

# BMI The Shirley Oaks 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	

# Summary of findings

## Letter from the Chief Inspector of Hospitals

BMI Shirley Oaks Hospital is one of the 52 hospitals which operate under the umbrella of BMI Healthcare. The hospital has 42 beds and provides a range of services for patients who require surgery or treatment for medical related conditions. There is an outpatient consultation department made up of 10 consultation rooms and two treatment rooms. A full range of diagnostic services are available, including x-ray, MR and CT scanners.

Patients who use the hospital facilities may have medical insurance, be self-payers or be booked through the NHS under arrangement made through the clinical commissioning groups.

- Patients were treated with respect, kindness and compassion. Staff were mindful to respect each person's dignity and took into account their individual needs and choices. Services were planned in a way which took into account the needs of people regardless of their point of referral.
- The hospital had enough staff with the right skills and abilities to provide the treatment and care for patients. Training, including safety related subjects were provided to staff. The skills and competencies of individuals were assessed by line managers as part of the appraisal process. Consultants who used the hospital did so under the agreement of practising practices and were required to provide evidence to support this, including professional qualifications and training completed.
- Staff had been trained in safeguarding adult's and the arrangements to safeguard vulnerable adults were clearly communicated and understood by staff. Consent and mental capacity was understood by staff and patient needs with this regard was fully considered. Nursing staff were confident to challenge consultants when they could not read information written on consent forms.
- The areas in which treatment and care was provided were visibly clean and tidy. Staff were supported to apply effective infection prevention and control practices and staff adherence to these measures were monitored.
- The environment was suitable for the services provided and were accessible to those who may have had reduced mobility. Areas which required restricted access were managed safely. Resuscitation equipment was accessible and was subject to regular checks. Staff were identified on each shift to be members of the emergency response team.
- Medicines were safely managed in line with professional standards. There was oversight of antimicrobial prescribing and medicines optimisation by the on-site pharmacy team. Patients were assessed for pain and given pain relief medicines in a timely manner.
- There was a well-defined system to report incidents, which staff were fully aware of and confident to use. Incidents were reviewed following a formal process and where learning was identified, this was shared with staff.
- Staff had access to a range of professional guidance, corporate and local policies and procedures to guide them in their work. Treatment and care to patients was delivered in line with professional practices. Monitoring of standards were measured through a range of audits, with results presented through performance dashboards. These were compared with other hospitals within the group.
- The individual needs of patients including their nutritional needs were fully considered and taken into account in planning their treatment and care. There was access to technical aids to support care and equipment used for treatment was available and subject to safety testing. A translation service was available and was regularly used.

# Summary of findings

- Staff felt valued and respected by one another. The leadership of individual areas within the hospital was suitable. Lines of reporting were clearly defined, and staff understood their responsibilities. Managers had the right experience, skills and commitment to ensure the hospital operated safely and effectively. Governance arrangements ensured oversight and scrutiny of performance and risks. Leaders recognised the value of learning and ensured information was communicated to staff.

However:



- Although the hospital had done a lot of work to improve the completion of consent forms with consultants, there remained times where consultants writing was not clear enough.
- Patient outcomes data collection was limited and therefore there was a lack of information to identify and support improvements.
- Clinical hand wash basins were not yet available in-patient rooms.
- The interpreting service was not wholly reliable and where it was known in advance of the need for an interpreter, staff did not pre-arrange this.
- Appointment times in outpatient's were not always provided to the specified time. The service was not actively monitoring start and finish times of individual consultation sessions and therefore did not know where frequent delays were occurring.

**Dr Nigel Acheson**

**Deputy Chief Inspector of Hospitals (London and the South)**

# Summary of findings

## Our judgements about each of the main services

Service	Rating	Summary of each main service
<b>Surgery</b>	Good 	<p>The surgery services at BMI Shirley Oaks provided a range of surgical treatments to self-funded, insured and NHS patients.</p> <p>We rated this service as good because it was safe, effective, caring and well-led, although it requires improvement for being responsive to people's needs.</p>
<b>Outpatients</b>	Good 	<p>The outpatients service at BMI The Shirley Oaks provides a range of clinics to patients who are self-funded, have private medical insurance or NHS.</p> <p>We rated this service as overall good. Safe, Caring, Responsive and Well-Led were rated good (Effective was not rated).</p>
<b>Diagnostic imaging</b>	Good 	<p>The diagnostic imaging department at BMI Shirley Oaks provided x-ray, ultrasound, CT, MRI and mammography scanning.</p> <p>We rated this service as good because we found the service was safe, caring, responsive and well led. Effective was not rated.</p>

# Summary of findings

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Good 

# BMI The Shirley Oaks Hospital

## Services we looked at

Surgery; Outpatients; Diagnostic imaging.

# Summary of this inspection

## Background to BMI The Shirley Oaks Hospital

BMI Shirley Oaks Hospital is operated by BMI Healthcare Limited. It is a private hospital in Croydon, Surrey. The hospital primarily serves the communities of the Surrey and South East London. It also accepts patient referrals from outside this area.

At the time of the inspection, a new manager had recently been appointed and was in the process of registering with the CQC to be the registered manager.

## Our inspection team

The team that inspected the service comprised of an inspection manager, three CQC lead inspectors, one

other CQC inspector, and three specialist advisors with expertise in surgery, outpatients and diagnostic imaging. The inspection team was overseen by Carolyn Jenkinson, Head of Hospital Inspection.

## Information about BMI The Shirley Oaks Hospital

The hospital has two wards, however, one ward was not being used at the time of the inspection. The hospital had three theatres, an outpatient's department and a diagnostic imaging department. The service is registered to provide the following regulated activities:

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

During the inspection, we visited one ward, theatre, the diagnostic imaging department and the outpatient's department. We spoke with 51 staff including registered nurses, health care assistants, reception staff, medical staff, radiographers, radiologists, operating department practitioners, and senior managers. We spoke with nine patients and two relatives. During our inspection, we reviewed 24 sets of patient records.

There were no special reviews or investigations of the hospital ongoing by the CQC at any time during the 12 months before this inspection. The hospital has been inspected seven times, and the most recent inspection took place in April 2018.

# 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?

Our rating of safe improved. We rated it as **Good** because:

- The service provided mandatory training in key skills to all staff and made sure everyone completed it.
- Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse, and they knew how to apply it.
- The service controlled infection risks well. The service used systems to identify and prevent surgical site infections. Staff used equipment and control measures to protect patients, themselves and others from infection. They kept equipment and the premises visibly clean.
- The design, maintenance and use of facilities, premises and equipment kept people safe. Staff were trained to use them. Staff managed clinical waste well.
- Staff completed and updated risk assessments for each patient and removed or minimised risks. Staff identified and quickly acted upon patients at risk of deterioration.
- The service had enough staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers, regularly reviewed and adjusted staffing levels and skill mix, and gave bank, agency staff and locums full induction.
- Staff kept detailed records of patients' care and treatment. Records were clear, up-to-date, stored securely and easily available to all staff providing care.
- The service used systems and processes to safely prescribe, administer, record and store medicines.
- The service managed patient safety incidents well. Staff recognised and reported incidents and near misses. Managers investigated incidents and shared lessons learned with the whole team and the wider service..
- The service used monitoring results well to improve safety. Staff collected safety information and shared it with staff, patients and visitors.
- Staff kept detailed records of patients' care and treatment. Records were clear, up-to-date, stored securely and easily available to all staff providing care.

Good





# Summary of this inspection

- The service used systems and processes to safely prescribe, administer, record and store medicines.
- The service managed patient safety incidents well. Staff recognised and reported incidents and near misses. Managers investigated incidents and shared lessons learned with the whole team and the wider service.
- The service used monitoring results well to improve safety. Staff collected safety information and shared it with staff, patients and visitors.

However:

- The patient rooms did not contain hand wash basins for staff to wash their hands.
- Consultants notes were not always clear and legible.

## Are services effective?

Our rating of effective improved. We rated it as **Good** because:

- The service provided care and treatment based on national guidance and evidence-based practice. Managers checked to make sure staff followed guidance.
- Staff gave patients enough food and drink to meet their needs and improve their health. The service made adjustments for patients' religious, cultural and other needs. Staff followed national guidelines to make sure patients fasting before surgery were not without food for long periods.
- Staff assessed and monitored patients regularly to see if they were in pain and gave pain relief in a timely way.
- Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for patients. The service had been accredited under relevant clinical accreditation schemes.
- The service made sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and development.
- Doctors, nurses and other healthcare professionals worked together as a team to benefit patients. They supported each other to provide good care.
- Staff followed national guidance to gain patients' consent. Patients consent forms had been completed and were legible and this was an improvement since our last inspection.

However:

Good



# Summary of this inspection

- The hospital did not have a high collection of patient outcomes data and was therefore limited in making improvements from information received through this system.

## Are services caring?

Our rating of caring stayed the same. We rated it as **Good** because:

- Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.
- Staff provided emotional support to patients, families and carers to minimise their distress. They understood patients' personal, cultural and religious needs.
- Staff supported and involved patients, families and carers to understand their condition and make decisions about their care and treatment.

Good



## Are services responsive?

Our rating of responsive stayed the same. We rated it as **Good** because:

- The service planned and provided care in a way that met the needs of local people and the communities served. It also worked with others in the wider system and local organisations to plan care.
- The service was inclusive and took account of patients' individual needs and preferences. Staff made reasonable adjustments to help patients access services. They coordinated care with other services and providers.
- People could access the service when they needed it and received the right care promptly. Waiting times from referral to treatment and arrangements to admit, treat and discharge patients were in line with national standards.
- It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff. The service included patients in the investigation of their complaint.

However:

- Although the hospital used a translation service, the reliability of its availability had impacted on the needs of a patient, resulting in their surgery being cancelled.

Good



## Are services well-led?

Our rating of well-led stayed the same. We rated it as **Good** because:

Good



# Summary of this inspection

- Leaders had the integrity, and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff.
- The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. Leaders and staff understood and knew how to apply them and monitor progress.
- Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service had an open culture where patients, their families and staff could raise concerns without fear.
- Leaders operated effective governance processes, throughout the service and with partner organisations. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.
- Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact.
- The service collected reliable data and analysed it. Staff could find the data they needed. Leaders had the integrity, skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff. They supported staff to develop their skills and take on more senior roles.
- The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. Leaders and staff understood and knew how to apply them and monitor progress.
- Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service promoted equality and diversity in daily work, and provided opportunities for career development. The service had an open culture where patients, their families and staff could raise concerns without fear.
- Leaders operated effective governance processes, throughout the service and with partner organisations. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.
- Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and

# Summary of this inspection

issues and identified actions to reduce their impact. They had plans to cope with unexpected events. Staff contributed to decision-making to help avoid financial pressures compromising the quality of care.

- The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were integrated and secure. Data or notifications were consistently submitted to external organisations as required.
- Leaders and staff actively and openly engaged with patients, staff, equality groups, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients.
- All staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them. Leaders encouraged innovation and participation in research.
- Leaders and staff actively and openly engaged with patients, staff, and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients.
- All staff were committed to continually learning and improving services.






# Detailed findings from this inspection

## Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Surgery	Good	Good	Good	Good	Good	Good
Outpatients	Good	N/A	Good	Good	Good	Good
Diagnostic imaging	Good	N/A	Good	Good	Good	Good
Overall	Good	Good	Good	Good	Good	Good

# Surgery

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

## Are surgery services safe?

Good 

Our rating of safe improved. We rated it as **good**.

### Mandatory training

**The service provided mandatory training in key skills to all staff and made sure everyone completed it.**

Training was delivered by e-learning or face-to-face sessions. The clinical service manager was able to demonstrate the systems they used locally to monitor staff training. Compliance was recorded and monitored using a computerised system maintained by the service. Topics covered included: infection prevention control, consent, information governance, medical gases, fire safety, moving and handling, safeguarding and equality and diversity.

At the time of our inspection, staff on the first-floor ward were 95.4% compliant against a corporate target of 90%. Of the 20 staff within theatres, 13 were 100% compliant with mandatory training. The remaining staff were part way through training and the completion rate ranged from 85.7% to 96.4%. Managers received alerts for when staff training was due.

Dates for training were set in advance and mandatory training was provided to staff one day per month, during which topics such as hand hygiene, aseptic non-touch technique, surveillance and sepsis screening were covered. Competency assessments were expected to be signed off for some skills, including correct hand washing techniques.

All registered nurses received immediate life support training, and for those staff who had yet to complete training, we saw evidence that staff were booked on courses over the coming months.

Staff we interviewed said they received enough training to ensure they had the skills to do their jobs. Staff reported having adequate time allowed to complete training and attend the organisations courses.

### Safeguarding

**Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse, and they knew how to apply it.**

Staff we spoke with knew how to recognise abuse and how to report it. They were clear about the hospital's safeguarding escalation process. Staff had received safeguarding training at the correct levels for their roles and were alert to any potential issues with patients. Safeguarding information, including contact details for the safeguarding lead was displayed in the ward. Staff told us the safeguarding lead was accessible and responsive.

The lead for adult safeguarding was the director of clinical services, with the quality and risk manager holding a safeguarding adult's champion role. The heads of departments had been trained to level three safeguarding, and registered nurses and other nursing staff were trained to level two. The clinical director was attending level four training in the week following our inspection.

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Safeguarding adults training figures provided to us showed 99% of staff had completed safeguarding level two training. PREVENT training had been completed by 95% of staff, and female genital mutilation (FGM) training had been completed by 90% of staff.

We were told by the director of clinical services the consultants undertook their safeguarding training at the substantive NHS hospital and were expected to provide evidence of this training.

The director of clinical services told us they engaged with Croydon local authority safeguarding team and a three-monthly safeguarding audit was carried out. At the time of the inspection there were no safeguarding events under investigation and no open investigations.

## Cleanliness, infection control and hygiene

**The service controlled infection risks well. The service used systems to identify and prevent surgical site infections. Staff used equipment and control measures to protect patients, themselves and others from infection. They kept equipment and the premises visibly clean.**

Overall the clinical areas we visited were visibly clean and tidy. These areas included patient rooms, the first-floor ward, theatres, storage areas, and clinical rooms. Policies and procedures for infection prevention and control (IPC) were provided from head office. These were accessible electronically. Any local policies or procedures were updated by the IPC lead in conjunction with the quality and risk manager. For example, the cleaning of electric fans had recently been updated. Staff we spoke with were able to explain the policy and the role they played in meeting the expected standards. For example, staff knew the IPC checklists they had to complete each morning.

The hospital had a member of staff who held the infection prevention and control lead (IPC). They had undertaken a train the trainer course to enable them to deliver training to staff, including the induction of the resident medical officer (RMO). The IPC lead monitored compliance with standards, environmental and post-surgical surveillance and screening. Care bundles were used for such practices as cannulation and checks of these post insertions. A report was also prepared and presented for the director of infection prevention and control (DIPC).

We saw care bundle results from June 2019, and these showed compliance was met in most areas. For example, catheter care insertion and ongoing care scored 100%, surgical sites, pre and post care was 100%. Results for peripheral lines insertion and ongoing care scored 95%. Action plans included, reminding all consultants and staff to date all intravenous cannulas. During the inspection we observed intravenous cannulas were dated. This demonstrated the service was following and monitoring National Institute for Health and Care Excellence (NICE) guidelines NG125: Surgical site infections: prevention and treatment guidelines of April 2019.

Patients were screened for meticillin-resistant staphylococcus aureus (MRSA) as part of their pre-assessment. During our inspection, we found MRSA pre-screening checks had been completed for all records we viewed. Data from January 2019 to April 2019 showed there had been no cases of MRSA.

The provider conducted monthly hand hygiene audits to ensure staff were following The National Institute for health and Care Excellence (NICE) QS61: People receive healthcare from healthcare workers who decontaminate their hands immediately before and after every episode of direct contact and care. Information we reviewed showed an overall compliance of 90% and above over a period of six months. Departments interchanged between each other when conducting hand hygiene audits to ensure they were completed correctly.

Alcohol-based hand sanitising gel was available in all clinical areas and at the entrance of the first-floor ward. We observed consultants, anaesthetists, and nurses wash their hands in line with the World Health Organisation's (WHO) "Five Moments of Hand Hygiene". They used the hand sanitiser where appropriate and washed their hands between patients on the ward and in theatres. Hand hygiene results we reviewed showed there was a high compliance rate of over 90%, and for staff we observed, all were 'bare below the elbow'. This had been an issue with some consultant staff within theatres, however nursing staff we spoke with said they were confident to challenge more senior staff when they did not follow best practice and had the support of senior managers within the organisation. Nursing staff said they had seen an improvement within the last year as the organisation had strengthened their focus

# Surgery

on this area. Staff wore personal protective equipment (PPE), of clean nursing uniform or scrubs (when working in the theatre environment) and wore clean gloves and aprons when attending to patients or handling equipment.

One operating theatre had higher levels of air filtration (laminar flow) in place, which was best practice for ventilation within operating theatres. This was important for joint surgery to reduce the risk of infection. The service had just received the Joint Advisory Group (JAG) accreditation for their endoscopy services, which meant the service was following IPC best practices for their endoscopes. JAG is a formal recognition that an endoscopy service has demonstrated that it has the competence to deliver against set criteria set out in JAG standards.

We saw “I am clean” stickers were visible on equipment such as electrocardiogram (ECG) machines, resuscitation equipment, and commodes. There was a good selection and availability of IPC materials such as gloves, masks and aprons within the service. The decontamination of reusable medical devices was conducted offsite by an external company and managed corporately. There was a turnaround time of 12 hours for routine items and six hours if fast tracked.

Cleaning audits were managed in conjunction with the housekeeping supervisor. Matters of concern were addressed immediately by housekeeping staff, who were part of the hospital workforce. The hospital used national colour coded equipment for cleaning the different areas of the hospital.

The IPC lead spoke about the recent patient led assessments of the care environment (PLACE) audit, which had been positive. They told us of improvements made, including the attachment of bumper strips to corridor walls, the removal of carpets, the replacement of the sluice on the ward. In addition, the treatment room on the ward was currently undergoing refurbishment.

Decontamination of reusable medical devices was managed by an external company through a service level agreement.

Quarterly IPC meetings were held with participation from microbiologist and medical advisor. There was a service level agreement for the provision of microbiology between the hospital and a local NHS trust. The hospital had an audit programme for monitoring matters related to IPC. The IPC lead provided a report on audit results which

included hand hygiene and bacteraemia's to the corporate IPC lead. They in turn provided reports to the IPC lead at Shirley Oaks. These provided an overview of surveillance by hospital. Information related to post-operative hips and knees was provided by the IPC to Public Health England. Post-operative wound surveillance results were sent back to consultants.

## Environment and equipment

**The design, maintenance and use of facilities, premises and equipment generally kept people safe. Staff were trained to use them. Staff managed clinical waste well.**

The first-floor ward consisted of 19 single rooms and there was an ambulatory care unit which had five patient bays. The single rooms were spacious and fifteen of the rooms had been refurbished and included wet rooms. However, four rooms still required refurbishment and had bathrooms which were dated. The hospital was in the process of updating these rooms. The refurbished rooms did not contain hand wash basins for staff to clean their hands after clinical care and we were told the organisation were in the process of having these fitted. There was an admission room and waiting area for relatives and patients who were using the ambulatory care unit. Hazard risk tape was placed along the entrance to the wet rooms, to indicate to patients there was a slight step.

There were three theatres with one mainly used for ophthalmic services or for procedures using sedation. This theatre had no waste gas scavenging system and could therefore, not be used for general anaesthetic procedures. Each theatre had a preparation and attached anaesthetic room. The theatres were bright appeared clean and were in a good state of repair. There was a recovery area which contained three patient bays and they were all equipped with Association of Anaesthetists of Great Britain and Ireland (AAGBI) and British Anaesthetic and Recovery Nurses Association (BARNA) recommendations, such as oxygen suction wave monitoring systems.

Staff checked equipment and logged their recordings on a daily basis. For example, anaesthetists checked the anaesthetic machine, and the log book was signed, dated and the number of breathing circuits were recorded. We looked at the resuscitation trolleys and found equipment was available, fit, and ready for use and had been checked regularly. Medical equipment in theatres and the first-floor



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ward we inspected had stickers to indicate they had been serviced and maintained and were in date. Fluids kept in the warming cupboard were labelled and this was an improvement since our last inspection.

There was a temporary clean utility room being used for equipment and medicines. We found the room was spacious and all cupboards were locked with access via a key entry system.

There were recording systems for implants, and we observed the recording registers for orthopaedic implants within theatres. A theatre log was completed each day and traceability stickers were logged for pieces of equipment used.

Waste in all clinical areas was separated and in different coloured bags to identify the different categories of waste. This was in accordance with HTM 07-01, Control of Substances Hazardous to Health and the Health and Safety at work regulations. Waste was managed well, there were no overflowing bins, and waste was collected at regular intervals throughout the day. Sharps were disposed of safely in correctly assembled and dated sharps disposal boxes.

## Assessing and responding to patient risk

### Staff completed and updated risk assessments for each patient and removed or minimised risks. Staff identified and quickly acted upon patients at risk of deterioration.

Staff completed comprehensive holistic risk assessments to determine a patient's suitability for treatment. Risk assessments were carried out as part of the preoperative assessment and on admission. Patients were monitored post operatively to identify any deterioration in their condition. Health assessments included electrocardiogram (ECG), blood pressure, weight, height and methicillin resistant Staphylococcus aureus, (MRSA) screening and discussions on the procedure itself.

The hospital accepted patients for surgery that were considered low risk. Exclusion criteria was followed due to there being no critical or intensive care facilities on site. For example, the service followed the American Society of Anaesthesiologists (ASA) grading system to determine

whether patients could proceed with treatment at the hospital. Any patients outside of this criteria were referred for multidisciplinary review before taking a decision whether to proceed.

Staff made regular checks with anaesthetists to ensure there was no increased risk of deep vein thrombosis (DVT). A staggered system was used which meant patients were treated in a timely manner and not kept waiting for too long.

There was a policy on the recognition and management of the deteriorating patient. This policy gave staff the necessary pathways to follow and the tools to recognise, assess and respond to patient deterioration. Pathways included a sepsis tool and pathway; asthma pathway, anaphylaxis pathway; and hypoglycaemia pathway, for patients with low blood sugar. Staff could describe the content of the policy, and in the event of a patient deteriorating and needing to be transferred to a local acute NHS trust, they should call an emergency ambulance to transfer the patient. The hospital was finalising a service level agreement with a local acute NHS hospital for the transfer of deteriorating patients.

In the event of responding to patient risk staff used a situation, background, assessment, recommendation (SBAR) tool to facilitate prompt and appropriate communication to the resident medical officer (RMO) or consultants. The tool made sure a set of standardised prompt questions within the four sections were completed so that information sharing was concise and focused. The hospital audited the SBAR tool and latest results from January to June 2019 showed a consistently high score of 98%.

Patient's vital signs such as blood pressure, pulse, and breathing rates were measured and escalated using the National Early Warning Scores (NEWS). This system provided an escalation trigger protocol. Patients who scored a high number were referred to the RMO, anaesthetists or consultants. If staff had concerns at any point during patient care, they could escalate for urgent review by the RMO. We saw NEWS was used in all patient records we reviewed. The hospital audited the completion of the NEWS, and latest audit results from January to June 2019 showed a consistent score of over 95%.

The hospital used the World Health Organisation (WHO) five steps to safer surgery checklist. This is a checklist used

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before, during and after surgery to help minimise errors. At our previous inspection in 2016, we found the WHO checklist was not being fully completed at all stages. During this inspection we found there had been an improvement and staff followed the correct procedures. The hospital had a stronger oversight and monitoring of the WHO checklist and identified any concerns through their patient pathway health assessment checks, and shared information at team meetings. We observed surgery staff use the WHO checklist correctly and this appeared embedded within the theatre culture. We observed two procedures for swab counts and these were documented on a white board within theatres. Patients were never left alone throughout all of the WHO checks. Audits from January to June 2019 showed a consistent high score averaging 100%. A WHO checklist was used for all cataract procedures.

We observed a patient handover to the recovery area and the procedure followed the Association of Anaesthetists of Great Britain and Ireland (AAGBI) guidelines, namely the procedure, anaesthetic drugs used, and the patient's co-morbidities were listed and discussed between staff.

At our last inspection we were not assured screening for Venous Thromboembolism (VTE) was being completed properly. Audits showed results were far below the organisations target of 95%. At this inspection we found an improvement and latest audits scored a consistent 100%. We reviewed eight sets of patient records and found VTE risk assessments had been fully completed.

Staff had received training in sepsis as part of their immediate life support training. These sessions included scenario-based activities. Staff told us they had transferred a patient to the local acute NHS hospital with suspected sepsis, although it was later diagnosed that the patient did not have sepsis. However, this showed, that staff were alert and followed the sepsis six steps used to monitor and assess potential sepsis cases.

Under the organisations practising privileges, anaesthetists were required to provide evidence of their mandatory training. The organisations current requirement for mandatory training was BLS. The anaesthetists did not form part of the resuscitation team and would only be expected to undertake airway management which formed part of their professional qualification if required by the team leader. The team leader was the RMO. All clinical staff were ILS trained and the RMO who was on site 24hours was ALS trained. The hospital also undertook unannounced

resuscitation scenarios carried out by an external company. We reviewed the latest report from 5 November 2019 and the report said staff performed the scenario to a high standard. For further assurance the hospital had asked all anaesthetists to complete ILS and ALS training and we saw a database which showed those anaesthetists who had completed ILS training and future dates for those anaesthetists who had not.

A resuscitation meeting was also held each morning staff discussed and agreed roles in the event of an emergency. Bleeps were used throughout the hospital in the event of an emergency. An external resuscitation company sometimes did unannounced emergency drills and staff's emergency reactions to scenario-based situations were assessed.

Haemorrhage training was mandatory, and at the time of our inspection all staff had received training. The hospital kept a fridge which contained emergency O negative blood, and this was stored and managed by an external organisation. In the event of an emergency O negative blood, the blood product of choice.

## Nursing and support staffing

**While we found the service provided enough nursing staff, with the right mix of qualification and skills, to keep patients safe and provide the right care and treatment, there was a high-dependency on bank and agency staff use.**

The hospital used a corporate staffing tool that had the ability to plan and track the staffing activities of the day and therefore provide staffing to match. The tool was used to determine staffing levels in advance. The hospital implemented the corporate five-day booking rule, which prevented patients from being booked five days prior to their surgery. This meant clinical managers could review staffing levels of the ward and theatres before a decision was taken on the patient's admission.

We found there was a heavy reliance on bank and agency staff particularly in theatres. However, most bank and agency staff used, were familiar with the hospital and were regularly used. Despite the frequent use of bank and agency staff, the service always had the right staff with the right skills for the day. The hospital used the BMI resource model in theatres which incorporated Association for Perioperative Practice (AfPP) guidelines for safer staffing.

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Staffing hours worked were reviewed daily during the morning communication cell meeting by the executive director and director of clinical services to ensure appropriate allocation of resources met the clinical needs of patients.

Within theatres and in accordance with AFPP guidance there was one anaesthetist, one registered circulating nurse, one scrub practitioner, one health care assistant and one recovery practitioner for each session. A circulatory nurse is responsible for ensuring that the operating room is sterile, and their duties involved helping all surgical staff present during the operation. There were two senior staff trained as surgical first assistants.

There were four registered nurse vacancies within the first floor ward, and regular bank and agency staff were used to fill these vacancies. During the inspection we saw that required and actual staffing were displayed on the wards which reflected the acuity on the wards. During the day three registered nurses and two health care assistants were rostered and at night two registered nurses. Where possible no agency staff were used for the night shifts. However, if required a permanent member of staff would work with the agency staff member to ensure continuity of service. The ambulatory care unit which had five-day beds and based within the first-floor ward was staffed by one registered nurse and one health care assistant.

Nursing staff received their rosters a month in advance and nursing staff had a minimum 11 hour rest in-between shifts.

Nursing staff used the situation, background, assessment and recommendation (SBAR) technique for handovers which occurred twice daily.

## Medical staffing

**The service had enough medical staff with the right qualifications, skills, training and experience to keep people safe from avoidable harm and to provide the right care and treatment.**

Consultants worked under practising privileges agreements in the service. Practising privileges is a well-established process within independent healthcare, whereby a medical practitioner is granted permission to work in an independent hospital.

There was a resident medical officer (RMO) and they were provided by an external agency, with the current period of employment having been arranged for a duration of a year.

This started in August 2019. The RMO worked on a week on and week off basis and had a rest room provided. The pattern of work was designed to enable the RMO to have minimum interruption as possible at night. They told us they attended the nursing handover at 8:30pm, as this provided an opportunity to identify any patient related needs to be done before retiring. Disturbances at night were very rarely reported. The RMO had breaks and time to eat during the day and evening. A multidisciplinary ward round took place at 9am, where patient needs were identified. The RMO took bloods and placed intravenous cannulas if required. They also assisted in pre-assessment, such as reviewing electrocardiogram (ECGs) and prescribing pre-procedural medicines.

The RMO told us the consultants were generally easy to contact and they felt valued by consultants asking their opinion too. We were told by the RMO that most consultants saw their patients daily, and that they (the RMO) reviewed the patients in the morning to assess their needs. Any concerns were reported to the consultant.

Consultants returned to review their patients. For those that did not, this usually involved very minor operations and a plan was given to the ward where the RMO would review and include their input. For more major surgery, for example, hip and knee operations the consultant always came back to review the patient. If a consultant was on leave they would handover patient care plans to other consultants.

## Records

**Staff kept detailed records of most patients' care and treatment, although records were not always clear, up-to-date, or readily available.**

Patient records were predominantly paper based, and we reviewed eight sets of records, which ranged from a variety of inpatient and day case procedures. Overall, the records were clear and provided alert prompts showing patient allergies and patient risks. Pre-operative assessments had been completed which included checks such as temperature and blood checks. Clinic notes were clear, in chronological order and of a consistent layout.

We checked eight patient records and found all consent forms were clear and legible with the risks detailed and all had been signed and dated prior to treatment. This was an improvement since our last inspection. Patient files were kept stored in a locked coded access room.

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Patient pathway audits were completed as part of managing patient records. We reviewed information provided to us which showed the audit covered general aspects of record keeping. The auditors also considered risk assessments, the completion of the World Health Organisation (WHO) safety checklist, pharmacy related entries and pain management. We saw there was an action plan to support areas of improvement. This included for example; the need for consultants to complete their medical notes more clearly and to make a daily entry in the patient records following their patient review. We noted too, some actions around training on SBAR. Target dates for all but one action had been set for December 2019.

The hospital maintained a medical records department which had received an electronic upgrade in April 2019. This allowed staff to electronically track all medical records that left the department. This central upgrade coupled with our information governance practices, contributed to the hospital recently achieving the ISO 27001 accreditation.

The hospital routinely audited patient records to ensure staff were completing them correctly. The audits were detailed and covered a set criteria. Although records we reviewed showed consultants had written clear up to date clinical notes, the audit findings from the most recent patient pathway health assessment, showed there was more work to be done to ensure consultants were consistently recording dating and signing their records.

GP's were provided with a letter from the consultant, which gave details of the outcome of their initial consultation. All patients admitted to the service would have a discharge summary sent from the hospital.

## Medicines

### **The service used systems and processes to safely prescribe, administer, record and store medicines.**

There was a good system of medicine management and optimisation in line with national guidelines. There was a safe management of medicines policy which had been ratified and was in date, and a medicines management operational manual to aid staff in safe management of medicines.

Staff we spoke with were able to describe the arrangements in place for the management of medicines and controlled drugs (CDs). The hospital conducted routine medicine audits to ensure staff were following best

practice. We reviewed several medicine audits. The April 2019 CD audit showed all standards had been achieved. Standards included, CD balance was correct, two signatures had been obtained one for witness purposes, and dose documented. Errors were recorded, and actions required, for example, one action included informing staff that any errors must not be crossed but bracketed. The patient pathway health assessment audit checked to ensure patients allergies were recorded. The most recent audit showed a 100% score.

We found all medicines including CDs were stored correctly in locked cupboards and fridge temperatures were correct and had been checked and logged daily.

There was a pharmacy manager, senior technician and a pharmacist who were contracted by the organisation. In addition to these staff the service was supported by temporary (bank) technicians and a bank pharmacist. The pharmacy manager had in excess of ten years' experience at the hospital and worked at another BMI location previously.

The pharmacy department was open from 8:30am until 4:30pm, Monday to Friday. On call arrangements were in use for urgent matters and for the dispensing of controlled drugs, which may be prescribed as a take home medicine. The service covered all clinical areas, providing a top up service to the ward twice a week, and once a week in theatres.

The multidisciplinary team (MDT) meeting held on the ward at 9am daily was attended by the pharmacy manager. Each patient was reviewed at this meeting with regard to medicines, including preparation for discharge home. Medicines optimisation and reconciliation was undertaken by checking the patient prescription chart. This was signed on completion of the reconciliation. Checks included antimicrobial stewardship.

We asked about medicines for out of hours or to take home and were advised that only stock-line medicines could be accessed from pharmacy out of hours. This required the RMO and key-holding nurse to check the location of the medicines in the pharmacy department.

The pharmacy manager attended the IPC committee where such matters of changes in guidelines were discussed. We were told the antimicrobial guidelines were under review at the time of our visit.

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There were three different types of patient prescription charts used for day case, in-patient and one where a patient had been prescribed longer term antibiotics.

The pharmacy manager informed us that there was a nurse trainer for medicine competencies. Pharmacy staff had access to the organisations learning system, with a range of modules to support continuous practice development and re-validation.

We were told about and saw information which demonstrated peer learning from incidents took place. For example, information from a medicines management clinical incident exercise referred to learning arising from expired medicines.

Medicines management was a regular slot at the clinical governance meeting and included any errors, near misses or medicine related matters. We saw there had been six medicines incidents, four of which were near misses during the period February 2019-end of September 2019. All of these were reported as no patient harm.

Medicine updates, including information related to CD's was circulated to staff via the clinical governance meeting. More urgent messages were communicated straight away.

Allergies were clearly recorded on all patient records.

## Incidents

**The service managed patient safety incidents well. Staff recognised incidents and near misses and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support. Managers ensured that actions from patient safety alerts were implemented and monitored.**

All clinical and non-clinical incidents were reported and logged directly onto the hospital's incident reporting system. From staff discussions, they told us the reporting incident culture was strong. Staff of all levels were confident to report incidents and how to escalate concerns. Staff said they received good feedback on incidents and the sharing and learning from incidents. Incidents reported,

were discussed the following day at the communication cell. A representative from each department was present at the meeting each morning and this meant feedback and issues from incidents could be cascaded quickly.

Heads of department (HODS) had a higher level of access to the system and the senior management team (SMT) had overall access. We viewed the data base and saw this was a well-structured and organised system. The hospital had a 48-hour key performance indicator for posting incidents.

We saw share and learn papers had been introduced and were circulated amongst staff. The communications folder which had been introduced by the clinical services manager, showed all incidents reported and the changes to practices as a result. For example, an incident which resulted in a misplaced document, showed areas of good practice and areas where improvements were required. Staff told us this was a good way of communicating change to staff as it highlighted positive practice as well as areas of improvement.

From April to March 2019 there had been no serious incidents reported. There was a total of 241 clinical incidents reported, 190 of those were categorised as no harm, 44 as low harm and seven as moderate. There had been no non-clinical incidents in the reporting period.

Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event. No never events were reported in surgery in the reporting period. We asked if there had been any never events in the past year and were told there had not been any of these. We were told about an unexpected death post discharge and were able to review how this was entered onto the incident data base. We saw each stage of the investigation and root-cause analysis undertaken

We reviewed incidents for surgery and noted there was a high level of information completed, including learning. We noted the incident process was well defined and followed through to satisfactory resolution. Shared learning was clearly indicated, along with information related to the groups and staff this was communicated too.

The electronic system produced monthly quality and risk reports, and these were discussed in the clinical

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governance meetings. Incidents was a set agenda item within this meeting. Mortality and morbidity were a set agenda item in the medical advisory committee (MAC) monthly meetings.

## Safety Thermometer (or equivalent)

**The service used monitoring results well to improve safety. Staff collected safety information and shared it with staff, patients and visitors.**

The service gathered patient information, for example in hospital-acquired infections, falls and venous thromboembolism (VTE) and discussed these at the hospital's clinical governance meetings. In the reporting period of April 2018 to April 2019, there were no reported incidents of hospital-acquired methicillin-resistant Staphylococcus aureus (MRSA), Meticillin-sensitive staphylococcus aureus (MSSA) or Clostridium difficile (c.diff) and one case of E-Coli.

Ward boards were in place which displayed information about the service for patients and visitors to read.

## Are surgery services effective?

Good 

Our rating of effective improved. We rated it as **good**.

## Evidence-based care and treatment

**The service provided care and treatment based on national guidance and best practice. Managers checked to make sure staff followed guidance.**

Care and treatment was delivered based on current legislation and nationally recognised evidence-based guidance. Policies and guidelines were developed in line with the Royal College of Surgeons, Royal College of Anaesthetists, and National Institute for Health and Care Excellence (NICE) guidelines. Staff were able to access policies and local protocols via the hospital intranet, and ward portfolios.

Policies, NICE guidelines and national guidelines were a set agenda items on the clinical governance committee meetings and were monitored through the BMI clinical governance bulletin and hospital and clinical governance committee.

We reviewed meeting minutes of May 2019 and found 20 NICE updates were reviewed. Any updates were then disseminated and shared through team meetings and local bulletins. The clinical services manager on the first-floor ward had developed an operational manual of day to day working standards expected, for example, appropriate uniform standards in line with local policy and national guidance.

Throughout the inspection we found staff followed national guidance and adhered to corporate policies. For example, the hospital followed NICE NG51: Sepsis: recognition, diagnosis, and early management. Staff used a sepsis screening and action tool and had received sepsis training. Staff NICE guidance QS61: statement 4: Urinary catheters, by ensuring infection control procedures had been followed when inserting catheters.

Staff had access to professional guidance and standards of practice related to endoscopic procedures. These covered all aspects of the patient's pathways from appointment booking to discharge and considered emergency and out of hours provision. The hospital had just received Joint Advisory Group (JAG) accreditation or their endoscopy service. This accreditation meant the hospital was following best practice for their endoscopy service.

From records we reviewed, the hospital followed the Royal College of Nursing (RCN) guidance for catheter care and NICE guidance on falls prevention, pressure area care and venous thromboembolism (VTE).

There was a corporate clinical audit programme. Audits included the World Health Organisation (WHO) surgical safety checklist, infection prevention and medicines management. This meant the hospital was bench marked against other BMI hospitals within the BMI healthcare group.

## Nutrition and hydration

**Staff gave patients enough food and drink to meet their needs and improve their health. They used special feeding and hydration techniques when necessary. The service made adjustments for patients' religious, cultural and other needs.**

Patients waiting for surgery were kept 'nil by mouth' in accordance with national safety guidance.

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Staff used the Malnutrition Universal Screening Tool (MUST) to assess patient's risk of malnutrition. Records we reviewed demonstrated staff had used the tool.

An external catering company provided all meals within the first floor ward. There was a choice of meals, which included lighter options and meals, which supported cultural and religious choices. Sandwiches were provided for patients for late night admissions.

The Patient Led Assessment of the Clinical Environment (PLACE) results of 2018 showed the hospital scored higher than the national average and organisational average for the quality of food.

## Pain relief

**Staff assessed and monitored patients regularly to see if they were in pain and gave pain relief in a timely way. They supported those unable to communicate using suitable assessment tools and gave additional pain relief to ease pain.**

There were effective processes in place to ensure patient's pain was managed well. Nursing staff used an assessment tool to rate patient's level of pain. We saw from patient records pain scores were recorded at regular intervals throughout the patients stay.

The hospital conducted comprehensive auditing of patient's pain levels through their patient's pathway audit. Standards such as, were any non-pharmaceutical pain methods advised and if so were they effective and is there evidence the nursing team has assessed the patient pain levels frequently enough were audited. We found results from January to June 2019 demonstrated high compliance with over 90%. Some areas needed improvement, such as "Is there documented evidence the patient pain levels were evaluated post analgesia?" where the score was 65%

The clinical services manager said more focus had been made on pain management and since the introduction of the morning bedside meetings where pain management was discussed with the patient, feedback had improved. Patient feedback results were now 84% for their pain being well managed, and this was an improvement of the 2018 results, when the score was 66%. Patients now had a pain care plan.

## Patient outcomes

**Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for patients.**

The Patient-Specific Functional Scale (PSFS) was a self-reported, patient-specific outcome measure, designed to assess functional change, primarily in patients presenting with musculoskeletal disorders. The PSFS was a valid, reliable, and responsive outcome measure for patients with back, neck, knee and upper extremity problems. It had also been shown to have a high test-retest reliability in both generic lower back pain and knee dysfunction issues. Patients were asked to identify up to five important activities they are unable to perform or are having difficulty with because of their problem i.e. putting socks on 0" represents "unable to perform" "10" represents "able to perform at prior level" we saw initial scores and discharge scores. Most scores were rated a high 10

The hospital participated in the national Patient Reported Outcome Measures (PROMS) for hip, knee and cataract surgery. From the BMI quality accounts of 2018, results showed, the total hip and knee replacement PROM had showed a consistent improvement in health gain and was better than the UK overall. The patient response rate was low however, and the hospital were finding ways of increasing the uptake. PROMs were discussed in the clinical governance committee meetings, and the hospital were working towards a PROM which captured five dimensions of health-related quality of life and included mobility pain and discomfort. In an effort to improve the capturing of PROM information the hospital were in the process of appointing a PROM champion, with the focus on arranging meetings with staff to encourage the importance of PROMS. The hospital was encouraging patients to complete the PROM during the existing 24 hour follow up phone call to the patient. PROMs were a set agenda item on the clinical governance committee meetings.

The hospital participated in the National Joint Registry (NJR) to collect information on orthopaedic joint replacement operations, to monitor the performance of implants and the effectiveness of different types of surgery. The hospital had been awarded the NJR quality data provider certification for reaching the standards relating to patient safety through NJR compliance. In order to achieve the award, the hospital was required to meet a series of six targets during the audit period of 2017 and 2018.

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The hospital regularly reviewed individual consultant performance. Advice from BMI Healthcare groups medical director and national director of clinical services would be sought if a consultant concern was raised. A more detailed audit of the consultant's outcomes would be undertaken if required.

The organisation participated in the extensive peer review integrated care audit in 2018 and all outstanding actions were closed in March 2019. The hospital engaged regularly with the clinical commissioning group (CCG) to discuss outcomes and performance improvements of the standard acute contract and commissioning for quality and innovation (CQUINS). The organisation worked with the Private Healthcare Information Network (PHIN) as they recognised there was a need for reporting patient outcomes across the independent sector.

## Competent staff

**The service made sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and development.**

The hospital made sure staff were competent for their roles. New staff completed an induction programme which involved local competency sign off before they were able to work independently. As well as mandatory training staff completed scenario based training sessions such as major haemorrhage and cardiac arrest.

There was an effective appraisal system, where staff were able to discuss development opportunities and had meaningful discussions on their wellbeing and support required for their role. Appraisals were held twice a year with one being a 'mid-term' appraisal. At the time of our inspection the appraisal rate was 100% and the hospital was only one of two locations within the organisation who had achieved this rate. We reviewed an action plan the clinical services manager had in place to progress with introducing one to one sessions every two months. The organisation had a profile of each staff member and this showed what training staff had completed and what courses they could sign up for. We could see that one member of staff was due to attend an ophthalmology course and all nurses had been trained in blood transfusion.

The hospital promoted development, for example, a member of the catering team had been successful in their application for health care assistant. They were able to tell us how well they had been supported by everyone within the organisation.

We reviewed two files of each consultants with practicing privileges working within gynaecology, urology, orthopaedics and anaesthetist specialities. All files contained the supporting evidence to grant practice at the hospital. For example, we saw self-declarations, evidence of registration with professional bodies, application and references, certificates and a curriculum vitae. Where the individual was more recently appointed references were present. All files contained evidence of appraisal and re-validation.

The hospital held certifications, training and Disclosure and Barring Service (DBS) certifications registrations for all agency and bank staff who worked within the hospital.

## Multidisciplinary working

**Doctors, nurses and other healthcare professionals worked together as a team to benefit patients. They supported each other to provide good care.**

We observed good collaborative multidisciplinary working across surgery. A patient bedside meeting was held each morning and was attended by the RMO, pharmacy, physiotherapist, and registered nurse where each patient care plan was discussed.

We observed a nurse handover where detail of the patient's condition and wellbeing and any potential risks were discussed. This was an informative and detailed meeting.

The theatre and ward staff worked well together to ensure patients received appropriate handovers along their pathway of care. To aid safe and effective handovers of care, between the ward, theatre staff used a written Situation, background, Assessment, Recommendation (SBAR) handover tool.

Staff told us consultants attended their patients on ward rounds and were easy to access for information.

Patients GP's were sent a letter on their discharge.

## Seven-day services

**Key services were available seven days a week to support timely patient care.**



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Support arrangements for patient care was offered 24 hours seven days a through a combination of 'on-site' and 'on-call' arrangements. Consultants and Anaesthetists engaged under BMI practicing privileges were available for their own patients and contact was made through the various departments should the need arise. Consultants and Anaesthetists were required to confirm suitable cover arrangements if they are unavailable or on annual leave.

There was a daily on-call team which included a pharmacist, radiographers, theatre team, engineer and a senior manager. The Resident Medical Officer (RMO) provided 24 hours 7 days a week service on a rotational basis. All RMOs were selected to specifically manage a variety of patient caseloads. The RMO had completed the Advanced Life Support (ALS) course. There was also an on-call physiotherapy rota out of hours during the week, and bank and agency staff at the weekends.

On the first-floor ward there were two registered nurses, a bank sister and no medical admissions took place on a Sunday.

## Health promotion

### Staff gave patients practical support and advice to lead healthier lives.

Information booklets were available on smoking, falls prevention and infection prevention and control. At pre-operative assessments patients were advised on weight management and smoking and additional support was provided if necessary. For example, physiotherapists had input into the patients care plan from an early stage to help mobilise and promote independence after surgery.

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

#### Staff understood how and when to assess whether a patient had the capacity to make decisions about their care

During our last inspection we found problems with the legibility of patient consent forms. We were not assured the patients treatment and risks were clearly documented and could be read. During this inspection we reviewed eight patient consent forms and found all of the information was clear, legible and risks were explained. This was an improvement since our last inspection.

The hospital had worked hard to ensure patient consent forms were being completed clearly and risks fully explained. We were told nursing staff were empowered to challenge and stop any patient procedures if they felt the patient consent forms had not been completed correctly. Nursing staff said they had the support from senior managers to do this. We heard about an occasion where staff could not read the consent form and as the consultant was not prepared to re-write them, the patients had their surgery cancelled.

The hospital closely monitored patient consent forms through their patient pathway audits. The patient pathway audit was completed twice a year so covered six months' worth of audit information collected. We reviewed the latest audit results and found for evidence collected to demonstrate consent had been signed was 100%. Consent being legible scored 100% and informed consent scored 98%. Consent signed before day of procedure scored 78%. For the consent signed before day of procedure criteria, the hospital were expecting improved results with the latest audit which was due in December 2019, as the message had been reinforced to medical staff.

Staff received training on the Mental Capacity Act as part of their mandatory training. Staff we spoke with had a good understanding of the Mental Capacity Act 2005 and could describe the key principles and practices when gaining consent from patients who may not have capacity to do so themselves. Staff had access to the BMI policies regarding consent and understood their roles and responsibilities when gaining consent from patients.

## Are surgery services caring?

Good 

Our rating of caring stayed the same. We rated it as **good**.

### Compassionate care

#### Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.

We observed care was given in a compassionate and dignified way. Staff were friendly, kind and treated patients with respect. Staff were discrete and ensured patient discussions on treatment took place in private consultation

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rooms. We spoke with five patients. They told us staff were professional and had asked them throughout their care if they were comfortable. Patients commented “I have had marvellous care, and they are a really good team.”

Staff within theatres were respectful to patient’s privacy and dignity and made sure patients were covered with gowns or blankets when being transported to other area within the hospital.

We saw several examples of thank you cards displayed throughout the first-floor wards with comments thanking the staff for their care and support during treatment, with comments such as “Everyone from reception desk nurses and theatre staff were kind attentive and helped relax me before my procedure.” The ward displayed patient satisfaction results and for the month of September 2019 the result was 98%.

Patient satisfaction results from the 2018 patient satisfaction survey showed 98% of patients would recommend family and friends to the hospital. 96% of patients said the quality of care was good and 98% said their expectations were met.

The Patient Led Assessments of the Care Environment (PLACE) audit for 2018 showed the hospital scored 98% for privacy, dignity and wellbeing which was better than the national average of 84.2%.

## Emotional support

### Staff provided emotional support to patients to minimise their distress.

Staff had the time to help those patients who required emotional support. Patients told us staff checked on their well being and treated them as individuals. During pre-assessment we observed a staff member reassuring a patient who was unsure of their treatment.

At handover meetings, staff discussed the patient’s wellbeing and emotional support they required.

Patients could be sign posted to the relevant supportive services if they required.

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

**Staff supported and involved patients, families and carers to understand their condition and make decisions about their care and treatment.**

We observed good relationships had been made between staff and patients, so informal discussions could take place. Patients told us they had been involved in all aspects of their care. One patient told us staff had explained everything in a way they understood, and staff used photographs for further explanation. Staff had told them how to appropriately look after themselves during their stay at the hospital and what to expect following discharge.

Another patient told us how they had been provided with a package of information which included an explanation of the procedure, after care instructions and contact details. We saw staff explaining to patients their care plan including timescales of their treatment, including when they could eat and when to take their medication. The staff member checked with the patient to make sure they understood.

The hospital displayed a wide range of information for patients and their families on large notice boards and leaflet racks throughout the hospital.

Appointment times were flexible to accommodate individual patient needs. Time was given to go through all information including costs for those patients who were self-paying. NHS and non-NHS patients were not treated differently in any way.

A telephone contact number was provided to those patients who paid for treatment. Options on costs and what consultant to see was discussed. The patient was then booked for a consultation, where the consultant created a personalised treatment plan. In most cases patients were provided with an all inclusive fixed price. Arrangements for payment through a variety of options was discussed before the procedure took place.

## Are surgery services responsive?

Good 

Our rating of responsive stayed the same. We rated it as **good**.

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

**The service planned and provided care in a way that met the needs of local people and the communities served. It also worked with others in the wider system and local organisations to plan care.**

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The hospital accepted both NHS and private patients for elective surgery. There were a variety of surgical treatments available which included orthopaedic, gynaecology and cosmetic. The hospital's intermediate gynaecology contract with their local clinical commissioning group (CCG) had recently ended. The local CCG had also redesigned the orthopaedic pathway for the local community which had resulted in a decline in referrals to the hospital. This had an impact on the hospital's ability to ensure that staff requirements equated to patient activity. The hospital had responded by engaging more closely with the CCG to better understand the new patient pathway. Staff had also been shared to other departments within the hospital.

Due to the changes made in local service delivery, the decision was made to keep the second ward closed and provide all surgery from the one ward and ambulatory care area. This made the service more efficient and able to manage its resources, including staff. The hospital occasionally accepted transfers from other trusts, but only after an assessment.

The pre-assessment process had recently been changed. The department now ran two clinics each day from 8am to 5pm. The clinics were not overbooked, and the nurses were supported by a main consultant anaesthetist who conducted a weekly clinic each Friday, to review all at risk patients. The enhancements were underpinned by policies and guidelines which had been developed centrally. A new pre-assessment registered nurse had been recruited in January 2019.

## Meeting people's individual needs

**The service was inclusive but did not always take into account patients' individual needs and preferences. Staff made reasonable adjustments to help patients access services. They coordinated care with other services and providers.**

The recording and use of translation services had been an initial concern raised in our inspection of August 2016 and subsequent inspections of June 2017 and April 2018. Although the hospital had made improvements in the recording and identification of patients who required translation services, we still found problems during our inspection. A patient who had attended treatment with a relative had not had the appropriate translation services booked and subsequently their treatment was cancelled on the day. The patient's relative explained they had been

translating on behalf of the patient and had contacted the service prior to the appointment to make sure the service was available. Staff told us on this particular day the translation service did not have the appropriate staff member to assist, and this was highly unusual and a rare occurrence. However, this meant the patient's treatment was cancelled and they were unable to have surgery on that day.

We saw evidence that the interpretation service had been used 71 times during the previous year up to August 2019 which demonstrated there was a good system for utilising translation services when patients required. Staff also placed labels on patient records to show that translation services had been contacted and arrangements had been made to accommodate patients who required support. This was an improvement since our last inspection.

Hearing loops were available to support patients who had a hearing deficit and text messages were used to remind patients of their appointments. The corridors and individual patient rooms could accommodate wheelchair access and there were lifts for patients with limited mobility to use to get access to the first floor.

The hospital had a designated room for patients with dementia. This room had been designed with a brightly painted door and a special day, night clock inside the room. Special pressure mats were available for those patients with a greater risk of wandering and a risk of falling. Staff had completed dementia training and wore dementia friends badges to show they had received the appropriate training.

Discharge planning was discussed with patients at the pre-assessment stage. Staff worked closely with social services and local authorities to make arrangements for those patients who required more support after discharge. Staff told us if there was a delay for arrangements they would not discharge the patient until the plans had been confirmed. However, we were told this was a rare occurrence, as they did not see many patients with additional supportive needs.

## Access and flow

# Surgery

**People could access the service when they needed it and received the right care promptly. Waiting times from referral to treatment and arrangements to admit, treat and discharge patients were in line with national standards.**

All surgery was planned, and people had timely access to initial assessments, tests results and treatment. The hospital implemented the corporate five-day booking rule, which prevented patients from being booked five days prior to their surgery, which meant the organisation could plan staffing levels more effectively. The service did not have a waiting list as all surgery was elective and access to the service was flexible to meet patient's needs.

The theatre operated from Monday to Friday opening 7.30am to 9.00pm with the last patient planned to be discharged from recovery at 8.30pm. On Saturdays the list opened from 7.30am to 6.00pm. Adhoc sessions were available if required.

The hospital ensured patients could access treatment by publishing the majority of its services on its electronic referral system; which gave patients a greater choice of appointment times. The hospital managed clinic capacity to ensure and maintain short wait times. Private patients were able to book appointments through a centralised team or website, which included a 'live chat' support function.

The referral to treatment (RTT) pathway is the key access target for NHS-funded patients which states that no patient should wait longer than 18 weeks from referral to the start of their treatment. The hospital's NHS team monitored patient wait times and helped facilitate admissions.

Results from June to November 2019, showed there were two returns to theatre in October 2019, one for a haematoma (which had occurred as a result of not having followed post-operative instructions. The second was as a result of urinary retention and the need for a flexible cystoscopy. As the private sector enables choice for patients in terms of when they want to access the care they need, the waiting times are not monitored.

Due to the current changes in the pathway for orthopaedic patient's theatre utilisation was currently under used. We reviewed monthly inpatient activity. From April to August 2019 there was a total of 206 inpatients. For day case treatment the total was 2784.

Weekly planning meetings were held where staggered waiting admission times for surgery was discussed. The majority of patients said they had been informed of the waiting times on admission, however, the hospital was constantly looking at ways of improving the waiting times for patients.

There was a total of 13 theatre cancellations from January to November 2019. The reason for cancellations varied, although we noted there were three occasions where staff could not read the consent form and when they challenged the consultants and requested them to be re-done, the consultants refused. Those patients were rebooked with the organisation's five day rule.

## Learning from complaints and concerns

**It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff. The service included patients in the investigation of their complaint.**

Complaints received by the hospital were acknowledged in writing within two working days. The complaint was then sent to the head of department or the relevant consultant for investigation or comment for a formal response within 20 working days. If the investigation required more than 20 days to complete a further holding letter was sent to the person regarding their complaint.

Complaints were captured on the hospital's electronic data base and categorised by level, entry level being one. We saw a category two investigation which had included a letter of apology from the consultant under the policy of being open and honest.

We were able to view the end to end process for managing complaints on the electronic system, selecting complaints related to surgery. The database was clear and informative, with details of the date the complaint was raised, the department the complaint related to, a summary of the complaint and who the designated investigator was. Information was recorded for each step of the investigation and attachments were added, for example, notes, letters written to the individual.

We saw changes the first-floor ward had made as a result of patient complaints. The service had received complaints relating to the visibility of staff and patients wanting more

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involvement in their care plans. As a result, bedside handovers were introduced, and every morning a bedside handover which includes a multi-disciplinary team of clinical staff is undertaken in each patient's individual room. Patients are asked about how they are feeling and are able to ask questions to the appropriate member of staff.

Patient complaints were discussed in the local team meetings.

## Are surgery services well-led?

Good 

Our rating of well-led stayed the same. We rated it as **good**.

### Leadership

**Leaders had the abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff. They supported staff to develop their skills and take on more senior roles.**

The hospital was led by a senior management team consisting of an executive director (ED), operations manager, director of clinical services and a quality and risk manager, as well as clinical services managers (CSMs) for both theatres and wards. The executive director (ED) had been in post for a relatively short time but had held a similar position at another hospital within the BMI group. Their initial reflections on the hospital was that the staff made up a great team and were 'friendly and welcoming to her.'

Staff within theatres and the first-floor ward felt well supported by the CSMs. Staff said they were visible and had an open door approach, in that they were available to offer guidance and staff said they could talk through any concerns they had. The CSMs had a good understanding on the departmental risks and challenges they faced. The CSMs said they received good support from their respective managers.

The ED had quickly understood the worry areas and saw these as relating to the completion of consent forms to the

required standard. They were also aware that the collection of patient experiences through PROMS needed to improve. They felt having a designated person to oversee this would help in increasing the data collection.

### Vision and strategy

**The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. Leaders and staff understood and knew how to apply them and monitor progress.**

The hospital's vision and strategy was underpinned by a clinical services framework, and this had been updated and reissued in July 2019. The aim of the strategy was to ensure an integrated approach where risk management, clinical governance and quality improvement was part of the culture and everyday management practice. The objectives of the strategy were to promote an honest, open and blame-free culture where risks were identified and addressed at every level and escalated appropriately, to ensure standards outlined by the organisations governing bodies, partners and regulators were achieved and maintained. We were provided with the hospital's statement of purpose, which set out the services objectives in relation to the population it served. A set of care values defined what the service would deliver to its users and how staff were expected to work with patients and others:

- Communication and working together.
- Aspiring and improving.
- Respectful and caring.
- Efficient and safe.

The mission statement of the hospital was: To strive to continuously improve the health of our local community by providing accessible, compassionate, quality healthcare.

A five year vision for the period 2015-2020 had set out eight strategic objectives and key priorities. These related to people, patients, communications, growth, governance, efficiency, facilities and information. We asked if there were any plans to refresh or update the vision as the service was going towards the new year and were told this had not been discussed.

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The hospital had its own business plan covering the period up to 31 March 2020. We asked the ED if there was a plan to develop a new plan. We were told a new business plan was in development and this would be discussed with the heads of departments in the near future.

There was a monthly staff newsletter where the service's vision was shared. Staff newsletters were printed and displayed in staff rooms.

## Culture

**Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service promoted equality and diversity in daily work and provided opportunities for career development. The service had an open culture where patients, their families and staff could raise concerns without fear.**

There were cooperative, supportive and appreciative relationships amongst staff. Staff told us they felt valued and well supported by the organisation. Teams within theatres and the first-floor ward worked collaboratively and shared responsibility equally and constructively.

We asked what improvements or changes had been made for staff since the last inspection. A news letter had just been introduced by the ED, called Shirley Pulse. The hospital had signed up to an external website which provided items for staff to try and give feedback on. Although there was no staff forum the hospital had recently started a social committee, with the first quiz night having taken place at the end of October. A choir had recently been established too. A 'happy mug' filled with sweets was awarded to an individual staff member in recognition of going above and beyond. They kept this for the week and then it was passed on.

Staff told us the culture had changed significantly since the last inspection. Managers had been given the autonomy and were empowered to challenge consultants. For example, staff within the surgery service were able to challenge those consultants where consent was not properly completed.

The team in theatres had changed completely with new staff and an improved culture. Safety huddles had been introduced, after recognising some aspects of service provision were muddled and lacked communication. The huddle, which we attended provided an opportunity to understand what was going on in each service area, to

identify any concerns or issues, such as capacity or staffing arrangements. The booking of patients into theatre now took into account the availability of ward beds, which previously it had not.

A staff member was the freedom to speak up guardian (FTSUG) and had been in this role since June of this year, in addition to their role as infection prevention and control lead. They advised there was no designated time for the FTSUG role, but that there was flexibility, which enabled them to be accessible to staff. If additional time was required for a specific matter they could agree this with their manager. They had received six direct contacts as part of the role, and each one was of a very different nature. Therefore, no specific themes or trends could be identified. There was a provider FTSUG, who was accessible to the post holder at the hospital, and regular meetings were held with other role holders in the BMI group. Cover was arranged with a neighbouring hospital for times of absence. The FTSUG maintained records of discussion, ensuring the individual was made aware of this and that such information could not be accessed by any other person.

Staff had received training on the duty of candour (DoC) and staff we spoke with had a good understanding and could describe occasions when the DoC would be applied. The first-floor clinical services manager gave examples of the duty of candour during staff meetings.

## Governance

**Leaders operated effective governance processes, throughout the service and with partner organisations. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.**

The organisation had governance and management systems in place and they interacted effectively to provide assurance and service improvements. Staff were clear about their roles and responsibilities and what they were accountable for. There were various governance meetings such as the clinical governance committee, senior team meeting, medical advisory committee (MAC), health and safety committee, infection prevention and control meeting, and local departmental meetings. These meetings were held on monthly or bi-monthly basis. Set agenda items were covered in these meetings.

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We reviewed four sets of meeting minutes from the clinical governance committee meetings. This meeting was attended by all hospital departmental leads and executive directors, director of clinical services and pharmacists. The set agenda items discussed included incident case reviews, patient complaints, medicine management, risks and quality improvements, policies, risk register, national safety alerts and patient satisfaction. We were able to see improvements that had been made through strong oversight and monitoring from the clinical governance meetings. For example, the compliance training target for clinical documentation and legal aspects had improved on a month by month basis as a result of strong oversight through the clinical governance meetings. In March 2019 the rate was 70% and by May 2019 this had improved to 93%.

The medical advisory committee (MAC) oversaw clinical governance issues, the renewing of consultants' practicing privileges, and monitored patient outcomes.

There was a system for granting and monitoring practicing privileges. New Consultants enquiring about practicing privileges were directed to the executive assistant to the executive director. Supporting documents collected by the hospital for each consultant with granted practicing privileges included a curriculum vitae, certificates of qualification, annual appraisal, General Medical Council (GMC) specialist register registration, medical indemnity certificate, and Information Commissioner's Office (ICO) certificate evidencing registration as a data control. Other supporting documentation included references and immunisation status and an enhanced Disclosure Barring Service (DBS) was performed by the organisation. Consultantsex with practising privileges were asked to produce the same documentation on an annual basis. Failure to provide or renew documentation prior to expiry could lead to temporary suspension or withdrawal of practising privileges. On a biennial basis a more detailed review was under taken to also include a review of clinical indicators such as return to theatre, readmission, infection rate, complaints and incidents, procedure volumes and scope of practice. This is then further ratified by the MAC.

## Managing risks, issues and performance

**The service had good systems to identify risks, plan to eliminate or reduce them, and cope with both the expected and unexpected.**

We spoke with the quality and risk manager who advised us that there were service level risk registers, which fed into the hospital one. The hospital risk register was reviewed yearly, and this was currently happening. We reviewed the hospital risk register and noted risks were categorised using a traffic light colour system and a risk score was applied. The top four risks were rated as red, three related to facilities and estates and one to staffing. Risks scoring 20 or above were escalated to head office.

We found risks listed on the hospitals risk register were realistic, relevant and understood by staff. For example, staffing and the high use of agency staff was a top risk within theatres and the wards. The risk register gave mitigating actions and review dates which meant the risks were regularly reviewed, and actions updated. Risk controls included regular internal and external advertising for roles, salary comparison conducted to ensure offering was competitive and recruitment events held at the hospital. At a local level both theatres and ward took extra mitigation by making sure they used regular bank and agency staff who were familiar with the service.

The director of clinical services met with the quality and risk manager on a Friday to review risks. They had worked to simplify the hospitals risk register. This was to ensure all staff understood the hospitals main risks and what actions were being taken. Staff we spoke with were able to list the risks within the hospital. A monthly report was produced by the quality and risk manager and this was discussed at the clinical governance meeting. The ED had recently recruited a patient representative to the hospitals MAC to ensure the service user has a voice in the governance of their local community hospital. Monthly bulletins were circulated for high grade incidents, along with any shared learning. Safety alerts come through at clinical governance meetings and cascaded down through team meetings.

There were effective systems to monitor quality and operational performance through internal and

external audit programmes. Audit findings were discussed in the clinical governance committee

meetings. Clinical auditing took place every month to an agreed schedule. Monthly departmental

health and safety checks were recorded so any non-clinical risks were controlled.

## Managing information

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**The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were integrated and secure. Data or notifications were consistently submitted to external organisations as required.**

The hospital had systems to capture and manage data to drive and improve quality performance. For example, the electronic reporting system meant the hospital could capture risks and monitor themes and trends. The system allowed the hospital to benchmark their outcomes against other comparable services both internally and externally.

Staff were able to access the relevant systems to gain access to the right information to perform their role. For example, they were able to get information on the latest policies and patient safety alerts. On the ward there were paper formats of policies and audit outcome information.

The organisation had group policies and processes for governing information governance, security and personal data protection. All data controller registrations for the processing of personal data were maintained in accordance with the requirement of The UK Information Commissioners Office. The organisation held the formal certification in relation to the operation and management of its information.

## Engagement

**Leaders and staff actively and openly engaged with patients, staff, equality groups, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients.**

The hospital encouraged patients to complete an independently managed questionnaire in either postcard format for day cases or a long questionnaire for inpatients. The results were collated on a monthly basis and patient response, rates and rating within categories were ranked against all BMI hospitals. Results were reviewed at the clinical governance meetings and MAC meetings. Patient satisfaction was also discussed at the head of departmental meetings. We viewed the September 2019 results and saw there was a snapshot of the hospital in comparison to all BMI hospitals. The top five most improved scores for the period September 2018 to

September 2019 month were summarised. This included for example; the quality of information provided during pre-assessment call, which had gone up from 35.4% to 85.2%. The bottom five scores were also summarised for the same period. We saw for example the following had gone down; quality of information about who to contact if worried, which went down from 79.2% to 67.6%. Overall the information reported that 98.5% of people who completed a feedback form, either on-line or on paper (130) would recommend the hospital. A group of patients were invited to review and provide feedback on different aspects of the patient's journey.

Annually the organisation engaged with the Patient Led Assessment of the Clinical Environment (PLACE) audit programme and a PLACE action plan was developed to respond to any concerns. The 2018 audit showed the hospital scored higher than the national and organisational average for all domains apart from cleanliness. Actions plans were in place that were due to be closed by December 2019.

The hospital also collected and submitted data for the NHS Friends and Family test, results we reviewed from January to June 2019 showed the hospital scored above 95% for patient satisfaction, with the average response rate ranging from 24% to 42%.

Staff were able to participate in the 'BMI Say' staff survey and we saw changes the hospital had made from results of the survey. For example, the rebranding of all single toilets to be made unisex and a shift for the Christmas party to a summer party which saw 145 of the 179 registered staff attend. The staff survey results of 2018 showed 67% of staff would recommend BMI and its services. This was a decrease from 2017 and was below the company average. As a result, the hospital took actions through recognition schemes such as, The Shirley Oaks superstar awards, where awards were given to team of the year and clinical staff member and non-clinical staff members. In addition, the hospital recognised long service staff members through regular ceremonies.

Staff were encouraged to attend forums and the organisation launched a voting system for staff to choose the company's new values and purposes. The hospital returned over 100 votes.



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Ward meetings occurred every two months and the meeting included case studies where staff could discuss and learn from each other. For example, staff told us they discussed a case study of a patient who had been transferred out of the hospital.

There was a staff communication book in the ward. This book allowed staff to write down any immediate concerns or any good ideas they may have. This book was used during the nursing handover.

## **Learning, continuous improvement and innovation**





**All staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them. Leaders encouraged innovation and participation in research.**

The hospital was in the process of arranging engagement with a charity, so they could provide additional training for patient care for older people.

The new ward clinical services manager had created an action plan for quality improvements. For example, for better flow of communication, staff now had their own pigeon holes where information could be sent directly to them, such as patient complimentary feedback. Eight new lockers had now been fitted, which meant staff could secure their personal belongings.

The director of clinical services was currently working with the MACs anaesthetic representative to implement a support telephone line that will see a named anaesthetist available to the nurses in the clinic each day of the week.

# Outpatients

Safe	Good 
Effective	
Caring	Good 
Responsive	Good 
Well-led	Good 

## Are outpatients services safe?

Good 

We rated it as **good**.

### Mandatory training

**The service provided mandatory training in key skills to all staff and made sure everyone completed it.**

Mandatory training for staff was available through a mixture of online e-learning and face to face classroom based teaching. Topics included fire safety, moving and handling, equality and diversity and basic life support as well as other mandatory training subjects.

Staff told us online e-learning was easily accessible and they were given protected time to complete it. However, staff told us that face to face classroom based teaching was harder to attend as staffing cover needed to be arranged in the department on the day of training. Staff told us they found the training useful, relevant to their role and interactive.

Information we received pre-inspection showed the outpatients department was 90.3% compliant with mandatory training, the department aimed for 100% compliance. Managerial staff we spoke with were able to tell us their plan of action for ensuring all staff were compliant, including the possibility of staff completing mandatory training at home and claiming overtime payment.

Medical staff completed training through the NHS trust within which they worked. Failure to complete mandatory training resulted in practising privileges being suspended

as per the practising privileges policy. Practising privileges give medical staff the right to work in an independent hospital following approval from the Medical Advisory Committee (MAC).

The resident medical office (RMO) was trained in Basic and Advanced Life Support (BLS) (ALS) and supported the outpatient's staff if a cardiac arrest situation arose. We saw completed certificates for these courses during our inspection.

### Safeguarding

**Staff understood how to protect patients from abuse and their service but rarely had to work with other agencies. Staff had completed the required level of safeguarding training.**

Staff understood their role in recognising patients at risk of abuse or when abuse was or had occurred. Staff completed training on how to recognise and report abuse and were able to talk us through the steps they would take if they suspected someone was being abused. Staff were familiar with how the referral process worked.

Information provided to us before inspection showed staff were 99% compliant in adult safeguarding level one and 96% compliant in adult safeguarding level two. This information also showed compliance as 99% for child safeguarding level one and 96% compliant for child safeguarding level two. The hospital had a target of 90%.

The director of clinical services was the location lead for adult and child safeguarding. Staff we spoke with told us they felt well supported in their decision making around referrals relating to potential safeguarding concerns. The director of clinical services had level three adult and paediatric safeguarding training. They told us they were due to undertake level four training in the near future.

# Outpatients

Staff had training in the recognition of female genital mutilation (FGM) and spoke confidently in their ability to recognise and report suspected incidences. Staff were also provided with Prevent training. Prevent works to stop individuals from becoming radicalised and involved in terrorism or extremist activity. Pre-inspection information provided to us showed two members of staff as non-compliant for FGM and Prevent training; however, information showed to us on inspection, showed all members of staff within outpatients were now compliant.

A corporate policy and local safeguarding standard operating procedure was in place and accessible to staff. The director of clinical services and quality and risk manager worked closely with the local community safeguarding team and met with the local children and adult safeguarding board every six months to review issues raised or reported around safeguarding.

All staff went through a pre-employment screening process prior to commencing their role and were subjected to a DBS renewal every three years and monitoring of professional registration. We reviewed records of these checks during our inspection.

## Cleanliness, infection control and hygiene

**The service controlled infection risks well. Staff kept equipment and the premises visibly clean. They used control measures to prevent the spread of infection.**

All areas within the outpatient's department we visited were visibly clean and tidy, and there were arrangements for domestic and clinical staff to ensure safe infection prevention and control (IPC) practices were followed for cleaning areas and equipment.

Cleaning schedules were audited, and staff told us that any urgent cleaning was completed quickly and to a high standard.

Personal protective equipment (PPE) including gloves and aprons were available for staff in all clinical areas and we observed these being used during inspection. We observed stock of PPE and staff told us there was an easy system for re-ordering new PPE.

Equipment within the department had an "I am clean" sticker in place to show the item had been cleaned. We also viewed weekly cleaning rotas which showed a list of equipment which had been cleaned as well as the time and date of when the cleaning took place.

Patients with an infectious disease were scheduled to be seen at the end of the day. Following their visit, a deep clean was carried out by cleaning staff.

Waste was split into clinical waste and non-clinical waste and each went into different bags. Hospital porters collected and disposed of this daily which we observed whilst on inspection. All sharps bin we saw were signed, dated and appropriately stored.

Hand washing facilities were available in each consulting room and hand gel readily available in all patient areas. We observed staff washing their hands according to the five moments for hand hygiene as set out by the World Health Organisation. All staff we observed were bare below the elbows.

Information supplied to us before the inspection showed the outpatients department scored between 96%-98% compliance for IPC audits for the previous three months before inspection.

There were no incidents of hospital-acquired infections between April 2018 to March 2019.

## Environment and equipment

**The medical care service had suitable premises and equipment for patients who accessed the service and looked after them well.**

Resuscitation trolleys were available within the outpatient's department. Adult resuscitation trolleys were checked daily by staff and no equipment was noted as missing or waiting replacement. A time, date and signature of the staff member who carried out the check was available on the daily checklist. The resuscitation trolley also housed an automatic external defibrillator (AED) which had been calibrated and checked according to manufacture instructions.

Toilets were clearly signposted and adapted for people with disability.

Electrical equipment was electrical safety tested with a clear label displayed indicating when another safety test was due. All equipment we viewed had in-date safety testing.

The waiting area was visibly clean and tidy and there were magazines and a water dispenser available for use.

# Outpatients

A laser machine used in the outpatient's department had a full audit of regular checks which we saw during inspection. The laser protection advisor was from a local NHS trust. The hospital had a protective equipment policy, an optical radiation safety corporate policy and a standard operating procedure for laser protection. Staff were familiar with how to access these policies. The laser room had signage outside to indicate when people should not enter.

The hospital had an equipment replacement programme in place. This showed which equipment needed replacing in priority order. Pre-inspection, the hospital submitted a capital plan which highlighted all equipment being used in the hospital and its timeframe for replacement.

## Assessing and responding to patient risk

### Staff completed an updated risk assessment if needed for an individual patient.

On our last inspection (August 2016) the hospital was asked to ensure patient records were completed fully including pre and post procedure observations in legible form. During this inspection we viewed ten records which showed records were completed fully including all stages of patient's observations.

Staff told us that if a patient became unwell whilst in the department, they would complete a set of observations and call the RMO to assess the patient. If necessary, staff would call for an ambulance to take the patient to an NHS hospital. The clinical service manager told us the hospital was working towards having a service level agreement with a local NHS trust and this was in the final stages of approval. Once this was approved, any patients requiring NHS hospital treatment would attend this local hospital.

The department had a number of emergency call alarms which when pressed made an audible noise which highlighted to staff the need for assistance. Staff we spoke with were able to tell us the process for calling the hospital's crash team.

The outpatient's department had a list of procedures which required the use of local safety standards for invasive procedures (LoCSSIP's), these included all

patients undergoing a minor procedure. We checked relevant records where we would expect to see completed LoCSSIP's and noted five out of five relevant records had one completed.

The hospital had an admissions criteria for patients attending an outpatient's appointment. NHS choose, and book patients were screened for admission suitability when making an appointment ensuring staff could safely care for the patient. This process was the same as our previous inspection.

The hospital did not see anybody living with mental, complex or severe illness.

## Nurse staffing

### The service had enough staff with the right qualifications, skills, training, and experience to keep people safe from avoidable harm and to provide the right care and treatment.

The outpatient's department was staffed by six full time registered nurses and five healthcare assistants (HCA's). HCA's were used to assist nursing and medical staff in clinics. Staffing levels were structured so that there was one HCA for every one nurse. Rota's, we viewed showed this to be the case.

At the time of inspection there was one full time equivalent (FTE) vacancy for nursing staff and one FTE for HCA.

As reported in our previous inspection report, there was a high usage of bank staff within outpatient's department, but there was no use of agency staff. Bank staff completed an induction into the department, this included a corporate induction checklist and an orientation of the department. Most bank members of staff worked part time hours within the department.

The department used a staffing planning tool. This allowed managers to track daily activity which provided a clearer picture of staffing requirements. Management staff told us this tool was useful in planning staffing rotas and meant staffing arrangements could be focused on areas where there was greater demand.

We found the outpatients nursing lead organised the staffing roster four weeks in advance. This was the same for reception staff. This gave bank staff an opportunity to state which days were preferable for them to work.

# Outpatients

There was access to clinical nurse specialists when required. We saw evidence of input from a tissue viability nurse in patient records.

## Medical staffing

### **The service had enough medical staff to provide the right care and treatment.**

There were 179 consultants who worked within the hospital. Consultants worked at the hospital under practising privileges. Practising privileges give medical staff the right to work in an independent hospital following approval from the Medical Advisory Committee (MAC). All applications for new posts had been through the MAC.

New consultants who wanted to work at the hospital under practicing privileges were directed to the central executive team. They were required to complete an application pack which included demonstration of all relevant clinical experience relating to the practice which they wish to bring into the hospital. They were expected to provide several supporting documents including; curriculum vitae, certificates of qualification, annual appraisal, GMC specialist register registration and a valid medical indemnity certificate. References and immunisation status were also requested, and an enhanced DBS check took place. Consultants were required to provide updated documentation annually. We were told failure to provide or renew documentation prior to expiry may lead to temporary suspension or withdrawal of practising privileges.

Outpatient clinics were planned according to consultant availability and would be cancelled if a consultant was not available. Medical staff supported nursing staff when clinical advice was needed.

The hospital employed RMO's who rotated to provide medical support to the outpatient department and to the inpatient wards.

## Records

### **Staff kept detailed records of patients' care and treatment.**

The department used paper patient records and did not have any plans to introduce electronic patient records. The hospital had a medical records department which oversaw the filing, distribution and tracking of patient records.

Medical records were prepared in advance of outpatient clinics. Records were collated by the medical records department at least 24 hours prior to a patient's appointment. Staff told us they rarely had a problem with patient records being available on the day of their appointment.

Patient records were eventually scanned for archiving. Appropriate staff could directly access these to review and where required, print archived medical records. This happened in the eventuality staff did not have access to medical records on the day of a patient's appointment.

Each morning, nursing staff placed patient records in the individual consultant's room and the door remained locked when a member of staff was not present in the room. We saw this practice was followed.

Outpatient nursing staff entered details into a patients record by exception, if they were changing a dressing or to document they had chaperoned. Nursing staff also kept their own 'wound care' records, which were documented within and locked away at the end of each day.

Staff told us that test results were appropriately filed in patient records prior to attendance and that medical record tracking and tracing was available through the online records tracking system.

There was no mechanism for flagging people with specific needs such as learning disability. However, staff reported they did not see patients with specific or complex needs as they would not meet the criteria for accessing the service.

The department lead carried out a monthly audit on completed medical records. Information supplied to us before inspection showed June 2019 audit was 91% compliant. During the inspection we viewed a number of more recent medical records audits which ranged from 95%-97% compliant.

## Medicines

# Outpatients

## **The service followed best practice when prescribing, giving and recording of medicines.**

Medicines were securely stored across all outpatient services. Medicines were kept in locked cupboards and the department lead held the key. Medicine fridges were locked, checked and temperatures recorded daily to ensure medicines were kept at the correct temperature. Staff knew how to escalate and action concerns regarding medicines and the correct process for highlighting temperatures which were out of range.

There was a system in place for recording NHS FP10 prescription pads within the department. The prescription pads were kept securely in a locked cupboard and a log was kept of the number of prescriptions, how many each consultant had used and where the remainder was located. The pharmacy team monitored the use of FP10 prescriptions within the department.

There was a storage cupboard which contained a small amount of stock which was audited and where necessary, ordered weekly to replenish. Items such as bandages, dressings, lubricating gel, condoms and sodium chloride were available. Staff were allocated the responsibility each week to check the cupboard, ensure items were in date and re-order stock where required.

The hospital had a management of health records and clinical documentation policy in place. This policy was in-date and version controlled. It informed staff how to accurately record, store and manage patient records. Staff we spoke with knew how to access this policy.

Any allergies patients may have, had been clearly outlined within the patient's medicine record.

### **Incidents**

**The service managed patient safety incidents well. Staff recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service.**

Prior to our inspection, we were told that in outpatients there were zero never events in the last 12 months and 241 clinical incidents throughout the hospital, 190 of these were classed as no harm.

Incident investigations were allocated to the nurse clinical lead for outpatients. Staff told us that any investigation involved speaking to those directly involved. An investigation report went to senior management who sent feedback that may advise on further action depending on context and circumstances.

There was a hospital wide lessons learnt meeting attended by staff of different grades, coordinated by the quality and risk manager. Learning was shared throughout the hospital via email, newsletters and team meetings. The most recent reportable incident in outpatients related to there not being enough space within the outpatient's department. Staff were hopeful a move to a bigger part of the hospital may take place next year.

The hospital used an online incident reporting system. This system was able to break down all incidents so that what might be attributable to outpatients could be identified. Incidents were discussed at monthly clinical governance meetings. Action plans were also created to ensure repeats of incidents were kept to a minimum or were not repeated at all.

All staff had access to the online incident reporting system and staff we spoke with understood their responsibility to report incidents. All staff were trained in its use and staff gave us examples of when they had used it, including using it for health and safety related matters and stock issues.

## **Are outpatients services effective?**

We do not rate effective.

### **Evidence-based care and treatment**

#### **The service provided care and treatment based on national guidance and evidence of effectiveness**

The quality and risk manager received updates on new practice and guidance from the corporate BMI team for dissemination to relevant teams. Local NHS trusts with whom there were contracts for work, also advised on best practice to follow. Staff were knowledgeable in the use of National Institute for Health and Care Excellence (NICE) guidance and we saw evidence of policies and guidance referencing evidence based best practice.

# Outpatients

External training courses, feedback and in-house training used evidence based best practice in their teachings. For example, we saw one member of staff's training documents on venepuncture and noted the training material was based upon WHO guidelines on drawing blood best practice in phlebotomy.

The hospital monitored the implementation of NICE guidance through the BMI clinical governance bulletin and the clinical governance committee. We reviewed notes from these which demonstrated discussion around evidence based practice.

We saw evidence of nursing staff accessing evidence based best practice guidance when applying dressings and carrying out wound care on patients. Staff had access to the Marsden Manual, (an online reference guide which provides up-to-date, evidence based guidance on over 200 nursing procedures).

## Nutrition and hydration

### Staff gave patients enough food and drink to meet their needs.

In the waiting area, patients, carers, friends and relatives had access to a water dispenser and free hot drinks. Patients were directed to the hospital's canteen for hot food. We also noted a vending machine at the entrance to the hospital.

## Pain relief

### Staff assessed and monitored patients regularly to see if they were in pain.

Nursing staff did not routinely assess patient to see if they were in pain, but consultants always explored this during a patient's consultation, as noted in patient's medical records we viewed. Consultants were also observed asking the location, duration, aggravating factors and associated symptoms using a 1-10 pain scale. We observed consultants giving advice to patients on managing their pain and prescribing pain medication where necessary. Consultants also gave thorough instructions on how best to use pain medication.

A pain management clinic was housed in the outpatient's department. The clinic provided pain relief injections for knee, hip and back pain. Nurses and HCA's had specific competencies to support pain management clinics.

## Patient outcomes

### Managers monitored the effectiveness of care and treatment and used the findings to improve them.

The hospital participated in the National Joint Registry (NJR) and Patient Reportable Outcome Measures (PROM). All hip, knee & shoulder replacement data was submitted to NJR.

Information provided prior to our inspection showed that outcomes were monitored following discharge through follow up appointments and patient surveys. Patients were given the option to receive a telephone or face to face consultation following surgery to review progress.

## Competent staff

### The service made sure that staff were competent for their roles.

All staff in the department had received an annual appraisal. Staff we spoke with found the appraisal useful in identifying new objectives and learning opportunities. Appraisals were conducted with staff's immediate line manager. There was also a tracking system in place to identify who was due an appraisal.

Staff completed competencies according to their role and responsibilities. Information on each member of staff was kept in a folder and showed certificates and other key training information. All certificates we viewed were in-date.

HCA's had completed competencies which enabled them to take on extra responsibilities. These included taking bloods, wound care, suture removal and removal of casts. Gaining competency would involve completing online training and shadowing someone experienced.

Staff we spoke with in the department told us they felt they had enough training and support to undertake their specific competencies. For staff working part time or flexible hours, they were encouraged to carry out their competencies at every available opportunity to ensure they remained competent and proficient.

All staff received an induction into the department when they first started in their role. This included an orientation

# Outpatients

and shadowing of existing staff. New members of staff were given a competency checklist to complete to ensure they understood how the department worked and where equipment was located.

Staff were encouraged to identify their own learning needs. Staff told us they were actively encouraged to attend courses relating to their practice. For example, one HCA we spoke with wanted to know more about wound care and had been supported by the hospital to attend a wound care course in the coming year.

## Multidisciplinary working

### **Staff in different roles worked together as a team to benefit patients.**

During our inspection we observed good multidisciplinary team (MDT) working. Nursing staff, pharmacy, porters, administrative, consultants and diagnostic staff worked together for the benefit of patients. We observed staff treating one another with respect and challenging each other when considering the best course of action.

A daily 'huddle' meeting attended by representatives from each department enabled discussion of activity, concerns or problems.

Staff worked well with diagnostic imaging staff whose patients shared a waiting area with the outpatient's department. Staff ensured there was a smooth pathway for patients who needed an X-ray followed by a consultant appointment. There were monthly joint meetings held between outpatients and diagnostic imaging staff.

There was a daily communication book for staff to leave messaged in between and at the end of each shift. This ensured staff on shift the following day was able to see if anything of interest had taken place the day before. This book was locked away securely at the end of each shift.

## Seven-day services

### **Staff in the general outpatients worked in the evenings five days a week to provide a responsive service to patients**

The outpatient department principally ran Monday to Friday from early morning until around 8pm. On Saturdays the department was open between 8am and 1pm. Pharmacy support was available Monday to Friday.

## Health promotion

### **Some health promotion information and advice was available.**

Patient information leaflets were available within the main reception area. However, the leaflet rack where the leaflets were held was at the far end of the waiting area and not completely visible to patients. Staff told us the leaflet rack had been moved to this location as children would play with the leaflets when they were at the other end of the waiting area.

Health questionnaires and advice was provided in clinics, included advice on how to stop smoking, alcohol intake, diet and mobility. Patients were referred for further help if required.

## Consent and Mental Capacity Act

### **Staff understood their roles and responsibilities under The Mental Health Act 1983 and the Mental Capacity Act 2005.**

Staff were provided with an online training session on mental capacity and deprivation of liberty. There were policies available for staff on these subjects, which were version controlled and in-date. Staff showed us how to access these policies.

Staff were aware of their responsibility regarding The Mental Capacity Act (2005) and Deprivation of Liberty Safeguards (DoLS). However, staff told us because of the admission criteria to see patients in the outpatient's department, they have never applied DoLS. Staff could not recall any patient attending the department who had issues regarding capacity.

We reviewed ten sets of patient notes, five were pulled at random from the medical records department and five were notes of patients seen during our inspection. We found that eight of the records were accurate, complete, legible, up-to-date and stored safely. However, two patient notes did not contain up-to-date consent forms. Although in both records, consent forms were signed,



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only one consent form was signed (March 2019) for three sets of minor procedures being carried out over the course of 12 months. Minor procedures included removal of skin lesions, skin biopsies and eye injections.

We did not see evidence of completed consent forms on each occasion the minor procedure was carried out. We brought this to the attention of senior staff during the inspection, who told us they would speak with the consultant responsible and carry out a more stringent audit of their records.

## Are outpatients services caring?

Good 

We rated it as **good**.

### Compassionate care

#### Staff cared for patient with compassion.

We observed staff treating patients with compassion; talking sensitively, quietly and kindly to patients, friends, relatives and carers. Staff displayed a non-judgemental attitude towards patients.

A chaperone was available for any examination or procedure. The chaperone would be a member of staff of the same sex as the patient. We observed chaperones in attendance during physical examinations of a patient.

The hospital collected friends and family patient satisfaction survey results. These showed a consistent 98%-99% score over the past six months prior to inspection (response rate averaging around 30%).

Patients we spoke with were complimentary about staff. We saw feedback cards filled out by patients who had used the outpatient services. Comments such as 'polite, nice staff', 'friendly receptionist' were left.

### Emotional support

#### Staff provided emotional support to patients to minimise their distress.

Patients were provided with print-out information to help them understand their symptoms and diagnoses. We saw consultant giving additional information, providing an

opportunity to ask and answer questions and sign pointing patients to useful websites. Patients were also provided with a contact telephone number in case they had any further questions.

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

#### Staff involved patients and those close to them in decisions about their care and treatment.

Staff dealt with all queries in a friendly and approachable manner. They did their best to accommodate the needs of patients. If patient transport was required, reception staff were able to provide this and book transport on behalf of patients.

We observed consultants taking time to explain surgery options to patients as well as gaining the thoughts of a patients loved one. We observed staff explaining cost of treatment, financial treatment plans and a breakdown of the cost of each treatment.

## Are outpatients services responsive?

Good 

We rated it as **good**.

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

#### The provider planned and provided services in a way that met the needs of local people

Patient information was displayed in the reception area. This included informing patients that children could not be left alone in the waiting area. There was information on disability access and mobility in an emergency which advised people to notify a member of staff. There was also an estimated 'wait time' displayed. Additional information on patient conditions were available in the waiting area.

Patients were seen in the outpatient's department through a number of channels including, referral from the NHS, private insurance companies and a self-payment option.

Car parking was available free of charge for patients and visitors. There were designated disabled spaces for usage and a local bus service was available.

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Once a consultation was complete, patients returned to the reception desk to book their next appointment. This was done in front of them and they were then provided with a printout of their appointment time. Patients could also opt to receive a text message reminder of their next appointment.

## Meeting people's individual needs

### The service took account of patients' individual needs and met these.

Individual needs were assessed, and this demonstrated in patient records. We saw information relating to allergies, past medical history, mobility, family history and test results. There was also infection screening and notes relating to MRSA results.

NHS referrals were screened before accepted for their first appointment. This identified whether patients were suitable to be seen within the hospital. We were provided with an 'admissions criteria', which included not accepting patients classed with a body mass index (BMI) if over 40, patients with complex medical needs and any history of psychiatric illness.

There was sufficient car parking and disabled spaces for patients. This provided easy access to the hospital. The outpatient's department was signposted, and staff greeted patients at the reception desk.

The department had a hearing loop to assist those patients who had hearing loss. Staff knew how to work this and there were clear instructions for patients. There was access to a language interpretation line.

Staff and patients were able to communicate effectively and sensitively around the reception area. The outpatient's booking team were based within the reception area making it easier for patients to book follow up appointments.

## Access and flow

**People could access the service when they needed it. However, appointment times on the day were not always on time and the service did not actively record wait times.**

Referrals came from BMI's national enquiry centre who added patients onto lists for appointments. Consultants sometimes added patients to their clinic list, which could have an impact on flow through the department.

Staff told us that clinics regularly ran late or did not start on time. When a consultant did not start on time, this was recorded in a book and reviewed by the department lead. If a consultant was continually late starting their clinic then they would be invited for a discussion on how they could improve time keeping. Staff told us this had happened with one consultant who decided not to see patients at the hospital any longer.

However, the department did not audit how often patients were late going in for their appointment. They only measured if a clinic was late starting. During our inspection, we noted at least three patients in one afternoon, ask reception staff how long until they would see their consultant. Two patients were 50 minutes over their allotted time. Staff told us the number of patients running over their allotted time was increasing and patients were increasingly approaching reception staff to ask when they would be seen.

## Learning from complaints and concerns

### The service treated concerns and complaints seriously, investigated them and learned lessons from the results and shared these with staff.

Information was clearly displayed in the reception area on how to make a formal complaint. Staff told us in the first instance, they would attempt to try and resolve the patient's complaint in person, on the day. If this was unsuccessful, staff would hand the patient a leaflet on how to make a formal complaint.

Complaints at the hospital was managed by the Executive Director (ED), with complaints of a clinical nature investigated by the director of clinical service. The personal assistant to the ED oversaw the administrative elements of the complaint whilst recording and inputting complaints onto the electronic reporting system. All complaints were received via the ED's Office, who acknowledged receipt to the complainant within 48 hours by letter or email. Copies of the complaint were then distributed to the relevant head(s) of the department(s) or consultant(s) for investigation. The final response comes from the ED.

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The hospital followed the corporate BMI Healthcare Complaints Policy Guidelines for managing complaints. Patient complaints followed a three-stage process, with each stage having set timeframes for responses. Stage one involved an investigation and response by the hospital within 20 days, whilst stage two resulted in regional or corporate review and response within 20 days. Stage three provided for an independent, external adjudication.

We saw completed feedback cards which patients had placed into a collection box. We saw email evidence of feedback provided to staff from these feedback cards.

Most complaints were concerning incorrect billings or financial charges not being understood and length of time to wait to see a consultant on the day of a patient's appointment. Staff told us they now displayed financial billing information more clearly in the form of posters within the waiting area and this was observed during inspection. Staff said they were working towards ensuring clinics ran on time which included ongoing discussions with consultants who were often running late.

## Are outpatients services well-led?

Good 

We rated it as **good**.

### Leadership

**Managers had the right attitudes, skills and abilities to run the outpatient service however they were a newly formed team and had just begun to address some of the challenges in the outpatient department.**

Staff in the outpatient department were managed by a clinical service manager. The outpatient's department also managed phlebotomy services. The clinical service manager reported to the hospital's clinical services lead who reported to the executive director.

The clinical service manager told us they felt well supported by the senior leadership team and was encouraged to come up with new ideas and improvements for the outpatient's department. The

clinical service manager told us they did not have a formal set frequency of when they met with the hospital clinical service lead but did say they met with them at least once per week and could contact them anytime.

Staff in outpatients told us that the clinical service manager, the hospital clinical service lead and the executive director was visible and approachable. Staff told us they received regular updates from senior leaders either through emails, newsletter or meetings.

Staff we spoke with felt the executive leaders had a focus on development, training and upskilling of staff and that this was also a corporate focus of BMI.

### Vision and strategy

**The service had a vision for what it wanted to achieve and workable plans to turn it into action, which it developed with staff, patients, and local community groups.**

The BMI corporate vision was to deliver high quality care and best patient outcomes. The department had a five year forward vision which described areas for improvement, including taking on extra staff and expanding the department into a more spacious part of the hospital. The department vision was created by the clinical service manager and had support from the executive director.

Staff told us there was an increasing focus on strengthening an integrated approach with other departments and other BMI hospitals. We were told that the aim of the strategy for the hospital was bringing together risk management, clinical governance and quality improvement and ensuring learning took place on a wide level. The objectives of the strategy were to promote an honest and open culture which was blame-free and where risks could be identified, addressed and escalated appropriately.

### Culture

**Managers across the department looked to promote a positive culture that supported and valued staff.**

Staff told us they enjoyed working at the hospital and felt a community spirit amongst one another. Staff said they mixed with other members of staff from different departments and most people working within the

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hospital knew each other on first name basis. Staff told us the culture encouraged honesty at all levels, which made staff feel more comfortable to report incidents and speak up where they felt improvements could be made.

Staff we spoke with told us they could see themselves working within the department for many years. They cited reasons such as friendliness, good senior support, developmental opportunities and a genuine ethos of caring for one another.

Staff were given a 'happy mug' in recognition of any 'above and beyond' duties they had carried out. This was a mug full of sweets which was situated within the department as recognition of any hard work which had been undertaken. Staff told us they enjoyed working towards winning the 'mug of sweets'.

## Governance

### **The service used a systematic approach to improve the quality of its services.**

There was an embedded structure of clinical governance. Hospital sub-committees fed into the clinical governance committee which then fed into the MAC. Outcomes from clinical governance meetings were shared to the outpatient department. The outpatient's department held a meeting every eight weeks which included a structured agenda and meeting minutes. We reviewed outpatient meeting minutes which demonstrated a good discussions around risk management, complaint and compliments and specific learning outcomes.

We also noted the meetings had a good attendance, apart from during the summer when some staff had taken annual leave. Meeting minutes were cascaded through email so anybody not in attendance could stay updated.

Staff undertook internal audits which assisted in driving improvements and gave staff ownership of things which required improvement. For example, one member of staff was allocated the task of ensuring costs of blood results were clearly displayed in the phlebotomy room. Team meeting minutes showed there had been discussion of audit results with staff.

The clinical service manager also attended a daily morning briefing with other heads of department within the hospital, the director of clinical service and the executive director. This brief meeting provided an opportunity to highlight any areas of concern such as

staffing levels, patient activity and any other needs of a department. During our inspection, we attended one morning huddle to observe a healthy level of discussion between all attendees.

Monthly meetings were held with heads of departments, health and safety, IPC, water safety and fire. The senior management team also met monthly where a set agenda was covered. For the other weeks in the same month a mini-meeting was held. The MAC was bi-monthly. The ED was expecting to appoint a new chair in due course, with an expectation they took a lead role and participated in dealing with any poor behaviours related to consultants.

## Managing risks, issues and performance

### **The service had good systems to identify risks, plan to eliminate or reduce them, and cope with both the expected and unexpected.**

The outpatient's department had its own risk register which was regularly reviewed. The top risk related to equipment replacement and its subsequent cost. Staff told us they regularly assessed equipment to ensure it was performing as expected and there was a rolling 'equipment replacement' log which showed when equipment needed replacing or new parts installing.

The risk register was scored out of low, medium or high impact and assigned to an 'owner' who took charge in resolving or reducing the risk.

## Managing information

### **The service collected, analysed, managed, and used information well to support all its activities, using secure electronic systems with security safeguards.**

The hospital had a dedicated Information Security Officer (ISO), who conducted audits which were reported locally and corporately. Staff were trained and confident their practices conformed to the required standards of General Data Protection Regulation and training had been updated accordingly.

Staff told us they did not use fax machines to send or receive information within the department. This limited the risk of information being sent to the wrong person.

## Engagement

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## **The department engaged with staff, patients and relatives and used their feedback to plan and develop services.**

Friends and family leaflets were available in the reception area and also handed to every new patient attending an outpatient appointment. Questions included, how can services be improved, how likely they are to recommend the hospital as well as demographic information.

The hospital collected patient feedback on their experience via an external company. Information was fed back to each hospital on a dashboard. The top five most improved scores for the period September 2018 to September 2019 month were summarised. This included for example; the quality of information provided during pre-assessment call, which had gone up from 35.4% to 85.2%. The bottom five scores were also summarised for the same period. We saw for example the following had gone down; quality of information about who to contact

if worried, which went down from 79.2% to 67.6%. Overall the information reported that 98.5% of people who completed a feedback form, either on-line or on paper (130) would recommend the hospital.





Staff were also invited to complete a staff survey annually. At the time of inspection, staff were awaiting results from these.

## **Learning, continuous improvement and innovation**

### **The service learnt by promoting improvement and innovation.**

The ED told us they had a drive to improve the outpatient's area, including increasing the number of consulting rooms. Patient activity was an area of focus to determine what capacity might be required, we were told that conversations with consultants about this would be starting shortly.

# Diagnostic imaging

Safe	Good 
Effective	
Caring	Good 
Responsive	Good 
Well-led	Good 

## Are diagnostic imaging services safe?

Good 

We rated safe as **good**.

### Mandatory training

**The service provided mandatory training in key skills to all staff and made sure everyone completed it.**

Staff mandatory training ran from November to October allowing staff 12 months for completion. At the time of our inspection all but one member of staff had completed the required training. The member of staff was part way through training and at the time was at 87.5% compliance.

Staff we spoke with confirmed they were up to date with their mandatory training and were positive about the content and the quality of the training they received.

We saw evidence that staff working with radiation had appropriate training and signed the local rules as competent to administer radiation which met with the Ionising Radiation (Medical Exposure) Regulations (IR(ME)R).

The mandatory training covered topics to provide staff with key skills appropriate for their role. The training included fire safety, chaperone training, information governance, consent and life support. Staff reported they received training to recognise and respond to patients with learning disability needs, dementia needs, mental health needs and autism needs.

Staff used an electronic system to keep track of their training record and to access the modules required for e-learning. Whilst staff took responsibility of their own training, they also received an update a month prior to when a course was due for completion.

### Safeguarding

**Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse, however not all staff knew how to apply it.**

The lead for adult safeguarding was the director of clinical services, with the quality and risk manager holding a safeguarding adult's champion role. The head of the diagnostic department had been trained to level 3 safeguarding, radiographers and other staff in the department were trained to level 2. The clinical director was attending level 4 training in the week following our inspection.

Staff received training on PREVENT. PREVENT aims to safeguard vulnerable people from being radicalised to support terrorism or becoming terrorists themselves.

Staff we spoke reported they had not made a safeguarding referral, although they knew the process to follow should they need to, this included who to inform if they had concerns. Staff told us they could contact the hospital safeguarding lead for advice if required.

However, staff were only aware of some types of issues that may need to be reported as a safeguarding concern or alert. This included physical abuse and information in relation to female genital mutilation (FGM). We were not assured staff would report concerns in relation to human trafficking or subtle signs of abuse.

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Staff we spoke with were aware of the Department of Health female genital mutilation and safeguarding guidance for professionals' March 2016.

Displayed in staff areas, was a safeguarding risk assessment, to direct staff on the appropriate cause of action following a safeguarding incident. Guidance was also available for all staff on relevant information and contact numbers. Staff we spoke with were aware of this guidance.

Staff undertook children's safeguarding training even though the service was no longer delivering children and young people's services. Training compliance rates were as follows - non-clinical level 1 96% compliance. Clinical staff level 2 96% compliance. Level 3 compliance is 100%

Staff reported when children attended the service with a patient they were under the responsibility of another parent or carer.

We were told by the director of clinical services that the consultants undertook their safeguarding training at the substantive NHS hospital and were expected to provide evidence of this training. We saw the evidence provided within our review of the consultant's practicing privileges folders.

The director of clinical services told us they engaged with Croydon safeguarding team and a three-monthly safeguarding audit was carried out. At the time of our inspection there were no safeguarding events under investigation and no open investigations.

We did not see any information regarding safeguarding from abuse displayed where service users could see it.

### Cleanliness, infection control and hygiene

**The service controlled infection risk well. Staff used equipment and control measures to protect patients, themselves and others from infection. They kept equipment and the premises visibly clean.**

The hospital had a member of staff who held the infection prevention and control lead (IPC). They had undertaken a train the trainer course to enable them to deliver training to staff, including the induction of the resident medical officer (RMO). The IPC lead monitored compliance with standards, environmental and post-surgical surveillance and screening. Care bundles

were used for such practices as cannulation and checks of these post insertion. A report was also prepared and presented for the Director of infection prevention and control (DIPC).

Mandatory training was provided to staff one day per month, during which topics such as hand hygiene, aseptic non-touch technique, surveillance and sepsis screening were covered. Competency assessments were expected to be signed off for some skills, including correct hand washing technique.

All areas we inspected were visibly clean and clear of clutter. We observed staff cleaning equipment between use and items not in use were labelled with 'I am clean' stickers.

Quarterly IPC meetings were held with participation from a microbiologist and medical advisor. There was a service level agreement for the provision of microbiology between the hospital and a local NHS trust.

The hospital had an audit programme for monitoring matters related to IPC. The IPC lead provided a report on audit results included hand hygiene and bacteraemia's to the corporate IPC lead. They in turn provided reports to the IPC lead at Shirley Oaks. These provided an overview of surveillance by hospital.

Cleaning audits were managed in conjunction with the housekeeping supervisor. Matters of concern were addressed immediately by housekeeping staff, who were part of the hospital workforce. The hospital used national colour coded equipment for cleaning the different areas of the hospital.

Policies and procedures for IPC were corporate in structure. These were accessible electronically. Any local policies or procedures were updated by the IPC lead in conjunction with the quality and risk manager. For example, the cleaning of electric fans had recently been updated.

The service used a three-step high level disinfection process for cleaning ultrasound probes both before and after an intimate examination. We reviewed the cleaning log and wipe stickers on equipment and found it to be fully completed.

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The IPC lead spoke about the recent PLACE audit, which had been positive. They told us of improvements made, including the attachment of bumper strips to corridor walls, the removal of carpets.

Staff followed infection control principles including the use of personal protective equipment such as gloves and aprons which were available around the clinic areas for staff to wear during care and treatment. We observed staff adhering to 'bare below the elbow' guidelines, and guidance posters were displayed for staff for what was considered 'bare below the elbow'.

Staff followed the hospital's hand hygiene policy. We saw a poster displayed in the radiology department informing staff and patients the service was 100 percent department compliant in hand hygiene results. Hand washing sinks were available in the departments and there were instructions for washing hands by the sinks.

There was hand sanitizer available throughout the diagnostic departments and posters advising visitors to use hand gel were displayed. We observed staff using sanitizing hand gels before providing patient care.

We saw staff used and updated weekly cleaning schedules and checklists to ensure tasks for cleaning the environment and equipment were completed in line with recommendations. We saw completion of checklists from 1 July 19 to 4 November 19. Arrangements were in place for the appropriate handling, storage and disposal of clinical waste, including sharps.

## Environment and equipment

**The design, maintenance and use of facilities, premises and equipment kept people safe. Staff were trained to use them. Staff managed clinical waste well.**

The service was located across two floors of the main hospital building. The magnetic resonance imaging (MRI) facility was located on the ground floor, whilst all other diagnostic imaging services were on the first floor.

The department had a range of equipment which included one MRI machine, one computerised tomography (CT) machine, one mammography machine, two computed radiography (CR) x-ray, and two

ultrasound machines. For each item of equipment there was a folder of information kept in the managers office to support staff in the event of a fault. This folder also included fault records.

The service undertook quality assurance of their equipment weekly. They rotated coils used in the MRI.

In the MRI department, we saw there was enough space around the scanner for staff to move and for scans to be carried out safely. During scanning all patients had access to an emergency call buzzer, ear plugs and defenders. A microphone allowed contact between the radiographer and the patient. Music could be played for patients.

The service had a radiation protection supervisor (RPS) who was a senior radiographer.

The necessary tests had been conducted on equipment to ensure it was safe for use before it had been used in the department. Records of regular service maintenance of all equipment were completed. We reviewed five pieces of equipment, all were maintained and up to date with service tests, one required a new sticker to demonstrate an up to date service test. This was completed whilst we were on site.

Risk assessments were completed for all new or modified use of radiation. We saw that this considered the risks for both staff and patients in the environment.

All relevant MRI equipment was labelled in line with Medicines and Healthcare products Regulatory Agency (MHRA) recommendations. The service had equipment which was marked as MRI safe including a trolley and a wheelchair which could safely be used to quickly evacuate patients safely from the MRI in the case of an emergency.

Rooms where ionising radiation exposures occurred were clearly signposted with warning lights. We saw these in use during the inspection.

The service has specialised personal protective equipment available for staff and carers. Staff wore lead aprons and neck collars to protect themselves from the risk of radiation exposure. The aprons were tested annually to ensure their effectiveness. We saw that these were in good condition. Staff were issued with dose



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monitoring badges by BMI. The doses were reviewed quarterly by an external company. There had been no incidents relating to dose monitoring badges within the last year.

MRI intravenous giving sets were single use and CE marked (this demonstrated legal conformity to European standards).

Scales were used to weigh patients. We saw they had been appropriately tested and there were sufficient number of scales available should one fail for any reason.

The service used an external company for their PACs system. PACs is a picture archive and communications system used to store diagnostic images. The external company provided 24 hours support to the service.

We checked the services resuscitation trolley during the inspection. The trolley and its contents appeared visibly clean. The trolley had all the items required and all items were in date. Weekly and daily checks were completed and signed off by staff.

Staff managed waste appropriately using a colour coded systems for separating general and clinical waste. All sharps disposal bins were labelled correctly and not overfilled.

Pull cords were available in areas where patients were left alone, such as toilets and changing areas. There was a button in the scanner that patients could press if they wanted to stop the scan for any reason.

The MRI magnet was fitted with emergency “off” switches, which stopped scanning and switched off power to the magnet sub-system, but would not quench the magnet. All staff we spoke with could fully explain the emergency nature of a quench situation.

Within the MRI department and on the scanner there were signs detailing the magnet strength and safety rules.

## Assessing and responding to patient risk

**Staff completed and updated risk assessments for each patient and removed or minimised risks. Staff identified and quickly acted upon patients at risk of deterioration.**

The senior radiographers were radiation protection supervisors (RPS) and provided radiation advice for staff as and when required.

Emergency resuscitation equipment was available in the department.

The service used a ‘pause and check’ process which met with Ionising Radiation (Medical Exposure) Regulations 2017 and the Society of Radiographer guidelines. Staff checked three points of the patient’s identification and the intended procedure against the referral with the patient. Posters were in place around the departments to remind staff of this process. We observed staff completed patient safety checks appropriately.

Pause and Check consisted of the three-point demographic checks to correctly identify the patient. There was a check with the patient the site/side to be imaged, the existence of previous imaging and for the operator to ensure the correct imaging modality was used.

We saw the Society of Radiographers (SoR) poster within the unit reminding staff to carry out these checks.

Staff we spoke with explained the processes to escalate unexpected or significant findings both at the examination and upon reporting. These were in line with diagnostic imaging with the services routine MRI guidance policy. For example, urgent scan findings and/or neurological condition when the patient needs urgent report. We were told about and shown the pathway for unexpected urgent clinical findings. In the case of NHS patients, an urgent report request was sent to the reporting provider. If a patient was a private patient, the reporting radiologist was contacted by a member of staff to advise them that an urgent report was required. This ensured the report received prompt attention.

Staff asked female patients under the age of 60 if they were or could be pregnant and the date of their last menstrual period which was documented on referral forms. Patients were requested to sign to confirm they had been asked. This was in line with the Ionising Radiation (Medical Exposure) Regulations 2017. We observed poster reminders for female patients to inform a member of staff if they were pregnant. The posters were displayed in the waiting area, changing rooms and on doors of treatment rooms which provided patients with information about pregnancy and diagnostic imaging.

# Diagnostic imaging

There were clear pathways and processes for staff with regards people using the service who became unexpectedly unwell or if an unexpected result was found during the scan or x-ray.

We reviewed the procedure for removal of a collapsed patient and found them to be sufficient. We reviewed evidence of the evacuation practices which the service held twice yearly. Staff we spoke with told us they had not had to respond to any real emergency situation.

The service ensured that the requesting of an MRI was only made by staff in accordance with Ionising Radiation (Medical Exposure) Regulations (IR(ME)R) guidance. All referrals were made on a dedicated MRI referral form.

All referral forms included patient identification, contact details, clinical history and examination requested, and details of the referring clinician/practitioner.

We reviewed the procedure for removal of a collapsed patient and found them to be sufficient.

## Radiographer staffing

**The service had enough medical staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment.**

The service used a purpose built 'staffing calculator', designed to take account of expected, and a degree of unexpected absences; ensuring sufficient staff availability across all operational periods. Required staffing levels were calculated using core service information including: operational hours, patient complexity and service specifications, physical layout and design of the facility/service, expected activities, training requirements, and administrative staffing requirements.

Radiologists were employed by other organisations (usually local NHS trusts) in substantive posts with practising privileges with The BMI Shirley Oaks Hospital. Radiographer could contact radiologist for advice during the working day.

We reviewed two files for radiologists with practising privileges. Both files contained the supporting evidence to grant practice at the hospital. For example, we saw self-declarations, evidence of registration with professional bodies, application and references,

certificates and a curriculum vitae. Where the individual was more recently appointed references were present. Both files also contained evidence of appraisal and/or re-validation.

The clinical services manager for imaging developed the staff rotas. Business continuity plans were used to guide the clinical service manager for imaging when responding to changing circumstances. For example, sickness, absenteeism and workforce changes. Agency staff were rarely used.

All staff we spoke with felt the staffing was managed appropriately.

## Records

**Staff kept detailed records of patients' care and treatment. Records were mostly clear, up-to-date, easily available to all staff providing care but not always stored securely.**

Following appointments, radiographers scanned patient paper records onto their secure electronic system. The paper records were filed in a lockable cabinet in the diagnostic administration office, which had coded pass on the door. The secretary checked each patient record was scanned onto the system before sending the notes to confidential waste.

Patients completed a MRI safety consent checklist form which recorded the patients' consent and answers to the safety screening questions. This was later scanned onto the electronic system and kept with the patients' electronic records.

Most computers were locked, and password protected when not in use. Computers were in rooms out of public areas to reduce the risk of confidential patient information being seen by other patients or visitors.

Patients personal data and information were kept secure and only staff had access to the information. Staff received training on information governance and records management as part of their mandatory training programme.

We reviewed three patient care records during this inspection and saw records were accurate, complete, legible and up to date.

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We saw the Radiology Information System (RIS) and Picture Archiving and Communication System (PACS) was secure and password protected. Each staff member had their own personally identifiable password.

Reporting of scans was in the majority of circumstances completed within two days of the scan. Reports were sent to the patient's referrer. The service audited reporting times and reported finding and learning at their monthly departmental meetings.

## Medicines

### **The service used systems and processes to safely prescribe, administer, record and store medicines.**

Medicines, including intravenous fluids, were stored securely. No controlled drugs were stored and/or administered as part of the services provided in this unit. Medicines requiring storage within a designated room were stored correctly, in line with the manufacturers' recommendations, to ensure they would be fit for use.

Staff were trained on the safe administration of contrast medium including intravenous contrast. We reviewed staff competency files and saw all staff had received this training.

Patients were given an information leaflet post scan which documented which medications they had been given. This included contrast media. The information directed patients to seek advice from their GP or accident and emergency department (A&E) if feeling unwell after leaving the service.

Emergency medicines were available in the event of an anaphylactic reaction.

Patient group directions (PGDs) were used for administration of contrast media. A PGD provides a legal framework that allows some registered health professionals to supply and/or administer specified medicines to a pre-defined group of patients, without them having to see a prescriber (such as a doctor or nurse prescriber).

An on-site pharmacist was available for assistance and advice locally if required.

## Incidents

### **The service managed patient safety incidents well. Staff recognised and reported incidents and near**

**misses. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support. Managers ensured that actions from patient safety alerts were implemented and monitored.**

Access rights were available to all staff to enable the reporting of incidents or near misses on the electronic database. Heads of department (HODS) had a higher level of access to the system and the senior management team (SMT) had overall access. We viewed the data base and saw this was a well-structured and organised system. The hospital had a 48 hour key performance indicator for posting incidents. We saw evidence provided by the service that they were meeting this KPI.

We reviewed incidents for the diagnostic imaging department and noted there was a high level of information completed, including learning from the matter. We noted the incident process was well defined and followed through to satisfactory resolution. Shared learning was clearly indicated, along with information related to the groups and staff this was communicated too.

There had been no notifiable safety incidents that met the requirements of the duty of candour regulation in the 12 months preceding this inspection. 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.

Staff we spoke with were able to describe Duty of Candour (DoC) and were aware of when to apply it. The service shared a culture of being open and honest and staff were encouraged to do the right thing.

Relevant national patient safety alerts were disseminated to staff at team meetings and by email.

We saw the Society of Radiographers (SoR) posters within the service reminding staff to carry out these checks. We also witnessed the staff using The Society of Radiographers (SoR) "Paused and Checked" system. Pause and Check consisted of the three-point

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demographic checks to correctly identify the patient, as well as checking with the patient the site/side to be imaged, the existence of previous imaging and for the operator to ensure the correct imaging modality is used.

## Are diagnostic imaging services effective?

We did not rate effective

### Evidence-based care and treatment

**The service provided care and treatment based on national guidance and evidence-based practice. Managers checked to make sure staff followed guidance. Staff protected the rights of patients subject to the Mental Health Act 1983.**

The service followed national guidance of the Society of Radiographers and The National Institute for Health and Care Excellence (NICE) guidelines to deliver evidenced based practice. NICE guidance was followed for diagnostic imaging pathways as part of specific clinical conditions. For example, NICE CG75 Metastatic spinal cord compression in adults.

Staff assessed patient's needs. Scans were planned and delivered in line with evidence-based, guidance, standards and best practice.

### Nutrition and hydration

**Staff gave patients enough food and drink to meet their needs.**

Patients received information to advise them about timescales for when they could eat and drink in advance of any invasive procedures. This was provided in the appointment letter. We observed reception staff informing patients of any preparation required before their procedure in relation to food and drink.

Water cooler machines were available in the waiting rooms for patients and those who accompanied them.

There was a café available for patients to use in the hospital.

### Pain relief

**Staff assessed and monitored patients regularly to see if they were in pain, and gave pain relief in a timely way.**

Staff within the diagnostic departments did not routinely monitor or administer any pain relief. However, we observed staff assessing patient comfort prior and during procedures.

Patients were informed in the pre-scan documentation to continue to use any pain relief medication they usually took.

### Patient outcomes

**Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for patients.**

The diagnostic imaging department conducted local audits such as infection control and World Health Organisation (WHO) checklist documentation. The service compared the audits with other departments and services. Audits we reviewed showed completed as per the audit calendar. Audits were discussed during the department monthly meetings. Audits reviewed for 2019 included MRI imaging quality, 96.6% good and 3.4% satisfactory for January 2019, 90% good and 10% satisfactory in February 2019 and 89.3% good and 10.7% satisfactory in March 2019. MRI reporting time audit results ranged from 1.53 days average to 1.93 days average length of time to report between March and July 2019.

The service completed a quarterly audit on the appropriate completion of records on female pregnancy and last menstrual period (LMP) to ensure the service on line with the Ionising Radiation (Medical Exposure) Regulations (IR(ME)R).

To comply with guidelines the service completed audits on the dosage of radiation which demonstrated the correct dosage was being used and was in normal range.

The service recorded the times taken between referral to them for a scan and a scan being booked. They also recorded the time from the scan to when the scan was reported on.

### Competent staff

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## **The service made sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and development.**

Staff had the right skills and training to undertake the scans and x-rays. This was closely monitored by the registered manager. Skills were assessed as part of the recruitment process, at induction, through probation, and then ongoing as part of staff performance management and appraisal and personal development processes.

All radiographers were Health and Care Professions Council (HCPC) registered and met standards to ensure delivery of safe and effective services to patients. We checked registration for a random selection of staff on the HCPC website and found them all to be registered appropriately.

Local induction for all staff ensured their competency to perform their required role within their specified local area. We reviewed subject areas covered within the inductions.

Staff had the opportunity to attend relevant courses to enhance their professional development and this was supported by the organisation and managers.

Staff had regular meetings with their manager and a performance appraisal undertaken biannually to review objectives and set goals. We reviewed records and found all staff had received their appraisal in the last year.

## **Multidisciplinary working**

### **Doctors, nurses and other healthcare professionals worked together as a team to benefit patients. They supported each other to provide good care.**

There was a daily multidisciplinary communications meeting attended by staff from all departments in the hospital. Information was shared and then disseminated across the services.

We saw effective team working between all staff groups. Staff across disciplines prioritised the patient experience and communicated well to meet their needs.

Patients could see all the health professionals involved in their care at one-stop clinics. For example, the service operated a one-stop breast clinic where patients were

able to see a breast radiology specialist or the breast surgeon, patients had a mammography or ultrasound scan as well as see the consultant for a biopsy at the same appointment.

Radiologists were accessible and there was a good working relationship with staff across the hospital. Staff told us they could contact them at any time for support and guidance despite no formal on call arrangement.

During our inspection we saw reception staff communicating appropriately, when required, with radiographers for advice and guidance when booking patient appointments.

Information was shared between radiologists and referring consultants in a direct and timely manner.

The service had good relationships with other external partners and undertook scans for local NHS providers and a clinical commissioning group (CCG). We saw good communication between services and there were opportunities for staff to contact refers for advice and support

## **Seven-day services**

### **Services were available six days a week to support timely patient care.**

The services were open Monday to Friday 8am to 7pm and Saturday 8am to 1pm.

The service had taken into consideration the requirement for having a range of appointments times available to patients and therefore appointments were scheduled to ensure patients could attend at a time which was convenient to them.

## **Health promotion**

### **Staff gave patients practical support and advice to lead healthier lives.**

Information leaflets were provided for patients on what the scan would entail and what was expected of them.

However, there was limited information displayed in the waiting area on general health and health promotion. There were some leaflets available to advise patients about health issues including breast care.

## **Consent and Mental Capacity Act**

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**Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients' consent. They knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health.**

Staff we spoke with had an understanding of the relevant consent and decision-making requirements of legislation and guidance, including the Mental Capacity Act (MCA). Staff were aware of how and when to assess whether a patient had the capacity to make decisions about their care.

Training on the Mental Capacity Act (MCA) formed part of staff mandatory training.

A consent policy written in line with national guidance was available to all staff. We reviewed three patient care records and saw all patient records included consent for treatment recorded. We observed staff obtaining verbal consent from patients during their treatment.

During the inspection there were no patients who lacked capacity to make decisions in relation to consenting to treatment. Where a patient lacked the mental capacity to give consent, guidance was available to staff through the consent policy. In addition to this, staff told us they would encourage a patient to be accompanied by a family member, carer or representative for support.

## Are diagnostic imaging services caring?

Good 

We rated caring as good.

### Compassionate care

**Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.**

We saw staff treated patients in a respectful and caring manner. Staff spoke about the personal, cultural, social and religious needs of patients in a non-judgmental way. Staff introduced themselves to patients in a welcoming manner and explained their role. We observed staff took the time to treat patients with kindness and compassion.

Staff introduced themselves prior to the start of a patient's treatment, interacted well and included patients during general conversation.

The reception desk was situated close to the waiting area, however, staff spoke with patients in a way they could not be overheard.

The service conducted a patient satisfaction survey to collect patient feedback of the service. Results collated from October 19 included comments such as, "Very kind staff" and particular staff names were mentioned with the comment "Are stars".

Patients we spoke with reported staff treated them well and with kindness. Patients and their relatives were all positive about the care and treatment provided in the department.

A chaperone policy was in place enabling all patients the option of a chaperone. Staff informed patients that chaperones were available, and posters were displayed in the departments informing patients they could request a chaperone.

Changing areas with curtains were available for patients to change before their procedure. We saw staff were respectful of patients as they brought them from changing areas into treatment rooms. However, the changing areas were in the main waiting area, allowing other people waiting to see as patients were brought into the treatment rooms.

Staff ensured that patients' privacy and dignity was maintained during their time in the MRI scanner.

Staff talked to patients who were anxious and discussed the process thoroughly. The service performed scans feet first into the scanner whenever possible for patients who were claustrophobic.

### Emotional support

**Staff provided emotional support to patients, families and carers to minimise their distress. They understood patients' personal, cultural and religious needs.**

Staff provided both patients and those close to them with emotional support and advice when they needed it. We

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observed staff welcoming patients prior to appointments in a reassuring and friendly way. They supported patients through procedures and kept them well informed throughout, whilst providing consistent reassurance.

Staff adapted their approach to provide further reassurance for patients who appeared nervous or anxious about their procedure. Staff provided information and timescales to help patients feel informed and comfortable. For example, we observed a receptionist explain the procedure and timescale to a patient several times. The member of staff remained patient and appeared happy to keep reiterating until the patient understood their treatment plan. The patient was extremely grateful and continued to thank the member of staff as they left the department.

The department had a calm and quiet atmosphere throughout our inspection and patients did not experience long waits for their procedures.

Staff supported patients who became distressed in an open environment and helped them maintain their privacy and dignity. Staff informed us they could use the manager's office to provide further privacy and dignity for patients and relatives if required.

Staff understood the emotional and social impact that a person's care, treatment or condition had on their wellbeing and on those close to them. We observed radiographers in the MRI department provide emotional support to patients through the intercom system during their MRI scans. Staff spoke with patients in a calming way and supported them through their procedure. Staff told us they would stop scanning immediately if requested. They would discuss with the patient how they would wish to proceed and would arrange for the patient to come back another day to complete the scan if the patient felt unable to carry on.

The service allowed family members or carers to accompany patients that required support into the scanning area.

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

**Staff supported and involved patients, families and carers to understand their condition and make decisions about their care and treatment.**

Staff talked with patients, families and carers in a way they could understand. Prior to their scan, we observed staff taking the time to discuss any concerns or answer any questions patients had. This ensured patients received clear information about their procedure.

Patients were fully briefed on the fees associated with their treatment prior to the treatment commencing. Patients we spoke with told us that fees had been discussed and agreed with them.

Patients and their families could give feedback on the service and their treatment and staff supported them to do this. Around the department feedback forms were available for patients to complete. In the MRI facility, staff provided patients with the feedback form and requested they returned the completed form before leaving the facility. This ensured all MRI patients shared their MRI experience.

Carers and relatives could stay with patients when they were having a MRI scan, to support them through the procedure. If Carers and relatives were to accompany a patient into the scanning room they were required to complete the safety questionnaire prior to the scan. We saw a relative of a patient sitting next to the scanner whilst the patient was having their scan providing reassurance for the patient.

Staff made sure patients and those close to them understood their care and treatment. Staff consistently explained procedures clearly to patients, and in a way they understood. They checked with patients if they had any questions, and confirmed they were happy with the information provided. We heard the reception staff inform a patient they would have the opportunity to ask any further questions with the radiographer.

We reviewed 10 patient satisfaction questionnaires completed by patients using the service and found them to be positive and complementary about the service and the staff.

### **Are diagnostic imaging services responsive?**

Good 

We rated responsive as good.

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## Service delivery to meet the needs of local people

**The service planned and provided care in a way that met the needs of local people and the communities served. It also worked with others in the wider system and local organisations to plan care.**

The facilities and premises met the needs of patients and those accompanying them and ensured a patient-centred environment. This included enough comfortable seating in the reception and waiting areas, a range of magazines, toilet facilities with disabled access and water coolers. The service did not provide any children's toys or areas for those who accompanied patients. However, the service no longer delivered children and young people's services.

The department planned services around the needs of patients with a choice of appointments available between 8am and 7pm Monday to Friday, with all services apart from MRI available on Saturday 8am to 1pm.

Outside of working hours radiographers provided an on-call service for urgent imaging required by the in-hospital patients. Three members of staff shared the rota to cover the on-call hours. Staff informed us 10 calls were made in the previous 12 months.

Staff ensured that patients who did not attend appointments were contacted. A new appointment time and date would be made. Managers reported a procedure was in place for patients who did not attend three times for them to be referred back to their referrer. However, this had never happened.

The hospital and department were clearly signposted and there was free car parking available on site close to the department. The facilities and premises were appropriate for the services being delivered. The MRI facility was located on the ground floor, whilst the other diagnostic imaging facilities were on the first floor, the service met the needs of the local people.

Information was provided to patients prior to their appointments. This included relevant information about the procedure, any fasting or samples required, a map with directions and a contact number. The information was only available in standard format and not in any other language or large print.

## Meeting people's individual needs

**The service was inclusive and mostly took account of patients' individual needs and preferences. Staff made reasonable adjustments to help patients access services.**

Appointment times allowed enough time for patients to ask questions and take their time prior to and after procedures. Staff went through information, provided reassurance and allowed flexibility to meet the needs of patients ensuring their appointment was not rushed.

When appropriate staff encouraged carers and/or relatives to attend appointments with patients. Staff we spoke with understood the importance of supporting people with additional needs such as living with dementia, a learning disability, mental health or autism, however they could not describe any adjustments they may make where appropriate.

Wheelchair access was available throughout the hospital. All areas across the department were large enough to accommodate wheelchairs and patients with mobility issues. Lift access was available for facilities located on the first floor of the building. An MRI safe trolley or wheelchair was available to assist patients with mobility issues enter the MRI scanning room. The MRI scanner was wide bore and equipment adaptable to accommodate the needs of bariatric patients.

Noticeboards in waiting areas were up to date and had a range of information about the processes conducted in the department and reassuring advice. For example, the service displayed information on the risk of an x-ray compared to "other" risks. The information was in an illustration format accessible to people using the service.

Interpreting services were available where English was not the patient's first language. Staff reported they offered interpreting services, whilst respecting patient wishes where a family member wished to interpret for them. We saw evidence that the interpretation service had been used 71 times during the previous year up to August 2019 across the whole hospital.

A poster displayed in the waiting area, asked if patients could be pregnant, and requested they inform a member of staff if they were. The text was written in 20 different languages. However, there was no other information such as leaflets, available in other languages other accessible formats.



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During MRI scans, staff aimed to make patients as comfortable as possible with padding aids, ear plugs and ear defenders to reduce noise. They ensured the patient was in control throughout the scan and gave them an emergency call buzzer to allow them to communicate with staff should they wish. Microphones were built into the scanner to enable two-way conversation.

Patients were advised should they wish to stop their examination, staff would assist them and discuss choices for further imaging or different techniques and coping mechanisms to complete the procedure. Explanations were given post examination on any aftercare of cannulation sites, hydration needs and how and where to get results of the scan.

The service provided imaging for outpatients and inpatients for the hospital and welcomed service users with any level of mobility. Lifts were available if required.

## Access and flow

### People could access the service when they needed it and received the right care promptly.

The service ensured people has timely access to initial assessment, test results and diagnostic treatment. For example, the service met the six-week diagnostic test national standard.

A bookings and administration team managed patient appointments. There was flexibility with dates and times so people could access the service at a time to suit them.

Following a consultation, patients could book appointments straight away. Although there was no local key performance indicator set, the majority of diagnostic tests were reported on, and patients received their results within 48 hours. Reports were sent to the referring clinician.

The number of appointments unattended was very low and staff informed us patients usually rang up the same day to reschedule if they missed their appointment.

During the inspection we saw patients that were able to be booked for their scan on the same day as they presented their referral requesting an appointment.

## Learning from complaints and concerns

**It was easy for people to give feedback and raise concerns about care received. The service treated**

**concerns and complaints seriously, investigated them and shared lessons learned with all staff. The service included patients in the investigation of their complaint.**

Patient feedback forms were available for patients to share their experiences. However, there were no leaflets to inform patients of the complaints process, how to make a formal complaint or what steps to take if complainants were dissatisfied with the outcome.

Complaints were captured on the electronic data base, lower and higher-level complaints. Duty of candour was always applied.

We were able to view the end to end process for managing complaints on the electronic system, selecting complaints related to diagnostics. The database was clear and informative, with details of the date the complaint was raised, the department the complaint related to, a summary of the complaint and who the designated investigator was. Information was recorded for each step of the investigation and attachments were added, for example, notes, letters written to the individual.

Staff were clear of the protocol to follow if there were concerns raised. There was an up to date policy which outlined the process and responsibilities. Staff told us they would try to resolve this at a local level where possible but would also inform the patient of the formal complaints process.

Learning from complaints was communicated to staff through the staff meeting.

## Are diagnostic imaging services well-led?

Good 

We rated well led as good.

## Leadership

**Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff. They supported staff to develop their skills and take on more senior roles.**

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The executive director (ED) had been in post for a relatively short time but had held a similar position at another hospital within the BMI group. There had been a comprehensive handover period with the previous ED. Their initial reflections on the hospital was that the staff made up a great team and were 'friendly and welcoming to them.' The senior management team (SMT) were viewed as strong and the heads of department (HODs) were described as being 'very engaged.' All staff wanted to do the best for the patients.

The ED had quickly understood the worry areas and was working to address them quickly.

The department manager was visible and approachable. They worked alongside other staff within the department and was clearly proud of their team and the service they provided for patients.

Staff we spoke with found the department and hospital management to be approachable, supportive, and effective in their roles. They all spoke positively about the management of the service.

## Vision and strategy

**The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. Leaders and staff understood and knew how to apply them and monitor progress.**

We were provided with the hospitals statement of purpose, which set out the services objectives in relation to the population it served. A set of care values defined what the service would deliver to its users and how staff were expected to work with patients and others:

- Communication and working together.
- Aspiring and improving.
- Respectful and caring.
- Efficient and safe.

The mission statement of the hospital was: To strive to continuously improve the health of our local community by providing accessible, compassionate, quality healthcare.

A five year vision for the period 2015-2020 had set out eight strategic objectives and key priorities. These related to people, patients, communications, growth, governance, efficiency, facilities and information. We asked if there were any plans to refresh or update the vision as the service was going towards the new year and were told this had not been discussed.

The hospital had one business plan covering the period up to 31 March 2020. We asked the ED if there was a plan to develop a new plan. We were told a new business plan was in development and this would be discussed with the HODs in the near future.

In terms of business functioning the ED had submitted business as usual requests for capital expenditure. This included work needed to improve areas of the building.

We asked about the arrangements for marketing of services and were told there fulltime marketing manager and a full time GP liaison shared between two BMI hospitals and a part time self-pay lead based at Shirley Oaks.

The director of clinical services (DoCS) explained that the strategy was generic in structure and linked into all the services and what staff did. The strategy also reflected the domains of CQC and the fundamental standards.

The diagnostic imaging department had a strategy and set of values displayed on a notice board in the staffing area. Most staff we spoke with were aware of the departmental strategy and values, however they informed us they had not been included in the input of them.

The diagnostic and imaging strategy was in place until 2020. Managers informed us of the completed improvements within the strategy and actions which still required completion.

All staff were introduced to the core values at their induction and when we spoke with them about the values during the inspection they were familiar with them. The appraisal process for staff was aligned to these values and all personal objectives discussed at appraisal were linked to the company's values.

We found the staff to be invested in and committed to this vision. They understood the part they played in achieving the aims of the service and how their actions impacted on achieving the vision.

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## Culture

**Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service promoted equality and diversity in daily work, and provided opportunities for career development. The service had an open culture where patients, their families and staff could raise concerns without fear.**

The ED felt there was a very positive culture amongst staff. We asked what improvements or changes had been made for staff since the last inspection. A newsletter had just been introduced by the ED, entitled 'Shirley Pulse'. The hospital had signed up to an external website which provided items for staff to try and give feedback on. Although there was no staff forum the hospital had recently started a social committee, with the first quiz night having taken place at the end of October. A choir had recently been established too. A 'happy mug' filled with sweets was awarded to an individual staff member in recognition of going above and beyond. They kept this for the week and then it was passed on.

Staff we spoke with were positive about their team and the support they received from both team members and managers. The diagnostic team shared a patient centred culture and worked positively together to achieve this.

Across all levels staff reported they could work autonomously and felt comfortable to suggest changes to improve the service for patients. Staff we spoke with told us the leaders were visible and approachable at all times and they felt they could approach them and were listened to.

The MRI service was located on the floor below the other diagnostic imaging facilities. However, staff across all services reported they felt included and part of the team. Staff worked across the two locations to support when required. For example, staff in the radiology department worked in the MRI service when additional staffing was needed. Across diagnostic services, staff spoke of attending team building days where all diagnostic imaging staff were included.

We found the staff demonstrated pride and positivity in their work and the service they delivered to patients. Staff were happy with the amount of time they had to support patients and described a positive team work approach.

Formal team meetings were held monthly and minutes were taken at these meetings. We saw the minutes from the last three meetings which included; updates rotas, health and safety management/incident reporting, infection prevention and control and training.

Staff told us there were good opportunities for continuing professional development (CPD) and personal development in the organisation. They also stated they were supported to pursue development opportunities which were relevant to the service.

Equality and diversity were promoted within the service. Inclusive, non-discriminatory practices were promoted. A whistle blowing policy, duty of candour policy and the appointment of a freedom to speak up guardian (FTSUG) supported staff to be open and honest. Staff could describe to us the principles of duty of candour.

The FTSUG took up this role in June this year, in addition to their role as infection prevention and control lead. (Has been a member of staff for more than 30 years) They advised us there was no designated time for the FTSUG role, but that there was flexibility, which enabled them to be accessible to staff. If additional time was required for a specific matter, they could agree this with their manager. Has had six direct contacts as part of the role, each very different so no themes or trends identified.

There was a provider FTSUG, who was accessible to the post holder at the hospital, and regular meetings were held with other role holders in the BMI group. Cover was arranged with a neighbouring hospital for times of leave or absence.

The FTSUG maintained records of discussion, ensuring the individual was made aware of this and that such information could not be accessed by any other person.

## Governance

**Leaders operated effective governance processes, throughout the service and with partner organisations. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.**

The hospital had governance meetings. Monthly meetings were held with heads of department, health and safety, infection prevention and control, water safety

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and fire. The senior management team also met monthly where a set agenda was covered, outside of this main meeting smaller update meetings were held. The medical advisory committee (MAC) met bi-monthly. The ED was expecting to appoint a new chair to the MAC in due course, with an expectation they took a lead role and participated in dealing with poor behaviours related to consultants.

There was an effective corporate and local governance framework which oversaw service delivery and quality of care. Staff were supported in incident reporting, complaint handling and developing local policies and protocols as well as implementing corporate policies and procedures. All disciplines were professionally accountable for the service and care that was delivered within the service.

The service had local governance processes, which were achieved through team meetings and local analysis of performance, discussion of local incident, where this was applicable. This fed into processes at a corporate level. We saw minutes and meeting notes during our inspection.

Staff were clear about their roles, what was expected of them and for what and to whom they were accountable.

## Managing risks, issues and performance

**Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events. Staff contributed to decision-making to help avoid financial pressures compromising the quality of care.**

We spoke with the quality and risk manager who advised us that there were service level risk registers, which fed into the hospital one. The hospital risk register was reviewed yearly, and this was happening at the time of the inspection. We reviewed the hospital risk register and noted risks were categorised using a traffic light colour system and a risk score was applied. The top four risks were rated as red, three related to facilities and estates and one to staffing. Risks scoring 20 or above were escalated to head office.

The director of clinical services met with the quality and risk manager on Fridays to review risks. A monthly report

was produced by the quality and risk manager and this was discussed at the clinical governance meeting. Monthly bulletins were circulated for high grade incidents, along with any shared learning.

## Managing information

**The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were integrated and secure. Data or notifications were consistently submitted to external organisations as required.**

The quality and risk manager had responsibility for information governance. They undertook audits in departments, produced reports and required actions. Required actions were added to a tracker and information was shared at the HODS committee. We saw an example of the audit carried out in the diagnostic imaging department in March 2019. This identified several improvements. A follow up audit carried out in August 2019 found the required improvements had been made.

There were sufficient computers in the department for the number of staff to be able to access the system when they needed to.

All staff we spoke with demonstrated they could locate and access relevant and key records very easily and this enabled them to carry out their day to day roles.

Information from scans could be reviewed in the department and remotely by radiologists to give timely advice and interpretation of results to determine appropriate patient care.

## Engagement

**Leaders and staff actively and openly engaged with patients, staff, equality groups, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients.**

The hospital collected patient feedback on their experience via an external company. Information was fed back to each hospital on a dashboard. We viewed the September results and saw there was a snapshot of the hospital in comparison to all BMI hospitals. The top five

## Diagnostic imaging

most improved scores for the period September 2018 to September 2019 month were summarised. This included for example; the quality of information provided during pre-assessment call, which had gone up from 35.4% to 85.2%. The bottom five scores were also summarised for the same period. We saw for example the following had gone down; quality of information about who to contact if worried, which went down from 79.2% to 67.6%. Overall the information reported that 98.5% of people who completed a feedback form, either on-line or on paper (130) would recommend the hospital.

We asked if there was a patient forum or similar and were told there was no such group. The hospital had a patient liaison officer and the ED was thinking about having a member of the SMT visit each patient on the ward as routine.

Locally, patient satisfaction cards were given to all those who had been scanned in the MRI unit to gain feedback on the service received. This feedback was overwhelmingly positive.

Staff who worked in the department were encouraged to voice their opinions and suggest improvements.

BMI provided an Employee Assistance Programme to offer staff support during times of crisis and ill-health.

### **Learning, continuous improvement and innovation**

**All staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them.**

Staff could provide examples of improvements and changes made to processes based on feedback, incidents and staff suggestion. Staff were alert to new ways of working.

# Outstanding practice and areas for improvement

## Outstanding practice

The hospital undertook unannounced scenario based emergency training, where staff were observed on their actions.

## Areas for improvement

### Action the provider SHOULD take to improve

- The provider should ensure that all patient consent are used for each procedure and are legible, dated and signed appropriately.
- The provider should record wait times for patients attending clinics and use the findings to improve the service.
- The provider should make sure they check interpreting services are confirmed and ready prior to the patient's treatment.
- The provider should make sure PROM data is captured more effectively and improvements are made in the return rate.
- The provider should make sure hand wash basins are fitted into all patient rooms, so staff can wash their hands.
- The provider should make sure consultants notes are clear and legible.