all consumables were in date. Staff checked the trolley daily and we saw completed checklists to confirm this.
- However, we found that the resus trolley within the diagnostic imaging department was not always checked daily. We spoke to a staff member about the gaps who explained that only two members of staff were responsible within the department for the checking of the trolley. If those members of staff were not in, the check did not occur, indicating a risk that all the equipment required, might not be available in an emergency.. Staff in the department were not aware of who the resuscitation officer was for the hospital.
- Following this feedback, the hospital had started weekly resuscitation trolley audits to be undertaken across all departments including outpatients and diagnostic imaging and we saw this had commenced at the unannounced inspection.
- In the minor operations room we found one pack of swabs that was out of date – we showed this to a staff nurse who immediately removed and replaced it.
- The specialised ventilation revalidation results for theatres were reviewed against the performance criteria as defined by Hospital Technical Memorandum (HTM) 03-01 2007. The recorded results together with the maintenance records provided for the minor operations treatment room indicated that suitable maintenance regimes were being carried out.
- One of the rooms in the diagnostic imaging department housed the dental x-ray machine which we were told was used, approximately once a month. The room had old computer equipment stacked in the room, covered by a sheet, which was unsightly and a collection point for dust. The room also housed a biopsy chair that we were told was no longer used by the department. This did not have any indication of when it was last cleaned or if it was fit for use. There were lead aprons hanging on a lead protection screen in this room. The construction of the lead protection screen meant that the way it was positioned was a trip hazard. This was pointed out to the imaging manager who moved the screen to a less hazardous position and advised us she would complete a risk assessment for this.
- The imaging manager completed a capital replacement plan for imaging equipment yearly. The computerised tomography (CT) scanner was over seven years old and

although still in working use, the imaging manager was hopeful this may be replaced in the near future but this was not on the departmental risk register. We saw that the CT scanner was last serviced in September 2016 and had passed all tests.

- Some eye treatments can be carried out using light amplification by stimulated emission of radiation (Laser) therapy. We saw the Laser was used in a designated room, with warning signs and a light which activated when the Laser was in use and we saw this worked. This was in line with Laser safety guidelines (BS EN 60825-1: 2007. Safety of laser products: Part 1. Equipment classification and requirements). The department had a trained Laser protection supervisor. The Laser protection advisor, based at another location, oversaw the use of Laser and local rules.

Medicines

- We reviewed medicines stored in the clean utility room and minor operations room. The clean utility room housed a medicines cupboard which was locked and all drugs were in date with the exception of one unit which expiry had passed the previous month (31/10/16). There was a register for the recording in and out of medicines cupboards keys and we saw that this was kept up to date. Records were kept for ambient room temperatures.
- The fridge housing medicines in the minor operations room had recently been serviced and the fridge temperature range recordings were seen for the previous four months. A pharmacy technician showed us that these were audited quarterly.
- CT contrast (a medicine used for injection during CT examinations) was stored in a locked cupboard in a secure room and keys for this were kept in a key safe box which diagnostic imaging staff could access.
- An up to date corporate policy related to the safe management of medicines was in place.
- A maximum of five private outpatient prescriptions were kept in a locked medicines cupboard on Cornwallis Ward. We saw a log, which indicated when a prescription had been issued, to whom and for what. This was in line with NHS Protect, security of prescription forms guidance 2013.
- The main office in outpatients held prescriptions pads. These were in a locked cabinet, the keys for which were in a key safe on the adjoining wall. There was a log book, which detailed when prescriptions went out and who to. We observed a consultant asking for a prescription sheet for a patient and the registered nurse followed the process ensuring this was signed out appropriately.

Records

- No patients were seen in the outpatients department in the last three months without patient records.
- We spoke to medical secretaries who told us that on receipt of referral, they would make up a set of notes for a patients first visit.
- However, we were told that on occasion a patient could be seen without notes, as some patients self- referred and would not have a GP referral letter. Although this would be rare, there would be some consultants who would see patients without a referral letter.
- Patient records were stored in a room with key pad access and notes were archived every two years. Staff told us patient records were not normally taken off site, however some consultants did take their notes off site. Following the inspection the hospital clarified that only consultants own notes were taken off site, not the patient records. Private and NHS patient record files distinguished by colour of file they were kept in.
- The diagnostic imaging serviced used an electronic patient record system called a patient archiving communication system (PACS) to store patient information and radiological images on. This system required usernames and passwords to log on, which only the diagnostic imaging team and relevant consultants had access to.

Safeguarding

- The Director of Clinical Services was the hospital's safeguarding lead and trained to level 3 which is in line with national statutory guidelines; 'Working together to safeguard children – a guide to interagency working to safeguard and promote the welfare of children'.
- The hospital withdrew services for children in August 2016 and during the period from July 2015 to June 2016, no children between the ages of 0-15 years attended the hospital. Two hundred and sixty eight young people between the ages of 16-18 (1% of overall attendances) were seen in the outpatient department.
- We saw that 11 members of staff from outpatients (100%) had completed their level 2 safeguarding

training. However only six members of staff from diagnostic imaging (66%) and eight members of staff from physiotherapy (66%) had completed this, which was worse than the mandatory training target of 90%.
- We saw an example where the diagnostic imaging department delayed a patient's scan as there would not have been anyone available to accompany the patient's child who had attended with their parent. This incident was reported and the scan was carried out later that day when a relative was available to supervise the child.
- No safeguarding concerns were reported to the CQC in the period from July 2015 to June 2016.

Mandatory training

- Mandatory training was accessed online with some supporting face-to-face sessions. Staff told us that the online learning was easy to access and that they were given adequate time to complete their online training.
- The BMI target for mandatory training compliance was 90%. Figures provided to us from September 2016 show that outpatients, diagnostic imaging and physiotherapy exceeded this target at 96%, and 100% respectively.
- We spoke to the managers for these services and were told that the bank staff had recently been added to the compliance rates for the teams, and these were the only members of staff who were not currently compliant.

Nursing staffing

- We spoke to the outpatients, radiology and physiotherapy team regarding their nursing and allied health professional staffing levels. All staff we spoke to felt confident they had the right level of staff to carry out their job well.
- The physiotherapy team consisted of a clinical services manager, five physiotherapists, a physiotherapy assistant and two hand therapists.
- The outpatient team consisted of a clinical services manager, six registered nurses and five health care assistants. We saw staffing rotas from August, September and October which demonstrated no staffing shortages, and we were told where there was potential for shortages, bank staff could be used. The hospital told us they had never used agency staff for the outpatient department and we saw that none were used within the last three months of the reporting period of July 2015 to June 2016.
- The diagnostic imaging team consisted of nine radiographers, including two bank members of staff. We saw copies of staffing levels for July, August and September that demonstrated there had not been staffing shortages. Where unplanned leave was taken; the imaging manager was supernumerary and would cover any gaps, which we saw on the rotas. No agency staff were used during this period.
- The pharmacy department included one pharmacy manager, two full time pharmacists, three part time pharmacy technicians and a pharmacy assistant. A bank pharmacist who covered annual leave and occasional Saturdays supported the department. The executive director managed the pharmacy manager who managed the remaining pharmacy staff.

Medical staffing

- The hospital employed 180 doctors, under practicing privileges, which included radiologists within the diagnostic imaging department.
- Two resident medical officers (RMO) were employed via an agency and would provide 24 hour cover. The RMOs were based on site.
- No medical staff members were subject to fitness to practice hearings at the time of inspection.

Assessing and responding to patient risk

- The health care assistants in the outpatient department were all acute illness management (AIMS) trained. This was a course that included training on the assessment and management of deteriorating patients and managing patients in acute pain. Staff in outpatients were all trained in either basic life support (BLS) training or immediate life support (ILS) training, and the clinical services manager was trained in advanced life support (ALS). Eight of the eleven diagnostic imaging staff (78%) were trained in either BLS or ILS. This meant that the majority of staff were able to provide basic life support to patients and visitors.
- We saw 'pause and check' signs in the CT department.
- We observed good radiation compliance as per national policy and guidelines during our visit. The department displayed clear warning notices, doors were shut during examination and warning lights were illuminated. There was keypad entry to some examination rooms and only authorised staff had access.
- A radiation protection supervisor, who was also the imaging manager, was on site for each diagnostic test

and a radiation protection advisor was available if necessary. This was in line with the Ionising Regulations,1999 and the Ionising Radiation (Medical Exposure) Regulations (IRMER) 2000.

- Local rules were available in the areas we visited in the diagnostic imaging department. Staff had a clear understanding of protocols and policies.
- Signs advising women who may be pregnant to inform staff were clearly displayed in the diagnostic imaging department in line with best practice and we saw 'stop and check' signs reminding staff to check a patient's identity before performing a procedure.
- In the minor operations treatment room, we saw examples of checklists used that were adapted from five steps to safer surgery, based on the World Health Organisation (WHO) Surgical Safety checklist. This included 'sign in' checks where the patient identity and operative site was confirmed and 'sign out' checks where the instruments used are counted back and any specimens are labelled and sent to the laboratory. We saw these forms were completed in eight sets of notes that we reviewed, and we saw compliance audits of these checklists were undertaken in October and November 2016.

Emergency awareness and training

- The outpatients' manager told us that there was a business continuity plan for the department but told us he was not sure whether his staff would know the location of this. We spoke to staff who knew there was a continuity plan but that they had not seen it and did not know specifically where to look.
- We saw an emergency call bell checklist was carried out weekly in the outpatient department.
- The physiotherapy department did not have emergency call bells, and therefore in an emergency would use the bleep system. Staff told us that this was on their risk register, but the bleep system mitigated the risk.
- Staff undertook unannounced simulation exercises which were led by the ward manager. This was carried out with ward, outpatient and theatre staff. Examples of competencies tested were the use and application of ABC (airway, breathing and circulation) and the National Early Warning Score (NEWS). They have unannounced monthly resuscitation training - the last date recorded as completed was 28 September 2016 which we saw. The outcomes for these were discussed at the monthly clinical governance committees which we saw minutes for.

Are outpatients and diagnostic imaging services effective?

Not sufficient evidence to rate

We inspected but did not rate effective, as we do not currently collect sufficient evidence to rate this.

Evidence-based care and treatment

- The Diagnostic Imaging department had policies and procedures in place. They were in line with regulations under the Ionising Radiation (Medical Exposure) Regulations (IRMER) 2000.
- We saw local rules available in the diagnostic imaging department that were in date.
- We saw a CT and magnetic resonance imaging (MRI) protocols folder which was in date.
- We saw dose reference level audits completed for CT, plain x-ray, dental x-ray and mammography. These audits monitored and ensured patients were not exposed to more radiation than medically necessary.
- The hospital was in the process of creating a dementia strategy based on National Institute for Care Excellence (NICE) guidance, Clinical Guidance (CG42): Supporting people with dementia and their carers in health and social care.

Pain relief

- We did not encounter any patients who were suffering from pain during our inspection.
- We saw an incident report for patient who experienced acute pain following being an insertion of a needle into their vein, in the diagnostic imaging department. The Resident Medical Officer (RMO) was called and provided immediate assistance.
- We reviewed a copy of the outpatient minor procedure checklist. This contained checkboxes for staff to complete with the patient at their follow up visits. Checks included pain scores and checking for signs of discomfort, and checking the patient had suitable strength analgesia (pain relief medication) at home and knew the correct dosage for this.

- The physiotherapy department provided acupuncture for pain relief, which they offered to appropriate patients.

Patient outcomes

- The hospital did not participate in imaging accreditation schemes. The Imaging Services Accreditation Scheme (ISAS) is a patient-focused assessment and accreditation programme designed to help diagnostic imaging services ensure their patients consistently receive high quality services, delivered by competent staff in safe environments.
- Patient outcomes in physiotherapy were monitored by recognised outcome measures such as range of movement, pain scores and the quality of life measures in order to establish the effectiveness of treatment.
- We saw an audit of turnaround times for dispensing medication, carried out in January 2016. We saw that the longest time a patient had to wait for an outpatient prescription was 20 minutes, with the average waiting time 10 minutes.

Competent staff

- We saw electronic (scanned) copies of three nursing staff competencies for a variety of areas.
- This included infection prevention and control, pain management, cannulation, acute care competencies, resuscitation, naso gastric tube (NG) insertion (insertion of tube into the nose), peripheral IV cannulation. These were signed and up-to-date.
- As of September 2016, 100% of outpatient, health screening and diagnostic imaging staff had an up to date appraisal. Physiotherapy staff were 75% compliant with appraisals with three out of eleven members awaiting an appraisal. These were all within the hospital's target rate of 70%.

Multidisciplinary working

- The physiotherapy service worked with the medical team to provide a service for oncology patients. The oncology unit provided a therapy service by two nursing staff and a physiotherapist who were trained to provide reflexology and acupuncture. These were available on request.
- During our inspection there was a cardiac CT list which we observed in operation. Cardiac CT is a procedure where a contrast (dye) is injected into the heart muscle prior to a CT scan in order to visualise any irregularities with the heart and or pulmonary muscles. This involved a radiologist, two radiographers and a consultant cardiologist.

Seven-day services

- The diagnostic imaging department provided a 24 hour on call service for patients requiring emergency x-ray. Radiographers were listed on an out of hour's rota, accessible via the main reception or after 10pm, via the senior sister. Radiologists however, were not rotated for on call out of hours. The out of hour's procedure for the hospital stated that any enquiries for screening or ultrasound, must be made by the on call radiographer who would then contact a radiologist.
- There was no specific on call rota for CT or MRI examinations. The policy stated that it may be possible to arrange an out of hours CT scan, but referred anyone requesting this to contact the on call radiographer.
- The hospital had a pharmacy which provided both inpatient and outpatients services. The pharmacy was open from 9am to 5pm Monday to Friday and 9am to 1pm on Saturday. We saw leaflets offering a free and confidential medicines helpline to patients, so they could contact the pharmacy department after their hospital visit. The helpline was available from Monday to Friday 9am to 5pm and Saturday 9am to 12:30pm.
- Either a pharmacist or pharmacy technician (with phone access to a pharmacist) provided an on-call service 24 hours a day seven days a week. There were processes in place for staff to obtain medication from the pharmacy department out of hours.

Access to information

- The hospital had a daily morning huddle attended by all heads of departments , including the outpatient and diagnostic imaging departments. We attended one of these meetings and saw that daily issues such as staffing and any anticipated problems from each department were discussed.
- Staff could access policies and procedures via the BMI intranet page and they demonstrated this to us.
- The diagnostic imaging department could access imaging investigations from local hospitals on request and this could be transferred securely via an electronic system. This was the responsibility of the medical secretaries to request on receipt of referral; however we

did see one complaint that referenced the imaging from a previous hospital was not available when a patient attended their outpatient appointment. However, other members of staff or patients we spoke with did not report problems with this.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff in outpatients and physiotherapy told us they rarely encountered patients with dementia or who lacked capacity. 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.
- We looked at eight sets of patient records. Of the eight records, there were seven consent forms and one was missing. Of the seven consent forms, three had documented the benefits and risk and four had been left blank. This indicated there was no evidence that benefits and risks had been discussed with these patients prior to the procedure, which was not in line with the hospital's consent policy.

Are outpatients and diagnostic imaging services caring?

Good

We rated caring as good.

Compassionate care

- We spoke to five patients and relatives during our inspection. They told us that the hospital appeared clean and that they felt it was a 'good' hospital.
- There were four reviews from 2016 on the NHS Choices website, all of these were positive feedback, however, it was not possible to break this down by service.
- The hospital completed the Friends and Family Test (FFT), which it reported on each month. The scores were similar to the England average of NHS patients across the period of January 2016 to June 2016. However, in May 2016 the score was worse than the England average. Response rate for completion of this survey were better than the England average from January 2016 to June 2016. However, in May and June 2016, they were worse than the average.
- We saw signs in the waiting areas in the department to inform patients they could have a chaperone if required and there was an in date policy on the provision of chaperones for the hospital.
- The hospital's Patient Led Assessment of the Clinical Environment (PLACE) from February 2016 to June 2016 scored 75%, for privacy and dignity. This was worse than the England average of 83%.
- The physiotherapy department used disposable curtains around the clinical area to provide privacy to their patients. We asked staff how they could give patients further privacy, if requested, and they had further access to a separate treatment room which provided better privacy and was mainly utilised for women's and men's health physiotherapy, however staff told us that patients could request more privacy which would always try to be accommodated. An example given was a patient that had become emotional during treatment and they were offered the treatment room to continue their treatment.

Understanding and involvement of patients and those close to them

- We saw patient information leaflets available in the main waiting area in outpatients. These included such topics as sports injuries, fertility, orthopaedics and pain control.
- The pharmacy department supplied patients' with supporting information with their medication. For example, they supplied leaflets regarding unlicensed medicine advice, safe and effective use of antibiotics and alert cards for novel oral anticoagulants to appropriate patients.
- We saw patient information leaflets that were sent to patients when they had a date for their diagnostic imaging procedure.
- However, we spoke with one patient who told us that when they booked their diagnostic imaging appointment by telephone they did not receive a letter confirming this or any patient information.
- We saw health screening leaflets and price lists that were sent out to patients. There was also a dedicated office for patients to discuss their billing and payment arrangements with hospital staff. This enabled patients to have these discussions in privacy on a one to one basis.

Emotional support

Good

Outpatients and diagnostic imaging

- The outpatient manager told us that all nursing staff were aware of how to break bad news and they did not have a nurse specialist for this. If further psychological support or counselling was required for a patient they could access this via an external company.
- The chaplain provided pastoral care, which included practical, emotional and spiritual support. The chaplain visited the hospital two days every week and on request.

Are outpatients and diagnostic imaging services responsive?

Requires improvement

We rated responsive as requires improvement. .

Service planning and delivery to meet the needs of local people

- The outpatient department was open from 8am until 6pm Monday to Friday.
- The waiting room was spacious and had a sufficient amount and range of chairs available for waiting patient that we saw during our inspection. The diagnostic imaging department was open from 8 am and until theatre and outpatient clinics finished, every Monday to Friday. The flexibility allowed the department to address the changing needs of the hospital. The department did not routinely open on Saturdays but could arrange urgent CT's, if required, in line with the out of hours procedure, which we saw.
- There was a hospital restaurant available for staff, patients, their relatives and visitors to purchase hot and cold food. This was undergoing refurbishment at the time of our inspection but staff told us that this was well utilised by both staff and patients.
- In the diagnostic imaging department, there were individual changing cubicles available for patients containing lockers to store their belongings securely. However, the cubicles were cramped and the doors did not have locks and therefore could not guarantee privacy. The doors were folding doors that could be closed by pulling the handle towards you. However, the light switch for the cubicles were on the outside of the door and once the door had been closed, the room was dark and it was not easy to locate the handle to open the doors. There was no risk assessment in place for this and the changing rooms were not due for replacement in the near future.
- The physiotherapy department was open from 8 am Monday to Friday and closed at varying times from 5pm to 8pm. The department did not see patients at the weekend but did have flexibility around their weekday appointment times to suit patients' needs.
- The physiotherapy department had a separate waiting area which was small and could seat approximately five patients. This was sufficient for the amount of patients we saw waiting during our inspection. There was a large main area for physiotherapy consultations that could be divided by disposable curtains, with one separate room used for enhanced privacy and dignity. There was also a physiotherapy gym with a range of equipment available.
- The hospital had a pharmacy which provided both inpatient and outpatients services. The pharmacy was open from 9am to 5pm Monday to Friday and 9am to 1pm on Saturday. We saw leaflets offering a free and confidential medicines helpline to patients, so they could contact the pharmacy department after their hospital visit. The helpline was available from Monday to Friday 9am to 5pm and Saturday 9am to 12:30pm.

Access and flow

- Above 95% of patients started non-admitted treatment within 18 weeks of their referral in the reporting period from July 2015 to June 2016. NHS England stopped the national indicator in June 2015. The hospital continued to treat the majority of its inpatients within 18 weeks of referral.
- The provider met the indicator of 92% of patients on incomplete pathways waiting 18 weeks or less from time of referral in the reporting period (July 2015 to June 2016), except for in November 2015.
- The physiotherapy manager told us that patients would be seen within 48 hours of referral.
- There was currently a one week wait for MRI scans, but urgent referrals could be seen on the same day. Reporting times by radiologists were between 24 and 48 hours. An audit of reporting times for CT and MRI was carried out on 10% of patient in September and October. This identified that CTs were reported between 0.88 days and 1.25 days, and MRIs were reported

between 0.6 and 0.7 days, which indicated the target was being met. Ultrasounds were reported the same day by the radiologist who completed the scan. Plain x-rays were reported by the next available radiologist, unless a specific radiologist was requested by the referrer, and would be reported within 1-2 days.

- We spoke to histology co-ordinators who told us that histology specimens were processed and reported off site, and there were different laboratories that took NHS and private patient specimens, the results of which were typically be back in 48 hours. Tissue sample for pathology could take up to five days. The NHS specimen results could be viewed online and all medical secretaries, pathology co-coordinators and the outpatient manager had a login to view these. Private patient results were brought back to the hospital by the laboratory courier. Staff gave us examples of samples taken from the morning theatre list, being processed and reported on by 4:30pm the same day. Urgent specimens were placed in a red bag to indicate they were urgent.
- We saw an audit of turnaround times for dispensing medication, carried out in January 2016. We saw that the longest time a patient had to wait for an outpatient prescription was 20 minutes, with the average waiting time 10 minutes.
- Delays to clinics were not routinely monitored, but staff told us that in event of any potential delay to a patient being seen by a consultant, the reception staff would inform the patient.
- Reasons for cancelled clinics were monitored by the outpatient manager. From January 2016 to November 2016, 179 clinics were cancelled. Of these, 125 (70%) of these were cancelled due to consultant annual leave.

Meeting people's individual needs

- Patients attending the oncology unit could experience a range of complementary therapies. We did not see any therapies provided during inspection but patients we spoke with valued them and felt they gained therapeutic benefit. We saw in the August 2016 oncology meeting minutes that a physiotherapist had completed the acupuncture course and was commencing an acupuncture course specific to oncology. This gave the patients an option as complementary therapy.
- There was ramped access leading into the main outpatients department that would allow access for wheelchair users and we saw a toilet suitable for wheelchair access in the main waiting area. However, we saw that the x-ray department changing cubicles were not large enough to accommodate a wheelchair. Following the inspection, the hospital told us that in the event of a wheelchair user requiring access to the department, they would utilise either an empty x-ray room, or use the CT and MRI department where there were wheelchair accessible changing areas.
- The hospital's Patient Led Assessment of the Clinical Environment (PLACE) scores (from February 2016 to June 2016) for disability, scored 80% which was worse than the England average of 81%.
- We noted that the designated fire escape doors along the main corridor leading to outpatients were stepped, meaning that non ambulatory patients or patients using a wheelchair would not be able to easily use the exit. We were initially told that there was not a risk assessment in place for this. However, following the inspection, we saw a copy of a hospital fire risk assessment dated June 2016 which noted that the "fire exits in the link corridor once opened have a drop of at least one foot. This is excessive and must be addressed with the installation of a ramp". The action plan for this had been assessed as a medium level risk, for action by December 2016. The hospital demonstrated that they had actioned this by 30th November 2016.
- In the fluoroscopy room in the diagnostic imaging department, there was an en suite toilet available for patients. Which allowed them easy access should they need it.
- The hospital's PLACE scores for dementia from February 2016 to June 2016 were 81%, which was better than the England average of 80%. The PLACE assessment for Dementia was included for the first time in 2015, and focuses on key issues such as, flooring, decoration (for example contrasting colours on walls), signage, along with seating and availability of handrails, which can prove helpful to people living with dementia.
- Staff told us that they knew how to access interpreters through an interpreting service for patients who did not speak English and also gave examples of requesting interpreters for deaf patients. However, we were also told that staff had allowed relatives to interpret for patients on some occasions which is not in line with best practice.

Good

Outpatients and diagnostic imaging

- The physiotherapy department had access to some bariatric equipment for patients including elbow crutches and walking frames. Staff told us that they could access bariatric wheelchairs from other hospitals when required.
- In the outpatients waiting area there was a hot and cold drinks dispenser, which patients could access for a nominal fee.

Learning from complaints and concerns

- The BMI Healthcare Complaints policy clearly set out the relevant timeframes associated with the complaint response process. An initial acknowledgment was sent within two working days and a full response within 20 working days. Patients were to be kept fully informed throughout this process if there was to be a delay. We saw copies of complaints files which indicated this was occurring.
- The outpatient department received two complaints between January 2016 and October 2016. The physiotherapy and diagnostic imaging departments did not receive any complaints during this period. Of the two complaints received by the outpatient department, 100% were responded to within the target 20 working day period.

Are outpatients and diagnostic imaging services well-led?

Good

We rated well-led as good.

Leadership and culture of service

- The outpatient, diagnostic imaging and physiotherapy departments each had clinical service managers. These managers were responsible for the overall running of their respective services and the management of the clinical staff. There was also a patient services manager who held responsibility for all of the non- clinical staff working in the service. The physiotherapy and diagnostic imaging clinical service managers reported to the executive director and the outpatient clinical services manager reported to the director of nursing. The patient services manager reported to the executive director.
- There had been considerable recent change in the management team, with the outpatient manager, patient services manager and executive director all relatively new in post. Staff we spoke with were extremely positive about the changes and felt they had contributed to making a difference.
- The patient services manager was new in post but had been employed at the hospital previously in a different role. Since appointment to this role, they had endeavoured to improve efficiency and streamline processes. Examples of these include changes to the way in which the rotas were planned and the purchase of a third computer to help process payments faster when patients were leaving the hospital.
- We spoke with staff members from each of the teams who felt their departmental managers were approachable and had an open door policy.
- Staff from all different areas of the service including outpatients, medical records and physiotherapy told us that they see the Executive Director (ED) regularly during her daily walk arounds and feel would be able to raise issues with her if needed.
- All staff that we spoke with spoke highly of the management team. The executive director was described by more than three members of staff as a 'breath of fresh air' and several staff members told us that she had an open door policy. Staff also told us that since the executive directors arrival they felt a lift in morale.
- The outpatient manager spoke enthusiastically about the development of health care assistants within the outpatient department and wanted to encourage development by offering opportunities such as observing endoscopy procedures.
- The rate of staff turnover for outpatient health care assistants was lower than the rate of other independent acute hospitals we hold this type of data for in the reporting period July 2015 to June 2016. There was no staff turnover for outpatient nurses in the same reporting period, demonstrating a stable workforce.
- Sickness rates for outpatient nurses were better than the average of other independent acute hospitals we hold this type of data for seven months in the reporting period (July 2015 to June 2016). In August, September, December 2015 and January and May 2016 the rates were worse than the average.

- Sickness rates for health care assistants were better than the average of other independent acute hospitals we hold this type of data for in the same reporting period, except for in July 2015, January 2016 and June 2016, when the rates were worse than the average.

Vision and strategy for this this core service

- The hospital vision was 'serious about health, passionate about care'. This was displayed in the waiting area in outpatients and also in the main office in outpatients.
- We spoke to staff members who were aware of the vision. Staff felt proud to work at the hospital and felt they were invested in, particularly with the refurbishment work the department was undergoing.

Governance, risk management and quality measurement

- The clinical governance committee (CGC) was responsible for ensuring that the appropriate structure, systems and processes were in place in the hospital to ensure the safe delivery of high quality clinical services.
- The CGC met monthly and discussed incidents, complaints, duty of candour and the risk registers. We saw the minutes of four of these meetings taking place between April and July 2016 and saw that there were representatives from outpatients, diagnostic imaging and physiotherapy in attendance.
- The risk register was kept electronically on the hospital intranet for the whole organisation. The executive director monitored the register in respect of this location. The risk register was for the whole hospital and this had clearly stated a clinical or non-clinical area and a department of the hospital within each risk description. This meant that staff in each department were able to identify which area a risk was related to.
- However, we spoke to the outpatient manager regarding the outpatient risks, and although they were able to talk about the risk assessments for the service, was unaware of the departmental risk registers and advised they would speak to the Quality and Risk Manager regarding this. This indicated the outpatient manager was not fully aware of the departmental risks.
- The senior management team met monthly and discussed the outcome of the clinical governance meetings, health and safety, new business and financial updates. We saw the minutes of four of these meetings taking place between April and July 2016 and saw that representatives from outpatients, diagnostic imaging and physiotherapy attended.
- The physiotherapy manager told us that they had two main risks on the risk register, which were the lack of central heating in the physiotherapy department, which was currently mitigated by use of mobile heaters. We were told that this had been on the risk register for an extended length of time. The other risk was staff having no access to emergency call bells in the physiotherapy department. Staff told us that in an emergency situation they would use the bleep system.
- All consultants working in the outpatient and diagnostic imaging service had practicing privileges. Staff told us they were assured of this via the Executive Directors secretary who managed the oversight of this.

Public and staff engagement

- Team meetings were held in the outpatient and diagnostic imaging departments. We saw the upcoming agenda for the November outpatient team meeting, which had been cancelled due to staff training. However, we spoke to staff who told us that they had regular team meetings and these were considered useful.
- The diagnostic imaging department had team meetings and we saw minutes from October 2016 but the imaging manager told us that these were difficult to organise due to the amount of staff that needed to attend and the department could not be closed. In order to try and reach all members of the team , the imaging manager had started a newsletter that she intended to circulate monthly.
- Patients were given re-usable canvas bags with the BMI Chaucer logo on. Several staff members also expressed an interest in these bags and the executive director ensured that staff were offered one as well as patients, indicating that staff were proud of the organisation they worked for.
- We spoke to a member of staff who came to the hospital from a different role with more responsibility. The ED recognised that the staff member was keen to and qualified to take on additional duties and this was recognised in the job description and salary.

Good

Outpatients and diagnostic imaging

- There were six monthly pathology user group meetings chaired by the BMI pathology network manager and attended by BMI representatives and pathology lab representatives. Any updates from these forums were communicated back down to staff at the hospital.
- We spoke to a staff member who was unable to use the staff coffee machine, due to allergies. The ED sourced a separate coffee machine for staff member to utilise so was not excluded.
- We saw the most recent copy of 'Nolan's news', which was started in October 2016 following feedback from staff forums. It included details of ongoing refurbishment work, encouragement to complete appraisals and upcoming events.
- The hospital ran an ongoing scheme where staff were entitled to a free meal in the restaurant on their birthday. We spoke to staff who had benefitted from this scheme who thought this was a thoughtful perk.
- We spoke to members of staff who had been at the hospital for a number of years. There was a staff recognition scheme known as the 'pin' awards where staff received a decorative pin in recognition of length of service.
- All permanent members of staff were eligible for health screening as part of their wellbeing. This included a 'Select' assessment, which included one hours' worth of doctor and nurse assessments. We spoke to staff members who had taken this up and felt this was a god initiative.
- There had been significant investment into the upgrade of the hospital including the replacement carpet programme and upgrade of desks in the outpatient waiting area. Staff were enthusiastic about these changes and felt that these upgrades made them feel "worth investing in".
- We saw patient satisfaction survey scores displayed on posters in the waiting area detailing that 96.6% of patients thought the quality of care was good or excellent. However, this was dated 'January to December 2013 and was therefore three years out of date.

Innovation, improvement and sustainability

- We spoke to the diagnostic imaging manager regarding Imaging Service Accreditation Scheme (ISAS) accreditation and asked whether the service was working towards this. ISAS is a patient-focused assessment and accreditation programme that is designed to help diagnostic imaging services ensure that their patients consistently receive high quality services, delivered by competent staff working in safe environments. The imaging manager was unaware of this scheme, which indicated that the service would not be accredited in the near future.

Termination of pregnancy

Safe	
Effective	
Caring	
Responsive	
Well-led	

Are termination of pregnancy services safe?

Incidents and safety monitoring

- There had been no incidents between July 2015 and June 2016 relating to termination of pregnancy patients or procedures.
- The staff followed their up to date corporate 'Incident Policy'. All staff we spoke with had a good understanding of the reporting system and how to report incidents. Staff told us they knew to report all incidents including 'low risk' and 'near misses'. Staff were able to give us examples of the types of incidents they reports.
- Between July 2015 to June 2016 there had been two serious incidents reported that required investigation. Serious incidents were investigated using the corporate root cause analysis (RCA) template. Neither incident related to people who had undergone termination of pregnancy at the service.
- The hospital reported three deaths in the period between July 2015 and June 2016, however, none of these deaths related to patients who had undergone termination of pregnancy at the service.
- For our detailed findings on incidents, please see the safe section in the surgery report.

Cleanliness, infection control and hygiene

- All the clinical and non-clinical areas we visited were visibly clean. Theatre and recovery areas were visited and found to be clean, well-organised.
- Staff in all departments we visited were observed to be 'bare below the elbow' policy to allow good handwashing to take place and reduce the risk of infection. The staff had access to hand sanitising gel in all patient bedrooms. In addition, we saw nursing staff carried and used small personal bottles of hand sanitising gel attached to their uniforms.
- We saw that there were no dedicated hand washbasins in patient bedrooms, which meant that staff and visitors used the basin in the bedrooms ensuite facilities or the handwashing facilities in the sluice. This is not in accordance with Health Building Note (HBN) 00-09 and the corporate 'Infection Prevention and Control, Hand Hygiene Policy (including training)'.
- Staff had access to personal protective equipment, such as gloves and aprons in all patient bedrooms. We found all equipment we looked at to be visibly clean, with 'I am clean' labels on them, which indicated the date the equipment had been cleaned and was safe to use. We saw waste segregated in compliance with Health Technical Memorandum (HTM) 07-01, control of substances hazardous to health (COSHH), and health and safety at work regulations.
- All elective patients undergoing surgery who met the hospitals screening criteria were screened for Methicillin resistant Staphylococcus aureus (MRSA) and procedures were in place to isolate patients when appropriate in accordance with infection control policies. There were no reported cases of MRSA within the reporting period.
- Between July 2015 and June 2016, the hospital reported 17 surgical site infections following surgery. No patients undergoing surgical termination of pregnancy had an infection following their procedures.
- The hospital had an up to date 'Disposal of foetal/ sensitive tissue' policy (dated June 2014), which specifically dealt with the disposal of foetal remains. Patients were provided with an explanation at consultation, how the remains would be managed.

Termination of pregnancy

- For our detailed findings on cleanliness, infection control and hygiene please see the Safe section in the surgery report.

Environment and equipment

- We looked at three resuscitation trolleys in theatre and on the wards. We saw the trollies were locked and checklists in place, which were up to date and fully completed.
- The ward comprised of single use rooms with en-suite bathroom facilities, suction equipment, piped oxygen, and emergency call facilities. Some of the patient bedrooms on both wards had carpets. Carpets are not recommended in clinical areas as they prevent effective cleaning in the event of a body fluid spillage. This does not comply with HBN 00-09.
- We saw storage facilities within the hospital were tidy and well organised. All disposable items such as needles and syringes were in date. Sterile surgical items were stored appropriately and were within their expiry dates.
- For our detailed findings on environment and equipment, please see the safe section in the surgery report.

Records

- There was an up to date 'Policy for the Retention of Records (including guidance for ALL business documentation and healthcare records), which staff followed. The policy included record keeping, maintenance, and closure of records and confidentiality.
- All the hospital's own medical records were kept on site, or recalled from the medical records store in time for the patient's appointment. The consultants' secretaries, whether internal or external, provided the consultant's own notes prior to any outpatient appointment. The individual consultant's secretary created patient record files for private patients seen for the first time in outpatients department (OPD).
- Medical staff, who used their own private patient records during the outpatient consultation, took responsibility for ensuring the records were available. It was a requirement of their practising privileges that they registered as a Data Controller with the Information Commissioner's Office. Any breaches in information security were reported through the incident risk management system. The hospital had taken steps to reduce the risks for any patient records managed off site by consultant secretaries. This included security checks for secretaries visiting the hospital and a request that they attend information governance training and sign a data protection disclaimer. The consultant held the records for the two patients for their outpatient appointment, and we were unable to review these during our inspection.
- Patient records for inpatients were well maintained and completed with clear dates, times and designation of the person completing the documentation. We reviewed two sets of medical notes for patients who had undergone a termination of pregnancy. The records were written legibly with no loose filing.
- For our detailed findings on records, please see the safe section in the surgery report.

Assessing and responding to patient risk

- The Hospital held a licence from the Department of Health to undertake surgical termination of pregnancy procedures. Most surgical abortions were carried out on women of early gestations, of 14 weeks and below.
- Both surgical termination of pregnancies performed at the hospital, were undertaken as day cases. Nursing staff had good access to medical support in the event a patient's condition might deteriorate. If the consultant gynaecologist was not available on site, they could be contacted at any time by telephone and would return to the hospital as quickly as possible. If a patient, required urgent medical attention the staff could call upon the resident medical officers (RMO) who were available on site 24 hours a day, seven days a week.
- There were alarm systems to alert medical and nursing staff when immediate assistance was required in the case of an emergency.
- Between July 2015 and June 2016, there had been ten cases of unplanned transfer, following surgical procedure. There was a service level agreement with a local NHS trust in the event of an emergency transfer. Staff we spoke with were aware of the escalation process and where necessary, patients were transferred by ambulance. No patients following a termination of pregnancy were transferred to the local NHS trust.

Termination of pregnancy

- Prior to termination of pregnancy procedures, all women should have a blood test to identify their blood group. This is to identify any patient who had a rhesus negative blood group, and ensure they receive treatment with an injection of anti-D. This treatment protects against complications should the patient have future pregnancies. We reviewed the two records of women who had, had a termination of pregnancy between July 2015 and June 2016, which showed all women underwent a blood test prior to the termination.
- Pregnancy testing was carried out at the initial consultation to confirm a pregnancy, prior to a termination. This was in line with the hospitals policy.
- The two women who had undergone a surgical termination of pregnancy did not have an ultrasound scan to determine gestation of pregnancy. The Royal College of Obstetrics and Gynaecologist, say that although use of routine pre-abortion ultrasound scanning is unnecessary, ultrasound scanning must be available to all services as it may be required as part of the assessment. The hospital did have access to ultrasound if required.
- For our detailed findings on assessing and responding to patient risk, please see the safe section in the surgery report.

Staffing

- The hospital used the corporate BMI Healthcare Nursing Dependency and Skill Mix Planning Tool, to determine staffing levels. The nursing rota was entered into the system monthly and adjustments made 24-hours in advance based on patient numbers and dependency.
- Unqualified staff members including health care assistants and reception staff supported clinical staff. Staff we spoke with told us they had enough staff on duty at all times to deliver good individualised care to all patients.
- Handover between shifts was undertaken in a small office on the ward to ensure privacy of confidential information. The hospital told us, and staff confirmed there was always a senior nurse on call to cover out of hours with the support of a duty manager at all times.
- We found the hospital complied with recommendations of the Association for Perioperative Practice (AfPP) for the numbers of staff on duty during a standard operating list. This consisted of two registered nurses, an operating department practitioner, a healthcare assistant, a consultant, and an anaesthetist.
- All patients were admitted under the care of a named consultant. There were 180 consultants who had been granted practising privileges at the hospital. Practising privileges is a term used when doctors have been granted the right to practise in an independent hospital. The majority of these also worked at other NHS trusts in the area.
- The consultant accepting women for termination of pregnancy procedures were responsible for the full episode of their care and booked admissions appropriately to ensure they would be available for the time required to care appropriately until their discharge. Staff told us that the consultant were always available and accessible when they needed support.
- For our detailed findings on staffing, please see the safe section in the surgery report.

Are termination of pregnancy services effective?

Evidence-based treatment and outcomes

- The gynaecological consultant adhered to the Royal College of Obstetrics and Gynaecology (RCOG) guidelines, The Abortion Act, and abortion legislation for the treatment of women for the termination of pregnancy.
- Staff followed their local 'Termination of Pregnancy' policy (dated August 2016), which included, roles and responsibilities, exclusion criteria, and referral and admissions. This reflected best practice in Royal College of Obstetrics and Gynaecology (RCOG) guidelines
- No patients who had surgical termination of pregnancies between July 2015 and June 2016 required a return to theatre.
- For our detailed findings on evidence-based treatment and outcomes, please see the effective section in the surgery report.

Nutrition and hydration

Termination of pregnancy

- Staff followed guidance on fasting prior to surgery, which was based on the recommendations of the Royal College of Anaesthetists, which states that food can be eaten up to six hours and clear fluids consumed up to two hours before surgery.
- Information regarding fasting was provided to patients in their pre admission pack stating that they needed to fast for six hours before surgery. We saw patients admissions were at different times to ensure compliance with this guidance. This ensured that patients were without food and water for the minimum amount of time.
- Additionally, staff told us, there was good communication between theatres and the ward, if the theatre lists were delayed, they would inform the ward so they could ensure patients were able to continue taking in clear fluids, as per guidelines. Although there were no patients during our inspection that were undergoing a surgical termination of pregnancy, staff told us the same procedure was followed for all patients undergoing a surgical procedure at the hospital.
- All surgical terminations were undertaken as day patients. We saw that Day patients were routinely offered a choice of sandwiches, soups, salads and jacket potato, or could be provided with specific requests for food that were not on the menu.
- Nutrition and hydration was included in the 'patient needs' prompt on the 'nursing intentional rounding' form used by staff, to ensure their patients were safe and comfortable. Intentional rounds were undertaken hourly for all inpatients and day patients.
- The hospitals 'post-operative nausea and vomiting care plan' contained clear escalation guidelines for symptom management for patients following surgery. The guidelines were clearly set out and presented in an easy to follow manner. Staff told us the guideline was easy to follow and use. We reviewed four care plans, which showed these had been completed correctly.
- For our detailed findings on nutrition and hydration, please see the effective section in the surgery report.

Pain relief

- Pain post operatively was assessed using the pain assessment scale in the National Early Warning Score (NEWS) chart. Pain was also included in the 'Nursing Intentional Rounding' form used by staff.
- Staff told us following surgical termination of pregnancies, the consultant visited patients on the ward to check pain levels and prescribe further pain relief as necessary. Patients were not discharged without being seen for an assessment by the consultant.
- For our detailed findings on evidence-based treatment and outcomes, please see the Effective section in the surgery report.

Patient outcomes

- No patients who had surgical termination of pregnancies between July 2015 and June 2016 required a return to theatre.
- For our detailed findings on patient outcomes, please see the Effective section in the surgery report.

Competent staff

- The hospital had systems in place for supporting staff with learning and development, however in practice; few staff working in surgery had received an annual appraisal due to capacity constraints. As of 27 October 2016, the appraisal rate for staff in theatre was 14%, pre admission and patient services 25% ward staff 82% and ward administrative staff 100%. Overall appraisal rate for the hospital was 70%. We were told that staff who had not had an appraisal were on target to have one completed. Lack of appraisals for theatre staff may have meant the service did not address any potential staff performance issues
- One-hundred percent of nurses and operating department practitioners (ODP's), who worked within surgical services for six months or more, had recorded validation of professional registration. This meant the hospital conducted annual checks to ensure all the nurses were registered with the Nursing and Midwifery Council (NMC) and ODP's were registered with Health and Care Professionals Council (HCPC).
- All nursing and theatre staff completed competency assessments to ensure they had the skills and knowledge to carry out the roles they were employed to

do. Staff were also encouraged to undertake continuous professional development (CPD), and was given opportunities to develop their clinical skills and knowledge through training relevant to their role.

- None of the nursing staff we spoke with had undertaken any further training in termination of pregnancies or in counselling of women, pre and post procedure.
- RSOP 27 states staff performing terminations over 9 weeks gestation require additional training. RCOG guidance RSOP 18 says 'there should be an adequate number of appropriately trained and competent nurses/ midwives available from the time treatment commences to the time treatment ends. Midwifery and nursing staff must be competent in the use of all the equipment they may be called upon to use as part of their duties' and 'each nurse or midwife should have the appropriate knowledge, training and confidence to initiate immediate action in the event of an emergency and before further medical help arrives'. With only two termination of pregnancy being performed in a year we were unable to gain assurance around whether staff had sufficient experience to ensure competence and currency of their practice in this area.
- The hospital did not have an identified lead nurse for termination of pregnancy.
- For our detailed findings on competent staff, please see the Effective section in the surgery report.

Multidisciplinary working

- Staff told us that they were proud of good multidisciplinary team working, and we saw this in practice. Staff were courteous and supportive of one another.
- Throughout our inspection, we saw evidence of good multidisciplinary working in all areas. We observed positive interaction and respectful communication between professionals.
- A nurse from the ward would attend a daily meeting every morning, this allowed them to assess the number of patients planned to ensure the ward filled all the shifts. It also allowed for escalation of concerns or shortfalls in staffing. All departments of the hospital were represented at this meeting.
- For our detailed findings on multidisciplinary working, please see the Effective section in the surgery report.

Seven-day services

- Surgical termination of pregnancy procedures were carried out as surgical day procedures.
- However, the hospital was open seven days a week 24-hours a day to care for patients after surgery that needed to stay in hospital overnight and the weekend. No patients who had a surgical termination of pregnancy in the reporting period required an overnight stay.
- The required Standard Operating Procedure set by the Department of Health says that women should have access to a 24-hour advice line, which specialises in post termination of pregnancy care. The consultant who undertook the surgical termination of pregnancy provided the patient with a direct telephone number so they could contact them if they felt they need further support. Additionally the hospital provided the patient with a contact telephone number for the ward on discharge.
- For our detailed findings on seven-day services, please see the Effective section in the surgery report.

Access to information

- Staff had access to relevant guidelines, policies, and procedures in relation to termination of pregnancy services.
- Department of Health registers were completed for every termination procedure carried out and these were stored securely in theatres.
- Discharge letters were sent to patients general practitioners (GP's) on the day of discharge with details of the treatment or procedure completed, follow up arrangements and medicines provided. Staff told us, women were asked if they wanted, their GPs informed of the procedure and care they had received post termination of pregnancy. Women's decisions were recorded and their wishes complied with.
- For our detailed findings on access to information, please see the Effective section in the surgery report.

Consent, Mental Capacity Act and Deprivation of Liberty

Termination of pregnancy

- There was access to guidance and policies for staff to refer to about Mental Capacity Act (MCA) and Deprivation of liberty safeguards (DoLS). The hospital followed their corporate 'Consent Policy (June 2016), which included responsibilities and duties, training, key principles and assisting with decision-making.
- We reviewed both the medical notes for the patients who underwent a termination of pregnancy and saw they contained signed consent forms. Possible side effects and complications were recorded and the records showed that these had been explained to the women.
- For our detailed findings on Consent, Mental Capacity Act and Deprivation of Liberty, please see the Effective section in the surgery report.

Are termination of pregnancy services caring?

Compassionate care

- There were no women attending outpatients or the ward for consultation, procedures, or advice during any of the days of our inspection. We were therefore unable to observe the way patients were treated by staff.
- We saw chaperones were available. The hospital followed their corporate "Provision of Chaperones during Examination, Treatment and Care", (dated September 2015), which outlined roles and responsibilities, training and best practice guidance. We saw posters were on display in the outpatients department, informing patients they were available.
- For our detailed findings on compassionate care, please see the Caring section in the surgery report.

Emotional support

- All patients' bedrooms on the wards and the consulting rooms in the outpatient department were private and could be used to ensure patient confidentially.
- Nurses told us that if a patient were having consultation or discussions about surgical termination of pregnancies, then they would make sure that there was a nurse present as well to provide additional support.
- Women undergoing termination of pregnancy were offered a counselling service prior to their treatment. This service was also available post termination procedure if required. Nursing staff told us that they would answer any queries.
- For our detailed findings on emotional support, please see the Caring section in the surgery report.

Are termination of pregnancy services responsive?

Access and flow

- The consultant gynaecologist undertook the pre-operative assessment of women undergoing a surgical termination of pregnancy, including pregnancy tests, counselling, along with other pre termination of pregnancy tests such as offering testing for sexually transmitted infections, such as chlamydia.
- The hospital complied with the Department of Health's Required Standard Operating Procedures, which says that women should be offered an appointment within five working days of referral, and should be offered the termination of pregnancy procedure within five working days of decision to proceed.
- Termination of pregnancy procedures were carried out as day procedures at the hospital. Women who had undergone a surgical termination of pregnancy were offered a follow up appointment, if they wanted one.
- We were told that on arrival at the hospital, women were booked in at reception and this was reflected on the computer system so staff working on the ward knew when the women arrived. When the ward staff were ready to admit, the women was escorted to the ward by the receptionist, and taken into the bedroom.
- Pre-admission checks and assessments were undertaken, when complete the women had changed they waited for their procedure in their bedroom. Staff then escorted the women to the theatre for their procedures. The majority of women walked to theatre rather than going on a trolley or wheelchair. Immediately after surgery, staff cared for the women in the recovery room.

Termination of pregnancy

- Once the women were stable and pain-free, staff took them back to the ward area to continue recovering. Patients had a responsible adult to collect, escort and stay with them for 24 hours.
- The time from outpatient's appointment to surgical procedure was no more than five working days. This was compliant with the Department of Health's 'Procedures for the Approval of Independent Sector Places for the Termination of Pregnancy (Abortion)', which says Women are offered the abortion procedure within five working days of the decision to proceed, and the total time from access to procedure should not exceed ten working days'.
- For our detailed findings on access and flow, please see the Responsive section in the surgery report.

Meeting the needs of local people and individuals

- All admissions were pre-planned so staff could assess patients' needs before treatment. This allowed staff to plan patients' care to meet their specific requirements, including cultural, linguistic, or physical needs.
- No women had expressed an interest in disposing of foetal remains themselves, but the hospital told us this could be accommodated.
- We did not observe any consultation or discussions with women regarding termination of pregnancy during our inspection.
- Staff told us the consultant would speak to the patients who had undergone a surgical termination of pregnancy before they were discharged. The consultant would give the patients a leaflet to tell them what to expect in the 24-hours following the procedure. This included the direct telephone number to the consultant and the ward that women could ring to seek any advice if they were worried, or required extra support.
- Intentional rounding by care staff was completed throughout the patients stay. This meant patient were visited in their rooms hourly to check for example, if call bells and a drink were in reach, if the patient had pain or had any other requests.
- The environment and provision of single rooms with television and en-suite bathroom facilities met individual patient's expectations of private healthcare facilities. This meant women could have privacy following their termination of pregnancy, and allowed any discussions to remain confidential.
- Patients had access to a variety of information leaflets in the hospital. All information leaflets were in English, however staff told us they could access written patient information in other languages through an electronic system and obtained when required.
- An interpreting service for patients who did not speak English was available and staff knew how to access it.
- For our detailed findings on meeting the needs of local people and individuals, please see the Responsive section in the surgery report.

Learning from concerns and complaints

- There was a clear process in place if a patient wanted to raise a concern or complaint. We saw a patient information guide on was available on both the wards, that included a section on the formal complaints procedure. The BMI leaflets 'Please tell us' were located throughout the hospital and contained information on how to raise any concerns. Staff gave patients the opportunity to complete the hospital's patient survey questionnaire.
- The hospital received 26 complaints between July 2015 and June 2016, however, none of these deaths related to patients who had undergone termination of pregnancy at the service.
- For our detailed findings on learning from concerns and complaints, please see the Responsive section in the surgery report.

Are termination of pregnancy services well-led?

Leadership/culture of service related to this core service

- The staff we spoke with during out inspection told us they enjoyed working at the hospital, felt they could be open with colleagues and managers, and felt they could raise concerns and would be listened to. In addition they felt senior managers were available and visible within the department.

Termination of pregnancy

- There was a flexibility and willingness among all the teams and staff we met. Staff worked well together, and positive working relationships existed between the multidisciplinary teams.
- We saw that the hospital maintained a register of women undergoing a termination of pregnancy. This was completed for each person at the time the surgical termination took place, and was kept for not less than three years beginning on the date of the last entry. This complied with the requirement of regulation 20 (6) of the Care Quality Commission (Registration) Regulations 2009.
- The hospital had a certificate of approval for carrying out termination of pregnancy, which is issued by the department of health. However, this was not on prominent display in the hospital. The Department of Health sees the prominent display of the certificate of approval a matter of good practice.
- The hospital does not carry out surgical termination of pregnancies, beyond 20 weeks of gestation. This complied with the requirement of regulation 20 (5) of the Care Quality Commission (Registration) Regulations 2009, which says, the registered person must ensure that no termination of a pregnancy is undertaken after the 24th week of gestation.
- For our detailed findings on leadership/culture of service related to this core service, please see the Well-Led section in the surgery report.

Governance, risk, management and quality measures for this core service

- The hospital had clear governance in place. The hospital held meetings through which governance issues were addressed. The meetings included Medical Advisory Committee (MAC), Senior Management Team (SMT), Infection Control and Health Safety and Environment meeting. We reviewed the agenda and the minutes of these meetings, which showed audits, and learning from complaints, incidents, infection control issues, good practice, and risk management were discussed. In addition, we saw there was discussion and review external and national guidance and new legislation, such as National Institute of Health and Care Excellence (NICE) guidance.
- The women who had a surgical termination of pregnancy, within the reporting period, self-referred to the hospital and then went to their General Practitioner (GP) who signed the HSA1 form as the second signatory. The HSA1 form is a form that must be completed, signed, and dated by two registered medical practitioners before a termination of pregnancy can take place.
- The Department of Health (DH) required every provider undertaking termination of pregnancy to submit demographical data, such as the patient's age, following every termination of pregnancy procedure performed. These contributed to a national report on the termination of pregnancy (HSA4 forms).The HSA4 the consultant gynaecologist who performed the procedure and sent to the Chief Medical Officer within 14 days of the procedure signed forms.
- Department of Health HSA4 'Abortion notification' forms were completed for every termination procedure carried out and these were stored securely on the ward. The HSA4 form was sent to the chief medical officer, within 14 days of termination of pregnancy procedure.
- For our detailed findings on governance, risk, management and quality measures for this core service, please see the Well-Led section in the surgery report.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider SHOULD take to improve

Outpatients and Diagnostic Imaging

- All waste bins should be correctly labelled in line with in accordance with Health Technical Memorandum (HTM): Safe Management of Healthcare Waste, control of substances hazardous to health (COSHH), and health and safety at work regulations
- The procedure for cleaning of nasoendoscopes should be reviewed to ensure dirty instruments do not come into contact with clean areas.
- The hospital should ensure that language interpreters are only accessed via the formal translation service.
- The hospital should ensure there is a named radiologist on the radiology on call rota.

Surgery

- Take action to ensure all staff are compliant with mandatory training.
- Take action to ensure all staff have an annual performance appraisal.
- Ensure that staff document consent in line with national guidance from the General Medical Council and Royal College of Surgeons.
- Ensure there is an accurate checklist is available for staff to use when checking equipment for the difficult intubation trolley.
- Ensure all medical equipment is up-to-date with service and safety checks.
- Ensure there are systems in place for making sure all medicines are within date.
- The provider should ensure that that appropriate balance checks of all Controlled Drugs (CDs) are carried out regularly.
- Take action to ensure all staff are compliant with safeguarding of vulnerable adults and safeguarding children training.
- Take action to ensure staff are aware of the mental capacity act, and deprivation of liberties, and how it applies to their role.
- Ensure dedicated hand hygiene sinks in patient bedrooms are included when carrying out refurbishment in accordance with the Department of Health's Health Building Note 00-09.
- Ensure carpets are removed from clinical areas and patient bedrooms in accordance with Department of Health's Health Building Note 00-09.
- Ensure that staff caring for women undergoing termination of pregnancy the required competencies.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

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