

BMI Three Shires Hospital Ltd.

Quality Report

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Date of inspection visit: 17, 18, 26 June and 13 July
2015
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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

Requires improvement



Are services safe?

Requires improvement



Are services effective?

Requires improvement



Are services caring?

Good



Are services responsive?

Good



Are services well-led?

Inadequate



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

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

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

Summary of findings

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

Summary of findings

Letter from the Chief Inspector of Hospitals

We carried out an announced inspection visit of BMI Three Shires Hospital LTD. on 17, 18 June and 13 July 2015 and an unannounced inspection on 27 June 2015.

The imaging department is operated by a separate provider via a joint venture agreement with BMI, therefore this department was not inspected as part of the outpatient core service.

We inspected the following four core services:

- Surgery
- Outpatients
- Services for Children and Young People
- Termination of pregnancy

Our key findings were as follows:

Are services safe at this hospital?

By safe, we mean that people are protected from abuse and avoidable harm.

- Staff were encouraged to report incidents and there was an incident reporting system in place that staff were aware of.
- Feedback from incidents was varied and we were not reassured that staff learnt from all reported incidents.
- Not all staff in the outpatients department were aware of the new Duty of Candour regulations.
- Out of hours, there was only the Resident Medical Officer (RMO) in the hospital at any one time who was an Advanced Life Support (ALS) provider.
- Despite procedures being in place to check the cleanliness of rooms in outpatients, we found equipment and some rooms and equipment that were not clean. Check lists were signed, but not specific to tasks undertaken.
- Although there were up to date records to demonstrate that a system was in place to maintain equipment in outpatients the system was not effective.
- We found some out of date medications and equipment in the outpatients department.
- Medications were stored safely and securely to prevent theft, damage or misuse, including Controlled Drugs.
- Services were generally clean and equipment was cleaned between patients; however we noted that in outpatients some areas did not appear to have been cleaned thoroughly.
- There were adequate hand-washing facilities and soap dispensers, hand hygiene foam and paper towels for staff and patients to use. 'However, we observed a number of staff not always washing or sanitising their hands when moving between theatre and recovery.'
- There were clear strategies for minimising the risk to adult patients. Staff demonstrated a good understanding of the assessed risks and how to avoid these. 'The hospital did not admit or treat patients who were anticipated as requiring critical care support and had an appropriate transfer policy in place with the local trust in the event that a patient became critically ill and needed to be transferred.'

Summary of findings

- The hospital had a screening system in place to ensure that patients were assessed pre-operatively to ensure their suitability for surgery and used an early warning system to alert them should a patient's condition deteriorate in the post-operative phase.
- Surgical procedures were carried out by a team of consultant surgeons and anaesthetists registered with the General Medical Council (GMC). The consultants were mainly employed by other organisations (usually in the NHS) in substantive posts and had practising privileges (the right to practice in a hospital) with BMI Three Shires Hospital.
- The Resident Medical Officer (RMO) provided out-of-hours medical cover 24 hours a day and as part of their practising privileges agreement, consultants were required to be contactable whilst they had patients under their care in the hospital. Staff said that consultants could be contacted out of hours.
- There was a system in place for planning and monitoring the number of staff and mix of staff needed to meet patients' needs in the wards and theatre.
- The records showed that there were no vacancies within the outpatient department or in patient wards. There was very little agency staff use in all departments.
- Staff were aware of their role and responsibilities with regards to safeguarding and the majority of staff were up to date with adult's safeguarding training. However, some staff, including the hospital leads for safeguarding, were unsure what level of training had been provided with regards to both adult and children's safeguarding when we spoke with them. The hospital subsequently confirmed that some staff were trained to level 2 or 3.
- Adult nurses, who did not have the appropriate level of safeguarding training, often looked after children.
- The hospital did not have a system to identify children or young person who may be at risk of abuse.
- Staff and managers told us they were up to date with their mandatory training. Overall compliance was 86% which was in line with the hospital's target of 85%.
- Patient records were up to date; risk assessments had been completed and documented for patients undergoing surgery, including the 5 Steps to Safer Surgery safety checklists.

Are services effective at this hospital?

By effective, we mean that people's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence.

- Surgical and outpatient care delivered was evidence based and in line with nationally agreed policies and practice.
- We saw assessments of people's needs were comprehensive and included the assessment of pain. However, this was not the case in children's services, where pain assessments were poorly completed.
- There was an audit programme in place, being undertaken in all services, except children and young people's services. There was recording and reporting of some patient outcomes.
- There was evidence of good multidisciplinary working across the hospital.
- Services could be provided over seven days to reflect demand.
- The role of the Medical Advisor Committee (MAC) included ensuring that consultants were skilled, competent and experienced to perform the treatments undertaken. These were reviewed annually.
- There was a process in place for checking General Medical Council and Nursing and Midwifery Council registration, as well as other professional registrations.
- There was a lack of formal supervision for nursing staff.

Summary of findings

- Most staff had yearly appraisals.
- Staff were confident about seeking consent from patients and staff had received training on the Mental Capacity Act 2005.
- Senior staff and those working within children's services were not aware of processes around Fraser Guidelines but did recognise the Gillick competency assessment.

Are services caring at this hospital?

By caring we mean that staff involve and treat patients with compassion, dignity and respect.

- Patients were treated with dignity and respect.
- We observed good interaction between patients and staff. Staff explained procedures and gave appropriate information to patients to help them to understand and be involved in decisions concerning their treatment. Initial consultations and pre-admissions assessments were thorough and included consideration of patients' emotional well-being.
- Most patients spoke positively about the care provided by staff. Patients we spoke with commended staff saying they were friendly and very attentive.
- The hospital sought feedback from patients about the service via a BMI questionnaire and the Friends and Family Test. The results were positive as 84% of patient said they would recommend the hospital as a good place to go for treatment.
- There was no mechanism for eliciting feedback from children and young people or their carers, but this was planned to be implemented in the future.
- Privacy and dignity was respected and protected.

Are services responsive at this hospital?

By responsive we mean that services are organised so they meet people's needs.

- The patients we spoke with told us that access to the hospital was good and did not have any concerns in relation to their admission, waiting times or discharge arrangements.
- Information about services provided at the hospital was provided in a way patients understood and appreciated. Staff told us that should a patient have communication problems they were able to address their individual needs. However, not all staff were aware that the hospital had access to an interpreting service.
- Staff said they were able to accommodate people's religious needs both pre and post operatively. They said they could contact the local community that offered support for example, church, mosque, temple or synagogue.
- There was information on the process for making complaints for patients. The hospital had received 54 complaints between April 2014 and April 2015, with 9 related to consultants, 5 related to clinical care and the rest shared between medical care, costs and arrangements surrounding admission and discharge. All had been acknowledged and responded to within the industry standard timeframes.

Are services well led at this hospital?

By well-led, we mean that the leadership, management and governance of the organisation, assure the delivery of high-quality person-centred care, supports learning and innovation, and promotes an open and fair culture.

Summary of findings

- There was a governance structure in place, with committees such as the governance and risk team feeding into the medical advisory committee (MAC) and hospital senior management team. The governance and risk committee was also responsible for clinical governance in the hospital. However, the terms of reference for the committee structure were ambiguous.
- The Clinical Governance Committee, did not discuss in detail appropriate categorisation of incidents, or if suitable action had been taken following incidents. Appropriate action following incidents was not always taken in both the CG and MAC.
- We saw evidence of anaesthetists and consultant surgeons being reviewed and discussed at the MAC. Consultants had their practising privileges suspended by the Executive Director if they did not provide the relevant information in a timely manner. Temporary privileges could be granted, if for example a specialist opinion from a consultant was required, who did not have privileges.
- We were not assured that the senior management team had sufficient control of or oversight of risk within the hospital. The hospital had a risk register in place; however two risks identified did not have an effective method of measuring the likelihood and impact of the identified risk.
- Appraisal rates were at 78% in May 2015, compared to 39% at the end of 2014. Staff said that the hospital's values were discussed during their appraisals. However, staff were not familiar with the vision for services.
- There was no vision or strategy for the children's service.
- We found there were no risks identified on the risk register for the children and young people's service.
- There was no one person who had clear responsibility for leading the service for children and young people.
- There was no monitoring of registered nurses skills and competencies which led to staff with no paediatric training caring for children.
- Senior managers confirmed that they did not identify children and young people within the completed audits. This meant that we could not be assured that risks were assessed, monitored and mitigated against.
- Staff spoke positively about the high quality care and services they provided for patients and were proud to work for the hospital. Staff reported that all their managers, including the Executive Director were visible. Staff told us that senior management were supportive and staff felt able to raise concerns.
- Audits were being undertaken in all services, except children and young people's services, to measure the quality of the service.
- Feedback was collected from patients, except young people's services. It was collected and the results shared with the staff. Patient feedback was positive.

We saw several areas of outstanding practice including:

- Excellent multidisciplinary working across the hospital, to ensure that patients received appropriate and timely care.
- A caring and responsive approach to patients after their surgery.
- The daily hospital 'Huddle' for exchanging information.

However, there were also areas of poor practice where the provider needs to make improvements.

Importantly, the provider **must**:

- Ensure that all equipment used by the service is clean, stored correctly and properly maintained.

Summary of findings

- Ensure that equipment checks in place are carried out efficiently in accordance with the hospitals policy or to identify all concerns.
- Ensure effective systems are in place to assess, monitor and mitigate the risks relating to the health, safety and welfare of service users, including ensuring that the risk register is reflective of service risks.

In addition the provider **should**:

- Ensure all incidents are recorded and staff receive feedback and learn from incidents.
- Ensure staff are aware of the new Duty of Candour regulations
- Ensure all staff sanitise their hands before entering the theatre area.
- Ensure that staff receive formal supervision and appropriate competencies.

Professor Sir Mike Richards
Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service

Surgery

Rating

Summary of each main service

Good



Surgical services were safe, caring, effective and responsive.

There was improvement required with regards to the hospital overall, being well-led.

There were integrated governance arrangements in place to minimise risk to patients and ensure shared learning. However, the terms of reference and what happened in practice differed.

The Clinical Governance Committee, (CG) did not discuss in detail appropriate categorisation of incidents, or if suitable action had been taken following incidents. Appropriate action following incidents was not always taken in both the CG and Medical Advisory Committee (MAC.)

There was no evidence that reports circulated prior to meetings had been read and the minutes showed that there was a subsequent lack of action.

The risk register did not show corporate risks that may affect the hospital.

The risk assessment process failed to consider the impact and likelihood of the risk happening.

Incidents were reported and dealt with appropriately and themes and outcomes were communicated to staff. Patient areas were visibly clean, tidy and appropriately equipped.

Patients were assessed, treated and cared for in line with professional guidance.

There were effective arrangements in place to monitor and manage pain.

Patient surgical outcomes were monitored and reviewed through formal national and local audit.

There was sufficient competent medical and nursing staff on duty to meet the needs of patients. Nursing, medical and other

Summary of findings

healthcare professionals were caring and patients were extremely positive about their care and experiences. Patients were treated with dignity and respect. Complaints were acknowledged, investigated and responded to in a timely manner. Information about the hospitals complaints procedure was available for patients and their relatives. The service reviewed and acted on feedback about the quality of care received. Staff had limited awareness of the hospital's new vision. There were good arrangements for monitoring the quality of the service provided. There was strong leadership and an open culture where staff felt valued.

Services for children and young people

Inadequate



The service for children and young people required improvement in were safe, caring, effective and responsive.

There service was rated inadequate with regards to it being well led.

The hospital did not have a system to identify children or a young person who may have been at risk of abuse. The children's nurses said they were unaware if staff who worked with children and young people were trained, with regards to safeguarding, at the appropriate level.

Although some safeguarding systems were in place and staff knew how to respond to safeguarding concerns.

The records identified inconsistencies in the recording of the resuscitation equipment checks. We saw the checklist was not checked and completed daily. We found that the registered nurses were unaware of the shortfall in the checking of equipment and did not ensure the equipment was safe for use by children and young people.

Not all children and young and young people had their weight and height recorded on admission.

Staff said they were encouraged to report any incidents which were then discussed at

Summary of findings

staff meetings. There was consistent feedback and learning from incidents reported. Staff were aware of the Duty of Candour, ensuring patients received an apology when something went wrong. The environment was visibly clean and staff followed the hospital policy on infection control.

Staffing levels were adequate for the service provision. The hospital had processes in place to attend to risks associated with emergencies.

Relatives told us how their children received good care. They said their children were treated with dignity, respect and compassion. The records showed that staff involved children and their parents/relative in decisions about their care and treatment. Relatives said they were supported and reassured if they were anxious or concerned.

The hospital did not gather children, young people or their relatives' feedback on the service provided. This meant the hospital was unable to action patient experiences to improve the service.

The children and young people services were responsive to their needs. Children and young people were admitted to and discharged from the hospital at appropriate times. Patients with a learning disability were provided with the necessary support. Staff had access to translation services although this did not extend to a sign language interpreter.

Rooms provided by the hospital were not specifically set up for children from a safety point of view. However, there were no children or young people on the wards during our inspection, so we were unable to verify the changes which might have been made to those rooms were they to be used by a child or young person.

Complaints were dealt with in line with hospital policy.

Summary of findings

We found that children and young people's services required improvement to be well-led. Staff were not aware of the vision or strategy for the service.

The governance processes had a focus on risk and quality for the hospital. However, this did not identify the objectives for the children and young people service. We found there were no risks identified on the risk register. Senior managers confirmed they did not identify children and young people within the completed audits. This meant that we could not be assured that risks were assessed, monitored and mitigated against. Policies and procedures were accessible to staff. The service held a monthly internal paediatric forum meeting. Within the service there was a culture of support and respect for each other. Staff were open and transparent about issues and concerns and felt this was positive for making improvements to the service. There was positive awareness among staff of the expectations for patient care.

Outpatients and diagnostic imaging

Requires improvement



Safety concerns were not consistently identified or addressed quickly enough. Cleanliness, hygiene and infection prevention and control risks were not adequately assessed and managed. Potential risks to patients due to the environment and equipment were not adequately identified, including on the resuscitation trolleys.

Systems, processes and standard operating procedures were not always reliable or appropriate to keep patients safe.

Monitoring whether safety systems were implemented was not effective. We found incidences of out of date medicine and FP10 prescription pads that were stored inappropriately.

There was limited evidence of how practice was audited against current evidence-based guidance, standards and

Summary of findings

best practice. There was no monitoring of patient outcomes of care and treatment. Participation in external audits and benchmarking was limited.

Not all staff had the right qualifications, skills, knowledge and experience to do their job. There were gaps in support arrangements for staff, such as supervision. Staff were supported to participate in training and development.

Multi-disciplinary teams worked well together to provide effective care. Nursing staff did not always have the complete information they needed before providing care and treatment.

Consultants had their own patient records and were able to access diagnostic results without any delays. Consent to care and treatment was obtained in line with legislation and guidance, including the Mental Capacity Act 2005 (MCA) by the consultants.

There was a lack of awareness by nursing staff regarding the MCA and why they would need to know this information. Limited numbers of staff had received MCA and Deprivation of Liberty Safeguards (DoLS) training.

Feedback from patients was positive about the way staff treated them. Patients were treated with dignity, respect and kindness during all interactions with staff. Patients were involved in their care and in making decisions, with any support needed. They received information in a way that they could understand, including the risks and benefits of potential surgery. Patients' privacy and confidentiality was respected at all times.

Care and treatment was coordinated with other services and other providers. Access to care was managed to take account of patient needs, including those with urgent needs. Services ran on time and patients were kept informed of any disruption/ delays to their care or treatment.

Complaint information or how to raise a

Summary of findings

concern was available for patients. Complaints and concerns were always taken seriously, responded to in a timely way and listened to.

Termination of pregnancy

Not sufficient evidence to rate



The hospital carried out only four terminations of pregnancy in 2014. Therefore this small service was inspected but not rated.

The hospital complied with The Abortion Act 1967, (as amended) The Abortion Regulations 1991, the Abortion (Amendment) (England) Regulations 2002 and the DoH Required Standard Operating procedures (RSOPS).

Summary of findings

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Requires improvement 

BMI Three Shires Hospital Ltd.

Services we looked at:

Surgery; Services for children and young people; Outpatients; Termination of pregnancy.

Summary of this inspection

Background to BMI Three Shires Hospital Ltd.

BMI Three Shires Ltd. is a private hospital in Northampton with 53 registered beds. Three Shires Hospital was established in 1982 and is built in the large grounds of another healthcare provider. The hospital has had several major additions and refurbishments including two ward extensions, outpatient refurbishment and a kitchen extension.

Three Shires Hospital Limited is a joint venture between St Andrews Healthcare and BMI Healthcare and owns and

operates BMI Three Shires Hospital. The hospital is managed by BMI Healthcare and is part of a network of 61 hospitals and treatment centres across England, Scotland and Wales.

The hospital undertakes a range of surgical procedures, to both adults and children over the age of three years. They also provide outpatient consultations.

The hospital provides NHS funded care, mostly via the Choose and Book system.

Our inspection team

Our inspection team was led by: Helen Richardson Head of Hospital Inspections, Care Quality Commission and

comprised a team of 11 made up of CQC inspectors and a variety of specialists: children's nurse, theatre nurse, an anaesthetist, governance specialist, and an expert by experience who had used hospital services.

How we carried out this inspection

Before visiting, we reviewed a range of information we hold about each core service. During the visit we held discussion groups with a range of staff who worked within the service, such as nurses, doctors, therapists and ancillary staff.

We carried out an announced inspection visit on 17, 18 June and 13 July 2015 and an unannounced inspection on 27 June 2015. We spoke with a range of staff in the hospital, including nurses, consultants, administrative, ancillary and clerical staff. During our inspection we reviewed services provided by BMI Three Shires in the two wards, operating theatre, and outpatients department.

During our inspection we spoke with 43 patients, 52 staff, including consultants, who are not directly employed by the hospital and 5 family members/carers from all areas

of the hospital, including the wards, operating theatre and the outpatient department. We observed how people were being cared for and talked with patients and reviewed personal care or treatment records of patients.

To get to the heart of people who use services' experience of care, we always ask the following five questions of every service and provider:

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive to people's needs?
- Is it well-led?

Summary of this inspection

Information about BMI Three Shires Hospital Ltd.

The hospital has 41 inpatient and 7 day care beds on the 1st floor, most with ensuite facilities. They have three operating theatres, two with laminar flow, 13 consultation rooms, 3 treatment rooms, a plaster room and minor operation room.

BMI Three Shires Hospital provides an outpatient service for various specialties to both private and NHS patients. This includes, but is not limited to, orthopaedics, gynaecology, general surgery, urology, and ophthalmology. The outpatient department also provides a minor operation service. In 2014, almost 32,000 people were seen in outpatients. This included children.

138 doctors have practicing privileges and their individual activity is monitored. In the 12 month period from January to December 2014, there were 6,798 visits to theatre including limb surgery (1,544) and pelvic surgery (608)

The hospital is accredited by all the major private medical insurers. In 2014, 49% of in and day patients were funded by the NHS, the remaining patients were self-funding or paid for by their insurance companies. In outpatients 46% of patient visits, both new and follow ups were funded by the NHS.

Bupa recognises Three Shires Hospital as an Accredited Breast Care Network Hospital and Accredited Bowel Care Unit. The hospital holds Joint Advisory Group (JAG)

Accreditation for the Endoscopy Service and is in the process of renewing this accreditation. Macmillan Quality Environmental Mark Accreditation has been in place for the hospital's Oncology Unit since April 2014.

All patients are admitted and treated under the direct care of a consultant and medical care is supported 24/7 by an onsite resident medical officer (RMO.) Patients are cared for and supported by trained nurses, allied health professionals such as physiotherapists and pharmacists employed by the hospital.

The hospital Accountable Officer for Controlled Drugs (CDs) is the Executive Director.

The hospital has a contract with Northampton General Hospital, which is nearby, to provide histology and pathology services, microbiology services and decontamination services in relation to theatre instrumentation.

The imaging department is owned and operated by a separate provider, The Pavilion Clinic Limited.

BMI Three Shires has been inspected four times by the Care Quality Commission, between 2010 and 2013, with 10 of the core standards being assessed during these inspections. All standards assessed were found to be compliant.

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?

By safe, we mean that people are protected from abuse and avoidable harm.

Requires improvement



- Staff were encouraged to report incidents and there was an incident reporting system in place that staff were aware of.
- Feedback from incidents was varied and we were not reassured that staff learnt from all reported incidents.
- Not all staff in the outpatients department were aware of the new Duty of Candour regulations.
- Out of hours, there was only the Resident Medical Officer (RMO) in the hospital at any one time who was an Advanced Life Support (ALS) provider.
- Despite procedures being in place to check the cleanliness of rooms in outpatients, we found equipment and some rooms and equipment that were not clean. Check lists were signed, but not specific to tasks undertaken.
- Although there were up to date records to demonstrate that a system was in place to maintain equipment in outpatients the system was not effective.
- We found some out of date medications and equipment in the outpatients department.
- Medications were stored safely and securely to prevent theft, damage or misuse, including Controlled Drugs.
- Services were generally clean and equipment was cleaned between patients; however we noted that in outpatients some areas did not appear to have been cleaned thoroughly.
- There were adequate hand-washing facilities and soap dispensers, hand hygiene foam and paper towels for staff and patients to use. However, we observed a number of staff not always washing or sanitising their hands when moving between theatre and recovery.
- There were clear strategies for minimising the risk to adult patients. Staff demonstrated a good understanding of the assessed risks and how to avoid these. The hospital did not admit or treat patients who were anticipated as requiring critical care support and had an appropriate transfer policy in place with the local trust in the event that a patient became critically ill and needed to be transferred.

Summary of this inspection

- The hospital had a screening system in place to ensure that patients were assessed pre-operatively to ensure their suitability for surgery and used an early warning system to alert them should a patient's condition deteriorate in the post-operative phase.
- Surgical procedures were carried out by a team of consultant surgeons and anaesthetists registered with the General Medical Council (GMC). The consultants were mainly employed by other organisations (usually in the NHS) in substantive posts and had practising privileges (the right to practice in a hospital) with BMI Three Shires Hospital.
- The Resident Medical Officer (RMO) provided out-of-hours medical cover 24 hours a day and as part of their practising privileges agreement, consultants were required to be contactable whilst they had patients under their care in the hospital. Staff said that consultants could be contacted out of hours.
- There was a system in place for planning and monitoring the number of staff and mix of staff needed to meet patients' needs in the wards and theatre.
- The records showed that there were no vacancies within the outpatient department or in patient wards. There was very little agency staff use in all departments.
- Staff were aware of their role and responsibilities with regards to safeguarding and the majority of staff were up to date with adult's safeguarding training. However, some staff, including the hospital leads for safeguarding, were unsure what level of training had been provided with regards to both adult and children's safeguarding when we spoke with them. The hospital subsequently confirmed that some staff were trained to level 2 or 3.
- Adult nurses, who did not have the appropriate level of safeguarding training, often looked after children.
- The hospital did not have a system to identify children or young person who may be at risk of abuse.
- Staff and managers told us they were up to date with their mandatory training. Overall compliance was 86% which was in line with the hospital target of 85%.
- Patient records were up to date; risk assessments had been completed and documented for patients undergoing surgery, including the 5 Steps to Safer Surgery safety checklists.

Are services effective?

By effective, we mean that people's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence.

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Summary of this inspection

- Surgical and outpatient care delivered was evidence based and in line with nationally agreed policies and practice.
- We saw assessments of people's needs were comprehensive and included the assessment of pain. However, this was not the case in children's services, where pain assessments were poorly completed.
- There was an audit programme in place, being undertaken in all services, except children and young people's services. There was recording and reporting of some patient outcomes.
- There was evidence of good multidisciplinary working across the hospital.
- Services could be provided over seven days to reflect demand.
- The role of the Medical Advisor Committee (MAC) included ensuring that consultants were skilled, competent and experienced to perform the treatments undertaken. These were reviewed annually.
- There was a process in place for checking General Medical Council and Nursing and Midwifery Council registration, as well as other professional registrations.
- There was a lack of formal supervision for nursing staff.
- Most staff had yearly appraisals.
- Staff were confident about seeking consent from patients and staff had received training on the Mental Capacity Act 2005.
- Senior staff and those working within children's services were not aware of processes around Fraser Guidelines but did recognise the Gillick competency assessment.

Are services caring?

By caring we mean that staff involve and treat patients with compassion, dignity and respect.

- Patients were treated with dignity and respect.
- We observed good interaction between patients and staff. Staff explained procedures and gave appropriate information to patients to help them to understand and be involved in decisions concerning their treatment. Initial consultations and pre-admissions assessments were thorough and included consideration of patients' emotional well-being.
- Most patients spoke positively about the care provided by staff. Patients we spoke with commended staff saying they were friendly and very attentive.
- The hospital sought feedback from patients about the service via a BMI questionnaire and the Friends and Family Test. The results were positive as 84% of patient said they would recommend the hospital as a good place to go for treatment.

Good



Summary of this inspection

- There was no mechanism for eliciting feedback from children and young people or their carers, but this was planned to be implemented in the future.
- Privacy and dignity was respected and protected.

Are services responsive?

By responsive we mean that services are organised so they meet people's needs.

- The patients we spoke with told us that access to the hospital was good and did not have any concerns in relation to their admission, waiting times or discharge arrangements.
- Information about services provided at the hospital was provided in a way patients understood and appreciated. Staff told us that should a patient have communication problems they were able to address their individual needs. However, not all staff were aware that the hospital had access to an interpreting service.
- Staff said they were able to accommodate people's religious needs both pre and post operatively. They said they could contact the local community that offered support for example, church, mosque, temple or synagogue.
- There was information on the process for making complaints for patients. The hospital had received 54 complaints between April 2014 and April 2015, with 9 related to consultants, 5 related to clinical care and the rest shared between medical care, costs and arrangements surrounding admission and discharge. All had been acknowledged and responded to within the industry standard timeframes.

Good



Are services well-led?

By well-led, we mean that the leadership, management and governance of the organisation, assure the delivery of high-quality person-centred care, supports learning and innovation, and promotes an open and fair culture.

- There was a governance structure in place, with committees such as the governance and risk team feeding into the medical advisory committee (MAC) and hospital senior management team. The governance and risk committee was also responsible for clinical governance in the hospital. However, the terms of reference for the committee structure were ambiguous.
- The Clinical Governance Committee, did not discuss in detail appropriate categorisation of incidents, or if suitable action had been taken following incidents. Appropriate action following incidents was not always taken in both the CG and MAC.

Inadequate



Summary of this inspection

- We saw evidence of anaesthetists and consultant surgeons being reviewed and discussed at the MAC. Consultants had their practising privileges suspended by the Executive Director if they did not provide the relevant information in a timely manner. Temporary privileges could be granted, if for example a specialist opinion from a consultant was required, who did not have privileges.
- We were not assured that the senior management team had sufficient control of or oversight of risk within the hospital. The hospital had a risk register in place; however two risks identified did not have an effective method of measuring the likelihood and impact of the identified risk.
- Appraisal rates were at 78% in May 2015, compared to 39% at the end of 2014. Staff said that the hospital's values were discussed during their appraisals. However, staff were not familiar with the vision for services.
- There was no vision or strategy for the children's service.
- We found there were no risks identified on the risk register for the children and young people's service.
- There was no one person who had clear responsibility for leading the service for children and young people.
- There was no monitoring of registered nurses skills and competencies which led to staff with no paediatric training caring for children.
- Senior managers confirmed that they did not identify children and young people within the completed audits. This meant that we could not be assured that risks were assessed, monitored and mitigated against.
- Staff spoke positively about the high quality care and services they provided for patients and were proud to work for the hospital. Staff reported that all their managers, including the Executive Director were visible. Staff told us that senior management were supportive and staff felt able to raise concerns.
- Audits were being undertaken in all services, except children and young people's services, to measure the quality of the service.
- Feedback was collected from patients, except young people's services. It was collected and the results shared with the staff. Patient feedback was positive.

Detailed findings from this inspection






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	Requires improvement	Good
Services for children and young people	Requires improvement	Requires improvement	Not rated	Requires improvement	Inadequate	Inadequate
Outpatients and diagnostic imaging	Requires improvement	Not rated	Good	Good	Requires improvement	Requires improvement
Termination of pregnancy	Not rated	Not rated	Not rated	Not rated	Not rated	Not rated
Overall trust	Requires improvement	Requires improvement	Good	Good	Inadequate	Requires improvement

Surgery

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

Information about the service

BMI Three Shires Hospital has 53 beds most of which are private patient rooms with ensuite facilities. There are three adjoining wards on the first floor for surgical inpatients and day patients.

The hospital has three operating theatres with associated anaesthetic rooms and a four bed recovery area. There is also a one room endoscopy suite with a three bed recovery area. The majority of the hospital's work is adult elective surgery, predominantly orthopaedic surgery. Cosmetic surgery is provided as is surgical termination of pregnancy. A small number of children are treated in the hospital, mostly for minor surgery on a day care basis. In the 12 month period from January to December 2014, there were 6,798 visits to theatre, these included operations on children and young people.

At procedure level the most frequent surgeries were:

- 300 – Multiple arthroscopic knee operations
- 269 – Primary hip replacements
- 209 – Prosthetic knee replacements
- 185 – Arthroscopic meniscectomy
- 234 – Colonoscopy

All patients are admitted and treated under the direct care of a consultant and medical care is supported 24/7 by an onsite resident medical officer. (RMO.) Patients are cared for and supported by trained nurses, allied health professionals such as physiotherapists and pharmacists employed by the hospital. There is an imaging department run as a joint venture with another company.

We carried out an on-site inspection of BMI Three Shires hospital, and visited the inpatient, pre admission clinic, theatres and recovery. We talked with 12 patients. We interviewed 14 staff including nurses, allied healthcare professionals, RMOs, consultants, support staff and managers. We observed care and treatment and reviewed clinical records. Prior to the inspection, we reviewed performance information about the hospital.

Surgery

Summary of findings

Surgical services were safe, caring, effective and responsive. For the service to be considered well led, some improvement was required. Incidents were reported and dealt with appropriately and themes and outcomes were communicated to staff. Patient areas were visibly clean, tidy and appropriately equipped.

Patients were assessed, treated and cared for in line with professional guidance. There were effective arrangements in place to monitor and manage pain.

Patient surgical outcomes were monitored and reviewed through formal national and local audit.

There was sufficient competent medical and nursing staff on duty to meet the needs of patients. Nursing, medical and other healthcare professionals were caring and patients were extremely positive about their care and experiences. Patients were treated with dignity and respect.

Complaints were acknowledged, investigated and responded to in a timely manner. Information about the hospital's complaints procedure was available for patients and their relatives. The service reviewed and acted on feedback about the quality of care received.

Staff had limited awareness of the hospital's new vision. There were good arrangements for monitoring the quality of the service provided. There was strong leadership and an open culture where staff felt valued.

Are surgery services safe?

Good 

The surgery service provided by BMI Three Shires Hospital was safe.

Staff had received up-to-date training in safety systems. Staff understood and fulfilled their responsibilities to raise concerns and report incidents and near misses. There was monitoring and reviewing of activity to enable staff to identify and understand risks.

Staff understood their responsibilities in Duty of Candour ensuring patients were kept informed of incidents that involved them. When something went wrong, there was an appropriate investigation that involved relevant staff and lessons learned were communicated promptly to support improvement.

There were systems, processes and standard operating procedures to keep people safe and safeguarded from abuse. These were understood by staff.

Excluding new starters, nursing staff on the wards had achieved an overall compliance rate of 90% and theatres a compliance rate of 65% for mandatory training, although some courses were already in progress.

A National Early Warning Score (NEWS) was used to identify deteriorating patients however recent audits showed records 36% of records were incomplete. Actions proposed included further training and at the time of inspection, dates for further training had been scheduled.

Staffing levels and skill mix were planned, implemented and reviewed. Any staff shortages were responded to quickly and adequately. There were effective handovers between shift changes, to ensure staff could provide safe and appropriate care.

Risks to people, who use services were assessed, monitored and managed on a day-to-day basis. These included signs of deteriorating health and medical emergencies. There were alarm systems to alert medical and nursing staff when immediate assistance was required.

Plans were in place to respond to emergency situations.

Incidents

Surgery

- Staff were able to discuss the correct process to respond to an incident in accordance with the hospital's incident reporting policy. Staff had a good understanding about reporting incidents and the need for incidents to be reported in a timely manner.
- Staff received regular feedback through departmental meetings and, in the operating theatre, daily briefing sessions to raise awareness and ensure a timely response to actions required.
- Incidents reported were followed up to ensure appropriate actions were completed. For example, there had been an incident resulting in a needle stick injury and actions taken complied with the hospital policy. Feedback about the incident had been included in the daily staff meeting to immediately raise staff awareness when handling and disposing of needles.
- There had been no incidences of a Never Event, serious injury or serious incidents requiring investigation in the reporting period January 2014 to January 2015. A never event is a serious incident that is wholly preventable, as guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and should have been implemented by all healthcare providers.
- There had been 499 incidents over the past three years, which was within the expected normal rate according to the number of discharges. There had been no trends identified.
- Clinical and non-clinical incidents were reviewed through the hospital clinical governance meetings where trends were analysed and any further actions required were communicated to staff through their departmental meetings. This included reviews of mortalities of which there had only been one, in the past year. We saw a selection of department meeting minutes which included feedback about incidents.
- The hospital reported cancelled operations as clinical incidents which were analysed to identify trends. There had been 64 incidents over a six month period from January to June 2015. Most reasons were due to patients being assessed as unfit for surgery on the day of admission due to unsatisfactory test results or patients having coughs and colds.

Duty of Candour

- Staff understood their responsibilities with regard to the legislation. The Duty of Candour requires healthcare providers to disclose safety incidents that result in

moderate or severe harm, or death. Any reportable or suspected patient safety incident falling within these categories must be investigated and reported to the patient and any other relevant person within 10 days. Nursing staff described the need for patients involved in incidents to be given an apology.

Safety thermometer or equivalent (how does the service monitor safety and use results)

- The hospital gathered patient information such as hospital acquired infections and reviewed this through its clinical governance processes. We did not see this displayed in the hospital however the hospital website for patients provided clear information about overall incidence of Methicillin Resistant Staph Aureus (MRSA), Clostridium Difficile (C. Difficile) and Methicillin Sensitive Staph Aureus (MSSA). In addition the infection control measures used to prevent and minimise risks of infection were shown.
- Patients were risk assessed for venous thromboembolism (VTE). The VTE screening rate had been consistently 100% compliant. There had been no incidence of hospital acquired VTE or pulmonary embolism (PE) in the previous 12 months.
- Patients were also risk assessed for risk of developing pressure ulcers, using the Waterlow scoring tool. There had not been any reported incidents of pressure ulcers in the previous 12 months.

Cleanliness, infection control and hygiene

- An infection control risk assessment of all departments had been completed and further actions with named personnel responsible documented. Compliance had been assessed through audits and review at clinical governance meetings. Infection control was a standing agenda item to ensure consistent review of progress.
- The hospital had policies and procedures in place to manage infection prevention and control. Staff were able to access the policies and procedures on the hospital's intranet and staff were able to demonstrate how to access policies easily. We saw there were also policies for the management of waste and processes surrounding decontamination.
- There were adequate hand washing facilities and hand sanitising gel in each patient's room. The practice of hand washing was variable and not always complied with particularly in theatres. We observed staff leaving

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and entering the theatre/recovery area without cleaning their hands. This was reported to the theatre manager and we observed the concern was raised at the daily staff meeting to ensure compliance.

- Audits of compliance with the infection prevention and control policy were completed. The results of the hand hygiene audit in April 2015 reported a 71% level of compliance. This was because staff were not decontaminating hands after leaving the patient environment. We saw evidence of actions taken to improve compliance with hand washing where required, such as ensuring staff training of hand hygiene was up to date. Posters demonstrating correct hand washing technique were also displayed.
- A system had been recently introduced in inpatient areas to record all surgical site infections for hip operations according to the Health Protection Agency (HPA) definition of surgical site infection. As this had only been recently introduced there was no data to review. Recording information with the HPA meant the provider would be able to benchmark performance with other healthcare providers.
- There was a lead nurse for infection control who had attended training with the HPA to ensure data was accurately collated to ensure its validity.
- We observed staff complied with infection prevention and control policies through the correct use of personal protective equipment such as gloves and aprons.
- There had been no incidents of a hospital acquired infection such as MRSA, C. Difficile or MSSA.
- Incidents of surgical site infections were monitored and reported to the clinical governance committee and there had been no incidents reported in 2014.
- We observed theatre shoes stored in the changing rooms were dirty and splashed with blood. There were no facilities in place such as wipes or gloves for the cleaning of theatre shoes in the female changing area. This matter was raised with the theatre manager who explained the system for managing the cleaning had recently changed and each staff member was now responsible for ensuring their own shoes were cleaned. The manager recognised the change had not yet been embedded and took steps to address this during the inspection.
- Porters were responsible for cleaning moveable equipment. We observed there was a record kept of the cleaning, the equipment was itemised to ensure no item of equipment was overlooked.

- Green, 'room cleaned' notices were used and displayed on room doors to notify staff the room was ready and safe for patient use.
- The endoscopy department had Joint Accreditation Group (JAG) accreditation, which demonstrated it had effective decontamination processes for endoscopes.

Environment and equipment

- Not all patient rooms on the wards had piped suction or oxygen. To address this there were supplies of portable suction machines and oxygen cylinders at key points on the wards for staff to easily access. These were found to have been checked and in good working order. The manager advised piped services to each room were included in the approved refurbishment plans scheduled for 2015.
- We observed there was lack of standardisation of anaesthetic rooms. For example storage of medicines. This meant there was a potential for delays in an emergency if new staff were not familiar with each room's different layout.
- The corridor from the theatre to the endoscopy department was crowded with equipment, however this was visibly clean and equipment was stored tidily and safely to allow adequate access of patient trolleys. We spoke with the theatre manager who was aware of the concern and able to evidence that there was a fire evacuation test scheduled for July 2015 when the whole area would be tested and enable the team to fully assess the degree of risk, if any, this posed.
- The resuscitation trolleys inspected were found to be visibly clean and in good order. Records showed these were checked on a daily basis.
- The ward and theatre areas appeared clean and well maintained. The Patient Led Assessment of the Environment (PLACE) score for the hospital was 98% in 2015 and had scored over 90% in 2014.
- We checked some equipment at random and all portable appliances were found to have been tested and labelled as safe for use.
- The hospital had an in house maintenance department to complete planned preventative maintenance. An equipment champion had been in theatre to lead the team to ensure equipment was available, stored correctly and fit for use. An equipment database provided automatic reminders when checks or servicing was due. Risk assessments of wards and theatres environments had been completed. These were

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reviewed annually and risk registers were seen. We saw an example of where the risk had been identified and responded to, of not having sufficient anaesthetic equipment. This had meant should a machine when checked pre operatively be found to be faulty, there was no backup which potentially could result in an operation being cancelled. A spare anaesthetic machine had been purchased to ensure patient safety and continuity of service.

- During operations staff used all necessary personal protective equipment including eye protection and gloves.
- There were systems in place to manage and respond to medical devices alerts (MDA's) and hazard warnings. These were logged and reviewed through the hospitals clinical governance processes to ensure appropriate actions were taken.

Medicines

- There were effective arrangements for the receipt, storage, dispensing and disposal of unwanted medicines managed by a team of pharmacists, a technician and pharmacy assistant. They ensured any drug alerts received were responded to and reported outcomes at the medicines management and clinical governance meetings.
- The pharmacy staff checked and maintained agreed stock levels and ensured there was appropriate stock rotation.
- Medicines were received on the ward from the onsite pharmacy in a sealed container.
- Allergies were recorded clearly on the medicines record.
- Nursing staff were aware of and able to easily access guidance such as the hospital's medicines policy and up to date British National Formularies.
- We did not observe the administration of medicines during the inspection but the medicine charts we checked were found to have been completed correctly. This included reasons for non-administration of medicines. Entries were signed and dated.
- Room and fridge temperatures were checked and recorded daily to ensure stored medicines were safe for use. There was guidance for staff about actions they should take if temperatures were found to be outside the specified range.

- The hospital staff had access to a consultant microbiologist regarding prescribing of antibiotics. An antibiotic protocol had been introduced and compliance with this was audited.
- Prior to discharge home patients were reviewed and prescribed any medicines required for their continuing care to take home with them. Nursing staff told us an explanation of the medicines was given to the patient when handing them over to ensure patients understood how to use the medicines safely and effectively. Details of such medicines were communicated to the patients General Practitioner in the patient's discharge summary.

Records

- The hospital used a paper based record system for recording patients care and treatment.
- Patient's records whilst in use on the wards were stored securely to ensure confidentiality.
- NHS patient's records were available for patients whose treatment was funded by the NHS.
- We examined four sets of patient records. Information was easy to access with each episode of care divided into separate sections to allow staff to access the most recent and relevant information about the patient.
- The records contained information of the patient's journey through the hospital including pre assessment, investigations, results and treatment provided. There were different pathways for each speciality or procedure.
- Some patient records were kept at the bedside, such as fluid balance charts and care plans. These were up to date and entries signed and dated.
- Theatre records were completed and included the 5 steps to safer surgery safety checklists which were completed. Monthly audits of the 5 steps to safer surgery checklist had been completed, which showed team briefing and debriefing had achieved 100% compliance. We saw corrective actions had been taken where non-compliance had been identified with signing the document at the end of a procedure, such as the manager writing to consultants to remind them about signing the document.
- Once patient records were no longer required their content was checked for completeness before being stored in a locked medical record store. Patient's records were securely stored off site once the patient's treatment had finished.

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Safeguarding

- The hospital had safeguarding policies and procedures available to staff on the intranet.
- Staff received training through electronic learning and had a good understanding of their responsibilities in relation to safeguarding of vulnerable adults and children. They were able to explain how to respond to and escalate a concern.
- Staff had received training about the Mental Capacity Act (MCA) to ensure they were competent to meet patients' needs and protect their rights where required. This also included training regarding the Deprivation of Liberty Safeguards (DoLS). Staff were able to briefly describe how DoLS might be required; they gave an example of how a patient might become confused and need to be restrained to ensure their safety. They explained they would contact the Director of Nursing and involve the consultant and relatives as appropriate.

Mandatory training

- Staff explained they received mandatory training to provide safe care. Some of this was completed through e-learning and some through on-site training, for example, manual handling. Staff described a range of topics included in their training such as information security and infection prevention and control.
- Excluding new starters, nursing staff on the wards had achieved an overall compliance rate of 90% and theatres a compliance rate of 65% although some courses were already in progress. This was data for a 'rolling' year. The company's mandatory training policy specified an 85% compliance rate at any one time. This meant that the compliance with mandatory training was below the hospital's target. Training levels were monitored and reviewed at clinical governance meetings. The main areas of non-compliance had been found to relate to practical, face to face training sessions. Heads of departments were encouraged to support staff to attend sessions to ensure compliance.
- The hospital used electronic learning to provide much of the training although some training, for example, manual handling was provided on site, or at two of BMI's nearby sister hospitals.
- Staff felt arrangements to keep up to date with their mandatory training were flexible. For example they

described how they could go in early (4pm for a 6pm duty) to do some e-learning and then finish the study at home. Staff preferred this arrangement as there were less time constraints.

- Staff told us they found the appraisal process helpful and were able to discuss and identify learning needs beyond that of their mandatory training.

Assessing and responding to patient risk

- Patients were assessed in a nurse led pre assessment clinic prior to their surgery. Recognised risk assessment tools, for example American Society of Anaesthesiologist (ASA) scores were not used. There was a policy regarding pre-operative assessment however this was only in draft format and did not contain recognised risk assessment tools at the time of the inspection. One of the anaesthetists was developing a patient questionnaire to assess pre-operative risk. This was not in use at the time of the inspection.
- During this clinic patients were swabbed to assess if they had MRSA. Where results were found to be positive the admission date if necessary was deferred and the patient provided with a treatment pack to use at home in accordance with the MRSA policy. A further appointment for the patient was rearranged once a clear swab result was received.
- Risk assessments were completed using nationally recognised tools, such as the Waterlow score to assess patients risk related to pressure ulcers. Other risks assessed were those of mobility and moving and handling.
- The '5 steps to safer surgery' were used. We observed checks as they were carried out. There was good interaction between staff and the required time out was taken to complete all final safety checks prior to the operation commencing. Practice appeared well embedded within the operating team.
- No operations were allowed to commence after 6pm. This meant that patients were recovered and returned to the ward within normal working hours, whilst a full staff compliment was available.
- There was a formal arrangement for patients to be transferred to the local NHS hospital if the patient required critical care to level two or level three. These are critically ill patients, who require either organ support or closer monitoring in the immediate post-operative period.

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- There was access to the minimum requirement of two units of O Rhesus negative emergency blood. The blood fridge temperature and stock was checked and recorded daily. Blood transfusion link nurses had been appointed and training scheduled for all staff involved in transfusion. Both link nurses attended the local trust meetings to ensure shared learning and consistency of practice.
- There were appropriate arrangements for ensuring blood required for elective surgery was available when required and for obtaining blood in an emergency.
- The practicing privileges agreement required the designated consultant to be contactable at all times when they had inpatients within the hospital. Furthermore, they needed to be available to attend within an appropriate timescale according to the risk of medical or surgical emergency. This included making suitable arrangements with another approved practitioner to provide cover in the event they were not available, for example whilst on holiday.
- Each patient room and bathroom had emergency call bells to be used to alert staff when urgent assistance was required, these were routinely tested to ensure they were fit for purpose.
- The National Early Warning system (NEWS) tool was used to identify the deteriorating condition of patients. This system alerted nursing staff to escalate, according to a written protocol, any patient whose routine vital signs fell out of safe parameters.
- Audits of NEWS records completed in April 2015 identified 36% of records were incomplete. This was due to a time not being recorded when the document was signed by the nurse completing the score. Actions proposed included further training and at the time of inspection, dates for further training had been scheduled.
- Audits of the correct use of the checklist '5 steps to safer surgery' was undertaken by the Quality and Risk Manager and Department Leads. To support compliance the local trust had provided the use of a training CD showing the use of the checklist in action for the training of new staff.
- If a patient became unwell after treatment, there were arrangements for the patient to be seen promptly by a doctor, the RMO, and if necessary reassessed by the admitting consultant or anaesthetist where required.
- Most of the senior nursing staff had current Intermediate Life Support certificates. Out of normal working hours, the only person in the hospital who was an ALS provider was the RMO.

Nursing staffing

- The hospital used a staffing tool based on the analysis of the dependency of the patient and nursing activity required to meet the patients' needs. From this the number of nurses and health care assistants (HCA) required for each shift was calculated, for example three registered nurses and one HCA.
- We saw that during the inspection and unannounced visit that planned staffing numbers were met.
- The hospital undertook elective surgery and also accepted emergency oncology admissions. While the number of nursing and care staff required on any particular day could be calculated and booked in advance, there may have been variances due to unforeseen oncology admissions. Contracted staff worked flexible hours to cover the rota and gaps were mostly met by overtime or bank staff.
- The hospital used a team of regular bank staff to cover unplanned absences to ensure they were able to provide safe care.
- Use of agency staff was minimal (less than 1%) in theatres over the past year. The wards had used between 1% and 2% due to covering long term absences earlier in the year but three of the four staff had since returned to work.
- Agency staff were recruited from specific agencies with which the hospital had a preferred provider arrangement. This ensured staff provided met key requirements such as having completed manual handling training and competencies to safely administer medicines.
- Agency staff, when used, were provided with an orientation when new to the hospital, which included access to and the location of emergency equipment and fire exits. Records of signed completed orientations were maintained by the hospital.
- Although on occasions an agency member of staff was required in theatres, they were not permitted to run a theatre unsupervised, to ensure patient safety.

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- We saw that duty rotas were planned four weeks ahead and reviewed on a weekly basis. Changes to rotas were clearly recorded to ensure accuracy. We saw there was always a minimum of two registered nurses on duty at any one time.
- Handovers between staff took place between each shift. The ward sister explained they had trialled doing this at the patient bedside. In response to patient comments, this had been discontinued and now took place in the ward office.

Surgical staffing

- Patient care was consultant led. The hospital practicing privilege agreement required that the consultant visit inpatients admitted under their care at least daily or more frequently according to clinical need or request of the Executive Director, Director of Nursing/Clinical Services, or Resident Medical Officer (RMO).
- There was an RMO in the hospital at all times supplied by an external contractor via BMI Healthcare. The RMOs worked one week on duty and one week off.
- Nursing staff and the RMO had found the consultants to be supportive and responsive when they were contacted for advice.
- The RMO told us they had sufficient time to handover to the new RMO coming on duty
- The hospital maintained a Medical Advisory Committee (MAC) whose responsibilities included ensuring any new consultant was only granted practicing privileges if deemed competent and safe to practice. Privileges were tracked using an electronic system.
- The MAC periodically reviewed existing practicing privileges to ensure continued compliance with the practicing privilege agreement and advised the hospital about continuation of practicing privileges. If there was non-compliance with practicing privileges, the Executive Director would suspend the consultant's privileges so that they were not able to practice at the hospital until all the required information had been given.

Major incident awareness and training

- The hospital had a service contingency plan in place for staff to use in the event of interruption to essential services. This included the provision of easy to use action cards specific to the type of incident such as loss

of telecommunications or interruption to the water supply. These informed staff of the actions they should take and who to contact to ensure assistance could be quickly summoned.

Are surgery services effective?

Good 

Surgery services were effective.

Patient's care and treatment was planned and delivered in line with current evidence-based guidance, standards, best practice and legislation. Patients had comprehensive assessments of their needs, which included consideration of clinical needs, mental health, physical health and wellbeing. The expected outcomes were identified and care and treatment was regularly reviewed and updated. Information about patient's care and treatment, and their outcomes, was routinely collected and monitored.

There was participation in relevant local and national audits, including clinical audits. Accurate and up-to-date information about effectiveness was shared internally and externally and understood by staff. It was used to improve care and treatment and patient outcomes. Staff were qualified and had the skills they needed to carry out their roles effectively. Staff were supported to maintain and further develop their professional skills and experience through the use of appraisals. Consultants were supported through the process of revalidation where relevant.

Staff could access the information they needed to assess, plan and deliver care to patients in a timely way. Consent to care and treatment was obtained in line with legislation and guidance.

Evidence-based care and treatment

- Policies were current and referenced in accordance with the hospital Clinical Governance policy.
- Policies were accessible on the hospital intranet and based on professional guidance such as National Institute of Health and Care Excellence (NICE) and Royal College guidelines.
- We saw that the hospital had systems in place to provide care and treatment in line with best practice guidelines (NICE CG50: Acutely ill patients: Recognition

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of and response to acute illness in adults in hospital.) For example an early warning score system was used to alert staff should a patient's condition start to deteriorate.

- Adherence to local policies and procedures was monitored through the use of local audits such as the correct management of waste and further supported through the provision of staff training.
- The hospital had a schedule of audits performed throughout the year showing the frequency of the audits such as medicines, records and audits of the correct use of the five steps to safer surgery checklist. There was a framework outlining how the information was to be reviewed and disseminated.

Pain relief

- The hospital had trained pain relief link nurses to provide support to the clinical team and ensure best practice. They met quarterly with other pain link nurses and head of nursing to review practice and share learning. Physiotherapists and pharmacists were also involved.
- The surgical pathway prompted staff to assess and record if pain was being managed effectively. This commenced in the pre-assessment clinic where actions to deal with pain management were discussed.
- Patient Controlled Analgesia (PCA) pumps were available and staff felt they had sufficient quantities to meet the needs of the patients at any one time.
- The staff audited the effectiveness of pain relief through the use of a patient questionnaire. Questions such as 'Was the likelihood of pain explained to you?' 'Did staff do everything they could to help control your pain?' Responses showed a satisfaction rate of over 90%.
- Anaesthetists we spoke with explained they would discuss and review a colleague's patient's pain control if requested, for example if the patient's consultant was not available.
- Anaesthetists described collaborative working with the local NHS trust pain team who also offered support and assistance as required. The teams worked together and told us their aim was to give all patients the same options for effective pain relief.

Nutrition and hydration

- Staff completed an assessment of patient's nutritional status and their needs as part of their initial assessment and updated this during their stay.
- Pre-operative fasting guidelines for adults were aligned with the recommendations of the Royal College of Anaesthetists. (RCOA) However there was no evidence of audits of fasting times to assess whether there was compliance with the RCOA guidelines.
- Nausea and vomiting were formally assessed and recorded.
- Intravenous fluids were prescribed and recorded as appropriate.
- Patients we spoke with told us the quality of the food was good and they mostly received the food they had selected from the menu provided.

Patient outcomes

- To evaluate the effectiveness of treatment the following were audited:
- Readmission rates within 30 days of surgery, which hernia and knee replacement procedures were found to be similar to expected. Hip replacement procedures had been worse than expected. These incidents were reviewed by the clinical governance committee and further investigation undertaken where appropriate. However, we found there was no evidence that this particular occurrence had been investigated by the CG committee.
- Patient Reported Outcome Measures (PROMS) for Hip replacements. The Oxford Hip Score for the hospital of 23.8 was better than the England average of 21.4.
- The incident rate of unplanned transfers per 100 discharges had fallen to eight in 2014.
- Unplanned returns to the operating theatre. There had been seven incidents during 2014. This was a similar to expected rate compared to other independent acute hospitals. No trends had been identified.
- Information provided pre operatively described what patients needed to do before and after surgery to ensure a desired outcome. For example to stop smoking before anaesthetic and wound management following surgery, to prevent infections.

Competent staff

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- Registered practitioners had completed Intermediate Life Support (ILS) training and Basic Life support (BLS) training was provided for other staff including porters to ensure staff were able to effectively respond to the needs of a deteriorating patient.
- At the time of the inspection only the RMOs had received Advanced Life Support (ALS) training however we saw evidence the recovery lead nurse had been provided with a date to undertake the ALS course.
- The hospital provided induction, learning development and appraisals for staff.
- Two staff had recently completed their induction and thought it was comprehensive and prepared them to work safely and effectively in their roles.
- Appraisal rates for staff were poor in previous years (2013 and 2014). This had recently improved with the theatre department having appraised 68% of staff and wards had 100% completion rate.
- Nursing staff had completed competencies in various areas such as medicine administration.
- The training for competency in scrub techniques was provided by theatre staff to new theatre staff.
- There were three staff trained in the safe use of lasers used for eye surgery and a named laser supervisor.
- There was a process for checking General Medical Council and Nursing and Midwifery registration, as well as other professional registrations. We reviewed the spreadsheets including this data which showed, for example consultants had up to date GMC registration and indemnity cover to practice.
- The role of the MAC included ensuring that consultants were skilled, competent and experienced to perform the treatments undertaken. Practising privileges were granted for a consultant to carry out specified procedures.
- There were arrangements which required the consultant to apply to undertake a new technique or procedure not undertaken previously by the practitioner at the hospital. The introduction of the new technique or procedure had to have the support of the MAC, which may take specialist advice such as that of the National

Institute for Health and Care Excellence. The practitioner was also required to produce documentary evidence that they were properly trained and accredited in the undertaking of that procedure.

- Practising privileges for consultants were reviewed annually. As well as ensuring that GMC and MDU memberships were up to date, the review included all aspects of a consultants' performance, including a review of their annual appraisal, volume and scope of activity plus any related incidents and complaints.

Multidisciplinary working

- Medical and nursing staff reported good working arrangements and relationships with the local NHS hospital.
- We observed effective team working among management, administrative, clinical, nursing and ancillary staff during our inspection.
- Discharge letters were sent to the patient's general practitioner (GP) with details of the treatment provided, follow up arrangements and medicines provided on the day of discharge.

Seven-day services

- The hospital undertook elective surgery only with lists planned in advance six days a week.
- Consultants were on call 24 hours a day for patients in their care.
- There was 24 hour RMO cover in the hospital to provide clinical support to surgeons, staff and patients.
- The hospital had on-call arrangements for theatres, radiology and physiotherapy services.
- During out of hours, if a prescribed medicine was not available on the ward, the RMO could access the pharmacy with a nurse present

Access to information

- There were arrangements to ensure staff had necessary information to deliver effective care. For example, staff had access to NHS notes for patients receiving treatment commissioned by the NHS. This meant when a patient was admitted for surgery clinicians had all the necessary information such as test results to hand.

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Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff we spoke with were clear about their responsibilities in relation to gaining consent from people, including those who lacked capacity to consent to their care and treatment.
- The hospital had a consent policy that staff were familiar with.
- The theatre manager explained patients were not allowed to be taken to theatre without having a completed consent form.
- We looked at four sets of notes and saw consents were fully completed, signed and dated by the consultant and patient. The forms identified the procedure planned and the associated risks and benefits. The hospital consent forms complied with Department of Health guidance.
- Staff we spoke with were aware of their role with regards to the Mental Health Act and gaining consent from patients who may lack capacity. In addition there was an awareness of their role with regards to Deprivation of Liberty Safeguards. Training had been provided.

Are surgery services caring?

Good 

Surgery services were caring.

Patients were supported, treated with dignity and respect, and were involved in planning their treatment and care. Feedback from patients, those who were close to them was positive about the way staff treated and cared for them.

Patients understood their care, treatment and condition and associated costs where applicable prior to treatment. Patients were communicated with and received information in a way that they could understand. There were appropriate arrangements to support and meet patient and staffs emotional needs.

Compassionate care

- Patients told us they would be happy for their family to come to the hospital for an operation.

- We observed good interaction between nurses, allied professionals and patients. The physiotherapist was observed to explain and ensure the patient understood before taking them through an exercise.
- On admission patients were asked to provide their signed agreement to use their own prescribed medicines during their stay and permission was also sought to display their name on their room door.
- People were spoken to in a courteous manner and their permission was sought before providing treatment, for example helping mobilise a patient to have a shower.
- Staff told us they felt they had sufficient time to spend with patients and their relatives. This was supported by the patients we spoke with. We saw 130 patient satisfaction survey results, which supported this view. However, response rates to the survey were not available.
- Patient feedback included comments such as, "I had a better experience here, I was fully informed about the proposed treatment, had reassurance from nurses, there was lots of double checking and anticipation of my needs."
- The Friends and Family survey results for 2015 showed 84% satisfaction with the quality of care for all types of patient (NHS or insured/self-pay). The scores showed 89% would be willing to recommend the hospital to families and friends. These scores had been consistently high over the previous year.
- The Patient Led Assessment of the Environment (PLACE) score for ensuring patients were treated with privacy and dignity at the hospital was 89% during 2015 and the hospital had achieved a similar score of 90% in 2014. This meant there was a consistency in ensuring this aspect of care was met.
- Staff took measures to maintain the patient's dignity when attending the theatre for an endoscopy or minor procedure when they were required to remove outside clothing. The patient was provided with two gowns worn back and front or the patient was allowed to bring and wear their own dressing gown if they preferred.

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- This was a stipulation of the Joint Advisory Group (JAG) on gastro intestinal endoscopy. BMI Three Shires Hospital had achieved JAG accreditation which meant they met a set of patient focused recognised standards which were independently assessed.

Understanding and involvement of patients and those close to them

- Patients told us staff were kind and attentive. They felt they were kept well informed about their care and were involved in making decisions about their treatment at each stage. The costs were explained to them before admission. One patient told us, “They (the hospital and consultant) made sure we had all the information to decide if we could afford it.”
- Patients were allocated a named nurse on admission who managed the admission process and supported the patient during their initial pre and post-operative period.

Emotional support

- Staff told us they had time to spend with patients and their families to provide whatever emotional support they needed.
- A patient we spoke with told us the staff took time to listen to any concerns they had and provided reassurance.
- Pre admission assessments included consideration of patient’s emotional well-being.
- A counselling service for staff could be accessed through a confidential help line provided by the hospital.
- During theatre lists for ophthalmic surgical procedures performed under local anaesthetic, a health care assistant was routinely rostered to sit with patients during the procedure and hold their hand when required.
- There was a list of clergy for staff to contact to meet patients different spiritual needs when required.

Are surgery services responsive?

Good 

Surgery services were responsive.

Services were planned and delivered in a way that met the needs of the local population. Flexibility, choice and continuity of care were reflected in the services. Access to care was managed to take account of patient needs, including those with urgent needs. The appointments system was easy to use and supported patients to make appointments. The needs of different patients were taken into account when planning and delivering services, for example, on the grounds of age, disability or gender.

Care and treatment was coordinated with other services and other providers.

Waiting times, delays and cancellations were monitored and were managed appropriately.

It was easy for patients to complain or raise a concern and they were treated compassionately when they did so. Complaints and concerns were taken seriously, responded to in a timely way and listened to. Improvements to the quality of service had been made in response to patient feedback and concerns.

Service planning and delivery to meet the needs of local people

- The booking system was conducive to patient needs in that where possible patients could select times and dates to suit their family and work commitments.
- Theatre lists for elective surgery were planned with the theatre manager and bookings team to ensure all aspects were checked and considered before booking a patient on to the list to ensure patients safety and needs were met. This was done to ensure there was effective utilisation of available operating time.
- Considerations of patient’s age and gender and type of operation and equipment required were taken into account. The theatre manager explained when approving theatre lists checks were also made to ensure availability of other services such as radiology.

Access and flow

- The hospitals pre admission policy and local contracts ensured all NHS patients received a pre-operative assessment. All private patients over the age of 40 years were assessed. Those patients under 40 years of age were pre assessed depending on the type of treatment planned. This meant patients were identified as being safe for surgery and unnecessary cancellations were avoided where possible.

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- When procedures had to be cancelled or were delayed this was recorded as a clinical incident and appropriate actions taken. We saw that 2% of patients had their operations postponed or cancelled. For example some patients had not fasted correctly prior to anaesthetic. The hospital had revised the written instructions provided to patients to minimise this type of incident. Cancellations were rescheduled within 28 days and there was no distinction made between NHS and private patients. There were no breaches of the 18 week referral to treatment times for patients receiving their care under the NHS.
- The number of admissions and planned treatments dropped at weekends with the provision of only one operating list on Saturdays. This was to ensure there was sufficient nursing and medical staff available to provide safe care.
- Although there were sufficient scopes available for the types of procedures performed, for example cystoscopies and endoscopies, the planning of the theatre list took account of the sterilising turnaround time to clean scopes between patients. This was 35 to 42 minutes and the booking manager took this into account to ensure the patient did not experience unnecessary delays. There was an arrangement with the companies who provided the scopes, that if a scope was found to be faulty; an alternative scope was loaned to avoid any impact on patient flow.
- Staff began planning the patients discharge during the pre-admission process where they gained an understanding of the patient's home circumstances and likely care needs.
- Patients' discharge plans took account of their individual needs, circumstances, ongoing care arrangements and expected outcomes. Patients were discharged at an appropriate time and when all necessary care arrangements were in place
- Satisfaction with food including temperature and overall quality were evaluated through customer surveys and Patient Led Assessment of the Care Environment (PLACE). Current satisfaction rates with food were above 80%. Feedback included comments such as 'helpfulness of catering staff had deteriorated' although choice of food had improved. This information was displayed on the ward for patients and visitors. The hospital manager explained the catering service had recently been outsourced and they had experienced some inconsistency of service during the changeover in the past few weeks and were taking steps to resolve any disruption to the service.
- Throughout the hospital we saw information for patients about the services offered and how to access them.
- Patients told us they had been given detailed explanations about planned treatment in addition to written information. The hospital website also contained a range of procedure specific information which included information about various procedures, what to expect post operatively and how the patient could aid their own recovery. We also saw there was a range of procedure specific discharge instructions provided.
- Theatre lists were prepared to accommodate male and female patients separately for endoscopy procedures.

Meeting people's individual needs

- All patient areas of the hospital were accessible to patients and relatives who had problems with mobility. An interpreting service for patients who did not speak English was available and staff knew how to access it.
- Patients' special needs such as specific dietary requirements were identified at pre admission. However there was no provision for screening for people living with dementia or an appointed nurse lead to ensure best practice.

Learning from complaints and concerns

- The number of complaints received by the hospital had decreased year on year since 2012 from 55 complaints to 31 in 2014. The Care Quality Commission had not received any complaints about the service during 2014.
- All complaints were reviewed by the Clinical Governance committee to identify trends and ensure complaints were managed in accordance with the hospitals Complaints policy.
- Staff we spoke with were familiar with the complaints policy and their responsibilities if a patient or relative raised a concern. One staff member said, "We always try to resolve the complaint there and then if we can, but we also let the director of nursing know when a patient was not happy with the care they received."

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- The patient guide available in the patient room folders provided a leaflet titled 'Please tell us' which encouraged patients to raise any concerns and explained how they would be managed.
- We saw examples of written responses to people's complaints once they had been investigated. Complaints were responded to in a caring manner and within the hospital policy's specified time frames.
- Complaints information was disseminated to heads of departments and the information was used for shared learning at department meetings.
- As a result of patient feedback the hospital had revised its discharge arrangements. The hospital had reviewed staffing levels on the ward during the busiest periods and increased staffing levels during the peak times to ensure administrative discharge was completed in a timelier manner. The patient feedback had improved as a result.

Are surgery services well-led?

Requires improvement 

The service overall at BMI Three Shires Hospital required improvement with regards to being well led. However, within the surgical services, there were elements that were good.

There were integrated governance arrangements in place to minimise risk to patients and ensure shared learning. However, hospital wide, the terms of reference and what happened in practice differed.

The Clinical Governance Committee, did not discuss in detail appropriate categorisation of incidents, or if suitable action had been taken following incidents. Appropriate action following incidents was not always taken in both the CG and MAC.

There was no evidence that reports circulated prior to meetings had been read and the minutes showed that there was a subsequent lack of action.

The risk register did not show corporate risks that may affect the hospital.

The risk assessment process failed to consider the impact and likelihood of the risk happening.

The hospital management team were highly visible. There was a statement of the hospitals values, based on quality and safety. Staff were aware of the new values recently introduced but these were not yet embedded.

The information used, within surgery reporting performance, management and delivering quality care was accurate, valid, reliable, timely and relevant.

People's views and concerns were encouraged, heard and acted on. Information on patient experience was reported and reviewed alongside other performance data. Performance issues were escalated to the relevant committees and the board through clear structures and processes. Clinical and internal audit processes functioned well with evidence of actions taken to resolve concerns.

Leaders encouraged cooperative, supportive relationships among staff so that they felt respected, valued and supported. The leadership actively promoted staff empowerment to drive improvement and a culture where the benefit of raising concerns was valued.

Vision, strategy, innovation and sustainability for this core service

- A new version of the company's values had been launched four weeks before the inspection. However there was no specific vision for the Three Shires Hospital. Although staff had received a presentation about the changes they were not fully familiar with the details. Staff we spoke with were able to describe the key principles. One staff member said, "To be honest I am more familiar with the old values but the new ones are similar." Information about the values was displayed in the ward areas.

Governance, risk management and quality measurement for this service

- There was regular review of the performance of BMI Three Shires at the monthly meetings of the Board of Directors of Three Shires Hospital Limited. In addition, BMI Three Shires had its own internal committee structure in place. The clinical governance (CG) meeting being its focal committee, with other sub-committees reporting to it. Terms of Reference for CG specified the membership, quorum and responsibilities as well as listing its sub-committees.
- There were a total of five sub-committees listed in the terms of reference, namely:

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- Resuscitation
- Hospital Transfusion
- Infection Prevention and Control
- Medicines Management
- Radiation Protection

- As part of the inspection process we were provided with a diagram depicting the CG sub-committees which differed from its terms of reference. The structure chart indicated there were 10 sub-committees and included health and safety, resuscitation, quality, infection prevention control as well as other departmental matters. Responsibilities of the CG included review of governance and regulatory compliance including provider visit reports, and regulator reports (for example, CQC, Health and Safety Executive (HSE) and Medicines Healthcare Regulation Authority).
- Some of the governance processes we saw reflected the hospitals Clinical Governance policy. This included the requirements to use a standard agenda, ensure sub committees provided reports, such as from the medicines management committee and what information was to be reported to the regional team.
- The CG committee considered a range of complaints, incidents, health and safety issues, patient satisfaction and claims. In addition, local audits, patient safety and care were included to ensure actions were completed by target dates.
- We reviewed a sample of minutes for each committee and found that in general, each set of minutes lacked detail of discussions held. For example, clinical incident reports had been shared at the March 2015 CG committee, the minutes recorded that reports had been 'read ahead' of the meeting and no trends/concerns identified. There was no further discussion, for example, how many incidents there had been or whether they were being appropriately categorised, or if suitable action had been taken following the incidents.
- Items discussed at CG meetings were not always shared at other meetings as required. For example at the March 2015 Clinical Governance meeting, it was agreed as an action that the next Clinical Heads of Department meeting (CHODs) should include as an agenda item, the process in recovery. This was following concerns being discussed around anaesthetists not remaining in theatre whilst patients were still in recovery. In addition

there were issues described around prescription charts not always being signed by a doctor before handing over to ward staff. From review of the next sequential CHODs meeting minutes, we saw that this had not been listed as an agenda item. The issues around prescription charts being signed, was included as a reminder under, 'Any Other Business' but there was no minuted discussion regarding anaesthetists leaving theatre whilst patients were still in recovery.

- The CG meetings included input from each hospital department and outcomes of the meeting were disseminated back to heads of department to discuss with their staff at departmental meetings. We saw the minutes of meetings for both the wards and operating theatres. Feedback to the operating department staff was very thorough. Some of the ward staff we spoke with said such information had not been shared with them.
- Audit results and proposed actions were reviewed in a range of topics such as medicines management, water safety, infection control and health and safety.
- The hospital participated in national audits including the National Joint Registry, Patient Reported Outcome Measures (PROMS), Friends and Family tests and Patient Led Assessment of the Environment (PLACE).
- We asked where performance indicators were discussed, the staff we spoke with were uncertain. One manager told us, performance was discussed at the quality committee, another told us it was discussed at the TSHL Board meetings. We found no evidence of performance as an agenda item at the quality meetings. Terms of reference for the quality group were requested but not provided.
- The Medical Advisory Committee (MAC) met quarterly, despite the terms of reference stating it met monthly. It was attended by a group of consultants who held practicing privileges and represented their colleagues with BMI Three Shires. Its terms specified membership, quorum and responsibilities which included regulatory compliance, practicing privileges, quality assurance and proposed new clinical services and techniques.
- The MAC carried out checks before granting new consultants practicing privileges, including checks on their scope of practice to ensure they were undertaking procedures that they were not competent to do.

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- Consultants were required to produce evidence annually of their professional registration, revalidation, indemnity insurance, appraisal, mandatory training and continuous professional development before their admitting privileges were renewed.
- We saw evidence of anaesthetists and consultant surgeons being reviewed and discussed at the MAC. Consultants had their practising privileges suspended by the Executive Director if they did not provide the relevant information in a timely manner.
- Temporary privileges could be granted, if for example a specialist opinion from a consultant was required, who did not have privileges. Again, an up to date CV, references, professional registration, revalidation, indemnity insurance and appraisal were required before temporary privileges were granted.
- The Medical Advisory Committee was responsible for receiving and reviewing clinical audits. We saw reported in the minutes for the March 2015 meeting, that audits had taken place, including hand hygiene, in theatre and recovery, all with good outcomes. There was no further discussion and the minutes did not state what the other audits were. At the same meeting, incident reports for November, December 2014 and January 2015 had been received. Minutes stated reports were taken as read and that there were no areas of concern to report.
- The risk management process had been outlined in a flowchart which explained that once a risk had been identified it should be rated using a specific formula and specified action to be taken according to the risk. The actions ranged from ensuring control measures were in place up to referral to BMI's Regional Director. However, the risk assessment process failed to consider the impact and likelihood of the risk happening and instead asked for an overall assessment of its seriousness. This may have failed to prompt staff to consider this part of the assessment process.
- BMI Three Shires had developed a central risk register. The risk register was developed from risk assessments undertaken by each ward/department within the hospital.
- When we reviewed the risk register we identified that corporate/strategic risks had not been considered. We asked the Executive Director if there was a separate risk register for higher level risks but he confirmed this was the only risk register in place. All risks were operational with the majority relating to equipment or the environment. The risk description did not always

describe the risk. One of the risks read: 'It was discovered that the back-up battery for the theatre lights had been damaged along with some of the circuits and therefore the process of 'back up' would fail'. This had identified a fault but did not explain what the risk to staff or patients actually was. For example that if the lights were to fail, surgery may need to be halted or cancelled. The mitigating control recorded on the register was: 'To be monitored whilst replacement of the damaged battery system is sought' with the recorded action, 'Replacement of the damaged battery to be implemented.' The risk was owned by the Facilities Manager with a completion date of November 2015. The date the risk was identified was not recorded; therefore it is unclear how long the battery had required replacement.

- There was one risk related to surgery and another related to endoscopy. Control measures were in place to minimise the impact of these risks.
- Following the inspection, we reviewed of BMI Three Shire's Business and Quality Improvement Plan and found that this included some strategic risks, four risks had been identified. These risks had been assessed for their likelihood and impact. Mitigation plans for these risks lacked detail and in one case where a risk had been assessed as high for both likelihood and impact, there was no mitigation plan in place with any details of whether one would be developed.
- Review of the risk register did not form part of the terms of reference for the CG or the MAC and we did not see evidence of discussion in minutes for these or any other committee meetings reviewed. It was noted however, in the March 2015 CG minutes that it had been recorded there were no risks to discuss.

Leadership/culture of service

- Patient's medical care was personally provided by their consultant.
- The Executive Director regularly visited the wards and introduced himself to patients. We observed the senior managers speaking with patients who clearly recognised them.
- Staff told us the Executive Director, Director of Nursing and the acting ward manager were highly visible and if required provided assistance. This level of support was

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valued by staff. One example given by staff was where the manager assisted with a moving and handling issue telling staff, "I have done my manual handling training so let me help."

- The theatre manager described how they were empowered to safely manage the theatre bookings and lists to ensure financial considerations did not take priority over safety.
- Staff in the theatre department felt they had strong effective leadership from the theatre manager. They held a daily meeting to brief staff on any day to day issues and ensure all team members were involved and had input into decisions made. Copies of the notes from the meetings were displayed in the theatre corridor for staff and consultants coming in to the theatres to refer to.
- There had been low staff turnover and sickness rates for all staff groups during 2014.
- Staff felt they could raise concerns. They told us they could go to the senior managers with anything and that they would always listen.






Public and staff engagement

- BMI Three Shires sought feedback from patients, whether they were funded privately or by the NHS via a monthly survey as well as the Friends and Family test. The Friends and Family test was specifically designed for

NHS patients (although BMI Three Shires uses this to gauge feedback from all patients) and included simple questions about the quality of the service and whether the patient would recommend it to their friends and family. Feedback was consolidated into a monthly report.

- We saw that the patient satisfaction reports were presented at the Quality Group meetings. The minutes from the April 2015 meeting showed that the patient satisfaction report for February had been presented although there was no evidence of discussion recorded in the minutes. The minutes stated the report had not been circulated but was available if required. The only action from this section of the minutes was for departments to count how many questionnaires were being sent for analysis. There was no evidence of discussion around any issues which may have been identified in the patient feedback report.
- Overall findings reported in the patient survey report for April 2015 was positive. The report was 68 pages in length which provided a detailed breakdown of all findings, although this made it cumbersome to glean information at a glance. There was a summary dashboard at the beginning of the report which provided details on the top five areas which were most improved as well as the top five areas which had seen the biggest decline, by comparison to the previous year.

Services for children and young people

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

Information about the service

BMI Three Shires Hospital is situated within the site of another hospital in Northampton and is managed by BMI Healthcare, a provider of independent healthcare with a nationwide network of hospitals and clinics.

BMI Three Shires Hospital has 53 registered beds and most rooms offer the privacy of ensuite facilities, satellite TV and telephone. The hospital has three theatres, an endoscopy and minor procedures room and a four bed day unit. However, the hospital did not have rooms dedicated specifically to children. The hospital sees about 112 children and young people a year, all on a private basis, which included both surgical day patients and outpatients.

The environment was visibly clean and staff followed the hospital's policy on infection control.

As part of our inspection we visited the children and young people's service. We were not able to observe the care and the treatment of patients as there was no consultations or surgery taking place during our inspection. We spoke with four parents after the inspection. We spoke with eight staff. These included children's nursing staff, a resident medical officer, (RMO) a pharmacist, domestic staff, administration staff and senior managers. We viewed ten records. We reviewed performance information about the service.

The hospital had two surgeons who conducted surgical procedures on children which included for example; tonsillectomy. They saw children from the age of three years to sixteen years old.

Summary of findings

Overall we found the children and young people's service required improvement in safety, effectiveness and responsiveness. Well led was inadequate and caring was inspected, but not rated, as there were no children or young people in the hospital at the time of our inspection.

The service demonstrated that care was provided in accordance with evidence-based national guidelines, although care was not monitored to demonstrate compliance with national standards.

Safeguarding systems were in place and staff knew how to respond to safeguarding concerns. However, not all staff who worked with children and young people were trained to an appropriate level of safeguarding. The hospital did not have a system to identify children or young person who may be at risk of abuse.

Consent forms were signed in line with DoH guidelines. All children and young people had a valid consent form prior to their procedure taking place. However, staff were not aware of processes around Fraser Guidelines but did recognise the Gillick competency assessment.

Staff were encouraged to report any incidents and there was consistent feedback and learning from incidents reported. Staff were aware of the Duty of Candour ensuring patients received an explanation and apology if something went wrong.

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Staff had access to training and had received an annual appraisal. There was no formal supervision of the nursing staff. Senior managers were aware of this shortfall in supervision and said they were reviewing this process.

The staff we spoke with, did not ensure that nursing staff who did not hold specialist registration, had the appropriate skills to provide safe and effective care. There was no monitoring of registered nurses skills and competencies which led to staff with no paediatric training caring for children.

There was no one person who had clear responsibility for leading the service for children and young people.

Parents told us patient's pain was appropriately managed as was their nutrition and hydration, but we found that pain assessments were not completed consistently.

Staff had awareness of the Mental Capacity Act (MCA).

During our inspection there were not any children and young people attending for outpatient appointments or for surgery and we were unable to observe the interaction between nursing staff, children, young people, parents and/or carers. We spoke with four parents by telephone to obtain their feedback on the service provided by the hospital. Parents said their child was treated with dignity, respect and compassion. This was extended to parents. Staff involved children and their parents/relative in decisions about their care and treatment, and they were supported and reassured if they were anxious or concerned.

The children and young people services were responsive to their patient's needs. Children and young people were admitted to and discharged from the hospital at appropriate times. The hospital provided a 48 hour telephone follow up support service.

Patients with a learning disability were provided with support. Staff had access to translation services, although this did not extend to a sign language interpreter.

Premises were not modified for children, they were allocated to adult rooms, although there were toys and games available. Children and young people could access the right care at the right time. Complaints were dealt with in line with hospital policy.

Most staff were not aware of the vision or strategy for the service. The hospital governance processes focussed on risk and quality but we found they did not identify the objectives for the children and young people's service.

We saw the risk register and there were no risks identified for the children and young people service. In addition, completed audits did not identify the children and young people service. This meant that we could not be assured that risks were assessed, monitored and mitigated against.

Children and young people were not engaged through survey feedback. Senior managers told us they were in the process of introducing a "smiley face" questionnaire for the service.

There was a positive awareness among staff of the expectations for patient care.

Services for children and young people

Are services for children and young people safe?

Requires improvement 

We found the children and young people's service required improvement with regards to safety.

Staff said they were encouraged to report any incidents which were discussed at staff meetings. There was consistent feedback and learning from incidents reported. Staff were aware of the Duty of Candour ensuring patients received an apology when something went wrong.

The environment was visibly clean and staff followed the hospital policy on infection control. There were systems in place to check the equipment used. However, the registered nurses did not ensure that the equipment that was used for children and young people's treatment was adequate and fit for purpose.

Safeguarding systems were in place and staff knew how to respond to safeguarding concerns. Only one of the registered nurses had been trained at the appropriate level to support children and young people who used the service. The registered nurses said they were unaware if staff who usually cared for adults, who worked intermittently with children and young people were trained at the appropriate level. The hospital did not have a system to identify children or a young person who may have been at risk.

Staffing levels were adequate for the service provision. The hospital had processes in place to attend to risks associated with emergencies.

Incidents

- There had been no "never events" reported in the children and young person services between January 2014 and December 2014. A never event is a serious incident that is wholly preventable, as guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and should have been implemented by all healthcare providers.
- There had been no serious incidents reported for the children and young person services between January 2014 and May 2015.

- The children and young people's service used an electronic system to record incidents and staff said they knew how to report incidents. Staff were able to describe the types of incidents they would report for example, errors with the administration of medicines. We saw this was reflected in the meeting minutes on display in the staff room.
- Staff that we spoke with said the feedback from incident investigations was shared with staff during staff meetings.
- Staff understood their responsibilities with regard to the Duty of Candour legislation. The Duty of Candour legislation requires an organisation to disclose and investigate mistakes and offer an apology. Staff described a working environment in which any mistakes in patient's care or treatment would be investigated and discussed with the patient and their representatives and an apology given whether there was any harm or not. Staff were able to describe the process to follow involving a conversation with a patient, a parent or carer by explaining what had happened and how they would provide assurance this would not occur again.

Cleanliness, infection control and hygiene

- We saw that the most of the areas we visited were visibly clean and we observed cleaning taking place.
- We saw the weekly toy cleaning log. In addition, toys were cleaned after use and prior to being put away.
- Staff were aware of the hospital policy on infection control. The 'bare arms below the elbow' policy was adhered to.
- There were hand-washing facilities and protective personal equipment, such as gloves and aprons available. Hand sanitisers were provided in the consulting rooms and treatment areas at the point of care.

Environment and equipment

- On the ward, staff told us that children and young people were cared for in the rooms which were closest to the nurse's station. This ensured they could be easily observed by staff.
- Rooms provided by the hospital were not specifically set up for children from a safety point of view. For example, the rooms did not have covers on the plug sockets so that they could not be tampered with by a child. There were no rooms used solely for caring for children. However, no children were receiving treatment at the

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hospital at the time of our inspection, so we were unable to verify what adaptations might have been made to patient rooms to ensure these were suitable for children.

- There was a system for checking resuscitation and other equipment in the outpatients and ward areas. The records identified inconsistencies in the recording of the resuscitation checks. For example, we saw that between May 2015 and June 2015 there were six days when the checklist had not been signed. The checking of the resuscitation equipment on the ward, was carried out by delegated staff. We found that the registered nurses were unaware of the shortfall in the checking of the resuscitation equipment and did not ensure the equipment was safe for use by children and young people. One registered nurse (child branch) told us that they did not check the equipment prior to surgery.
- The hospital did not have systems in place to audit the safety of rooms being used by children and young people.
- We saw the monthly department workplace inspection for April 2015. This identified areas of concern and the actions taken. Examples included up to date electrical portable appliance testing (PAT) and personal protective equipment.

Medicines

- Medicines were stored correctly, including in locked cupboards or fridges where necessary.
- Paediatric pharmacists provided support when required and reviewed medicines.
- The pharmacists told us most medicine doses were based on the children or young person's height and weight. The pharmacists said they predominantly dispensed over the counter medicines which were safe for use without the child's or young person's height and weight being taken into account. They said that should they have an uncommon medicine prescription this would be checked thoroughly using height, weight and whether the medicine was licenced for children's use. We saw from the 10 records read that four children adults had not had their weight recorded on their medicine chart. This was brought to the attention of the pharmacist who told us they were able to additionally check the anaesthetic records to confirm the person's height and weight. We were able to confirm that the children and young peoples' weights were recorded on the anaesthetic sheets.

- The RMO said all medicines for children and young people were prescribed by the consultant. They said they linked all medicines with the British National Formulary (BNF). We saw this was in line with hospital protocol.

Records

- We reviewed 10 records of children and young people using the service. Medical and nursing records were in paper form and followed the same format which meant information could be found easily.
- The records read, which included admission details, were legible which was in keeping with General Medical Council guidance.
- Records were stored safely in accordance with hospital policies.
- Vital signs such as nutrition and hydration were well documented and we saw observations of temperature, pulse and respirations were clearly recorded.
- Most nursing assessments were documented for example; nausea assessments. However, of the 10 records read, we found only one had a completed pain assessment.
- Records were designed in a way that allowed essential information, for example, allergies and medical history to be documented and easily viewed. The records contained treatment details and care plans. This meant that staff had access to information on how to care for a child or young person.

Safeguarding

- Staff were able to explain safeguarding arrangements and said they would raise any queries with the director of nursing. Staff were able to describe when they might be required to report issues to protect the safety of vulnerable patients. We saw a flow chart in place which outlined who to contact and how to escalate any concerns.
- The hospital used the Working Together to Safeguard Children (2013) guidelines. Senior managers told us the guidelines were used to ensure staff were suitably trained. We observed the document did not incorporate the changes to the Working Together to Safeguard Children as of March 2015.
- The Royal College of Nursing states that all nurses who may come into contact with children and young people, including ancillary and office staff should receive mandatory safeguarding training at level two with

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annual updates. We found that all staff who dealt with children and young adults had not been adequately trained to the correct level. This was confirmed in the training records that we saw.

- The registered nurses (child branch) had been trained in safeguarding. One had level 3 training and the other said they had received awareness training (level 1) in safeguarding. However the hospital subsequently confirmed the staff member in question had actually undertaken level 2 training.
- In addition the director of nursing had undergone level 3 training. However, when reviewing when children and young people were being operated on, we found that the registered nurse (child branch) who had the level 3 training wasn't always on duty. This meant that children and young people were, on occasions, looked after by a registered nurses, and adult nurses who had not undergone level three safeguarding training.
- The National Institute of Health and Clinical Excellence (NICE) guidelines for when to suspect child maltreatment (CG8) outlines the "alerting features" that may be observed when a child presents with both "physical and psychological symptoms that may constitute alerting features of one or more types of maltreatment." The hospital did not have an alert system to identify children or young adults who may be at risk of maltreatment.
- We found that both medical and nursing staff were unaware of "disguised compliance". Disguised compliance involves parents giving the appearance of co-operating with child welfare agencies to avoid raising suspicions and allay concerns away from allegations of harm.
- Senior managers said if they had any concerns about the way a member of staff or parent behaved towards a child they would make a referral to the Local Authority designated officer.

Mandatory training

- We spoke with the RMOs on duty who told us they had been trained in European Paediatric Life Support (EPLS).
- We saw there was updated training in place for the Advanced Paediatric Life Support (APLS). The children's nurses both had undertaken their APLS training. This meant that staff had the necessary training to support children and young people in the event of an emergency.

- The RMOs said they had not been specifically trained in paediatrics but said they were confident in the management any child or young adult attending the hospital. Senior managers told us that they ensured that all doctors involved in treating children and young people were competent in dealing with and supporting them. They said the child's consultant was also available to support any issues or concerns.
- The Royal College of Nursing states that all staff in contact with children and young should be trained in the development, psychological and communication aspects of care. The registered nurses (child branch) told us they could not ensure that the staff's nursing skills were suitable within the wards to look after children and young people. Senior managers told us they were aware of the shortfall in the competencies of staff and were reviewing this to ensure that all staff had the appropriate training and ability to support and care for children and young people with regards to psychological care.
- The registered nurses told us they had completed their mandatory training which was confirmed in the records seen.
- We found that the hospital did not ensure that recovery nurses had specific competencies in children and young people's care. This meant that children and young people were looked after by staff who did not have the necessary qualifications to ensure their safety and well-being.

Assessing and responding to patient risk

- Risks to children and young people who used services were not always assessed, and their safety monitored and maintained.
- Children and young people attended the hospital for outpatient consultations and day surgery procedures. On occasions where children were not well enough to be discharged, there was a formal, written transfer agreement in place for patients to be transferred to another hospital. However, this was an extremely rare occurrence. The staff we spoke with said they could not ever remember this happening.
- The department used a Paediatric Early Warning Score (PEWS) system to alert if a child's clinical condition deteriorated.
- Nursing staff we spoke with were aware of the appropriate action to take if the patient's score was higher than expected.

Services for children and young people

- The 10 completed PEWS charts we looked at showed that staff had escalated correctly, and repeat observations were taken, when required, within the necessary time frames.
- The hospital did not have an audit of the PEWS at the time of our inspection.

Nursing staffing

- The director of nursing said that the staffing levels for children and young people had been recently reassessed. They told us they had increased the levels of children's nursing staff and said the service was fully staffed. There was always at least one registered nurse (child branch) on duty for children over 12 years and two nurses if a child was younger. However, children were on occasions, cared for by adult nurses, under the supervision of the children's nurses, with no specific training to do so.
- We reviewed the staffing levels and they were in line with the recommendations of 'Mandatory Nurse Staffing Levels' as outlined by the Royal College of Nursing (RCN 2012) which states that there should be one nurse to every four children over two years of age. Children on the wards were often looked after by adult nurses with a registered children's nurse present.
- The two children's nurses had Nursing and Midwifery Council specialist registration and experience which meant they had the knowledge and skills to care for children.
- During our inspection there were no children and young people procedures happening within the hospital and the children's registered nurses were utilised within the wards caring for adult patients.
- Surgery on children and young people was undertaken once a month on a specific day in order that staffing could be planned appropriately.

Medical staffing

- All consultants were registered with the General Medical Council (GMC). This meant patients could be assured that they were treated by competent and registered practitioners.
- There was 24-hour, seven days a week, RMO cover, which was shared with adult patients, for the children and young people's service.

- The children and young people services had allocated appointment days with the consultants which meant they were able to have the appropriate staff to attend their clinics.
- Although the surgeons and anaesthetists who operated on children did not do so exclusively, they had received specific training to treat children and did so in their NHS practice.
- The surgeons who operated on children did so within the NHS practice. We saw that as part of their annual practising privileges renewal, their scope of practice included the type and number of procedures they were undertaking in the NHS. The type of procedures being undertaken at BMI Three Shires reflected their NHS practice. This meant the surgeons were undertaking procedures that were within their routine practice and skill set.
- The surgeons utilised the services of specific anaesthetists with who they worked with regularly and who had, according to their scope of practice, the training and skills to administer anaesthesia and care for children and young people, during the pre-operative, peri-operative and post-operative phases.
- Paediatric physicians saw children in the outpatient clinics.

Major incident awareness and training

- Major incident training was included within the staff induction programme which included for example, fire training. We saw the children's nurses had completed training and said they were aware were aware of what to do in the event of a major incident.
- The hospital had a business continuity plan in the event of an electronic system failure.

Are services for children and young people effective?

Requires improvement 

The children and young people services required improvement to demonstrate effective care.

Services for children and young people

The service demonstrated that care was provided in accordance with evidence-based national guidelines. We saw that the policies had been reviewed and were in line with NICE guidance. However, we found that care was not monitored via audit to demonstrate compliance.

The records showed that the children and young people's needs were being met by the surgical team. However, we saw no evidence of any referrals or escalation to other health professionals for example; health visitors and/or school nurses.

Parents told us that their child's pain was appropriately managed, but medical records showed that pain assessments were not completed in most cases.

Senior managers were aware of the lack of formal nursing supervision and told they were reviewing the process.

The children's nurses and more senior nurse managers had knowledge of the Gillick competencies. This is a term used to assess whether a child (16 years or younger) is able to consent to his or her own medical treatment.

Policies and procedures were accessible for staff on the hospital's intranet system.

Staff had received their annual appraisals. Staff had awareness of the Mental Capacity Act (MCA).

Evidence-based care and treatment

- The hospital had a Care of Children policy which was in line with the Department of Health's guidance on National Service Framework for Children. We saw the Care of Children Policy and found this had been recently updated and was due to be communicated to all staff. This meant the hospital had undertaken some steps to ensure that children and young people were cared for in line with best practice.
- Anaesthetists undertaking procedures on children worked within the Royal College of Anaesthetists "Guidance on the provision of Paediatric Anaesthesia Services," 2013.
- Staff were able to show us how to access policies and procedures using the hospital's electronic system.
- The hospital did not have audits specific to the children and young people's service. This meant that care was not monitored to demonstrate compliance with the

NICE guidelines (CG89) when to suspect child maltreatment and the Royal College of Paediatrics and child health (RCPH) guidelines, for example, allergy care pathways and decreased consciousness levels.

Pain relief

- We found of the 10 records read; only three had completed pain assessments. Parents we spoke with told us that their child's pain had been well managed.
- The medicine records showed clear prescribing of pain relief, the time, route and dose of the medicine administered.
- Parents said the nursing staff were "brilliant" in distracting children and young people who were experiencing pain and required pain relief involving the use of needles.

Nutrition and hydration

- The nursing records we reviewed held a copy of the Screening Tool for the Assessment of Malnutrition in Paediatrics (PYMS) which were completed.
- We saw that food and fluid charts were maintained when required.

Patient outcomes

- During our visit we found that the hospital did not have an audit programme which was specific to the children and young people's service and therefore we were unable to see outcomes in relation to this service. Senior managers told us they did not complete any audits in relation to children and young people. This meant that there was no assurance that risks were assessed, monitored and mitigated against,
- The children's and young people's service was small and surgery was undertaken intermittently. However, the hospital did not have play specialists to support children and young adults during their visit to hospital.

Competent staff

- Medical staff told us there was access to clinical supervisors within the hospital.
- The director of nursing told us and we saw that, any surgeon or anaesthetist operating or anaesthetising children, had to demonstrate via their scope of practice document, reviewed at the MAC, that they had the experience and competence to do so. In addition, the scope of practice was reviewed annually in line with maintaining practising privileges.

Services for children and young people

- There were surgeons dedicated to conducting surgery on children within the hospital, which reflected their NHS practice. The director of nursing confirmed and we saw supporting documentation to demonstrate, that all surgeons were appraised and deemed competent to carry out their role within the hospital.
- When children were seen in the outpatients department, one of the registered nurses (child branch) was present within the hospital and could be called on if required.
- Staff confirmed they had received annual appraisals. These processes covered training and development needs and practices.
- Registered nurses said they had not received any supervision. The director of nursing said they were aware of the shortfall in supervision and this was a work in progress. They said there were currently reviewing the supervision process and structure.
- Registered nurses said they were not encouraged to review or monitor staffs' competencies when they were working with children and young people.
- The hospital did not have a competency framework in place to ensure that nursing staff could demonstrate they were competent to care for children and young people. This meant there could be a risk that staff did not have the appropriate skills to support the care and treatment of children and young people.
- Children's short stay cover was provided by the surgical and/or surgical anaesthetic consultant who remained within the hospital until the child was discharged from recovery. Following this they were available by telephone.
- There were facilities for radiology and physiotherapy on an on call basis, should they be required out of hours.

Access to information

- Staff were aware of the process to request medical records which was in line with the hospital policy reviewed.
- We were informed that hospital medical records were not removed off site by consultants. The consultants had their own medical records, managed by the medical secretaries, which stayed with the patient whilst they were in the hospital.

Consent

- Of the 10 records read, we saw that only one of the records evidenced that consent to their procedure had been signed by a young person. We did not see processes in place for young people who were old enough to consent, having their care and treatment discussed with them. The other nine records showed that the parents and/or carers of children and young people were asked for their consent to treatment and procedures.
- The hospital's Care of Children policy identified the Gillick competencies which assessed whether a child under the age of 16 had the maturity to make their own decisions and to understand the implications of those decisions. Staff we spoke with were aware of these guidelines.
- Staff were aware of The Mental Capacity Act 2005 and could show how this related to the children and young adults they cared for.
- Staff we spoke with confirmed they had received training regarding MCA which was identified in the training records seen.

Multidisciplinary working

- Staff said they had good working relationships with other colleagues which included consultants. We saw good communication between the administration staff, nursing staff and medical secretaries.
- We saw two children's records which indicated that one child, according to their height, age and weight, was overweight and another underweight. There was no evidence of intervention, referral or escalation to a health professional, for example, health visitors or school nurses. This was brought to the attention of the director of nursing.

Seven-day services

- The children and young people's service had a doctor, the RMO, in attendance 24 hours per day.

Services for children and young people

Are services for children and young people caring?

Not sufficient evidence to rate 

This was inspected but not rated due to children not being present on site at the time of the inspection.

During our inspection there were not any children and young people receiving treatment in the hospital, so we were unable to observe the interaction between nursing staff, children, young people, parents and/or carers. We spoke with four parents after the inspection to obtain their feedback on the service provided by the hospital.

We found that children and young people received good care. Parents said their children were treated with dignity, respect and compassion. Parents said that staff involved children in decisions about their care and treatment, and they were supported and reassured if they were anxious or concerned.

The hospital did not gather children, young people or their relatives' feedback on the service provided. This meant the hospital was unable to use the patient experience to improve the service.

Compassionate care

- Parents said that staff cared for their child in a kind, compassionate and professional manner. They said that they were treated with the utmost respect and dignity throughout their treatment. They said nurses were attentive and were always in close proximity to their child.
- Parents spoke positively about the care provided by staff. One relative said staff were: "Brilliant." Another said the care was: "Fantastic."
- The hospital did not gather children, young people or their relatives/carers feedback on the service provided. This meant the hospital was unable to relate the care to the patient experiences to improve the service.

Understanding and involvement of patients and those close to them

- Parents told us they had been involved in decisions around the care and treatment their child received and that they were able to ask questions if they needed to.

- One parent told us that they were impressed with a consultant who had spoken with their teenager directly, rather than them. They said everything had been explained in easy terms which meant that their child could also understand the procedure.
- One parent said the risks and benefits of the proposed procedure had been explained to them. They said that their child had undergone a procedure before at the hospital and they were happy for the surgery to be repeated as the experience had been good.
- The nursing records we reviewed showed that staff had asked the parents for their opinion.
- One parent said they had been shown around the hospital two days before the procedure was due to take place. They said this ensured their child was relaxed and aware of what was going to happen.

Emotional support

- Parents said staff were passionate and driven to provide good care to patients. For example, one relative said they appreciated the time staff spent talking to their child who was disorientated after surgery. They said staff were very supportive.
- Because the service was so small and required only sporadically, other members of staff, for example, play leaders were not employed to assist with distraction and emotional support.

Are services for children and young people responsive?

Requires improvement 

The children and young people services were not always responsive to the needs of patients.

Not all patients were pre assessed in line with hospital policy. Discharge checklists were not always completed.

Children and young people were admitted to and discharged from the hospital at appropriate times. The hospital provided a 48 hour follow up support service. We found no measured outcomes to ensure this service was being provided.

There were no allocated rooms within the wards dedicated to children/young adults and their needs.

Services for children and young people

Patients with a learning disability were provided with the necessary support, including the services of a learning disability nurse. Staff had access to translation services although this did not extend to a sign language interpreter.

Facilities and premises were appropriate for the service being delivered. Children and young people could access the right care at the right time.

Complaints were dealt with in line with hospital policy.

Service planning and delivery to meet the needs of local people

- To ensure the safe planning of children's surgical lists, all operating dates were published in advance. This ensured that the hospital could plan and be compliant with the Royal College of Nursing guidance and standards which state a minimum of two registered children's nurses should be on duty throughout the time in which children are cared for.
- Staff told us that all children and young people being treated were pre-assessed prior to surgery. However, of the 10 records read we found that five (50%) did not have a completed pre-assessment.
- Children and young people undertaking procedures at the hospital had their appointments pre-planned.
- Staff told us when a child under 12 years attended outpatients, a registered nurse (child branch) was required to be on site and where possible in attendance to provide support and guidance.
- All children, young people, their relatives/carer received a follow up call within 48 hours of discharge. Parents we spoke with said they had received a follow up call from the consultant within 24 hours. However, we found no evidence of this being recorded or monitored to ensure all parents/carers received this service.
- Parents told us they were given a welcome pack which provided them with the information they required prior to accessing the hospital.

Access and flow

- All children and young people who were operated on at BMI Three Shires, were private patients.
- Staff told us any child or young person who may require extended observation, for example, following tonsillectomy, were routinely scheduled first on the operating list. This was confirmed by the director of nursing.

- The consultant reviewed the child prior to their discharge home. There was a discharge check-list in the nursing records. However, of the 10 records read, we found that three had not been completed or signed.
- Staff told us discharge took place up to 9pm, but they aimed for 7pm, so that the child or young person was not discharged too late.

Meeting people's individual needs

- The hospital did not have special rooms set aside to accommodate children and young people and the hospital did not adapt the rooms to ensure they suitable for children and young people's needs. Although children and young people were seen in the same environment as adults, there was an array of toys and books to occupy children. Senior managers told us they were considering introducing DVD's.
- There was support for children with a learning disability. The hospital had a dedicated learning disability nurse who was able to provide support to children during their visit to the hospital. Nurses told us they were able to access the specialist nurse when required. The children's nurse told us they had utilised the service of the specialist nurse to support a visit to the theatre for a young child who was anxious and distressed. Family members we spoke with told us they had visited the theatre with their child to allay their fears.
- Parents were able to accompany their children to theatres and recovery areas. The recovery room had a specific area especially for children, which was cordoned off from adult patients.
- There were no child-friendly or easy-to-read information leaflets available throughout the hospital.
- The hospital had access to Language Line to support a child or young person's needs. Staff were aware of the availability of translation services but said they had not had to use the service. Staff told us that children and young people were always accompanied by their parent or carer who would assist them during consultations with regards to translation. However, there were no facilities to support a child or young person should they require sign language services.
- We saw that children's toys were compliant with the British Safety Standards and CE marked.
- The outpatient area visited was bright and airy, and was child-friendly.

Learning from complaints and concerns

Services for children and young people

- Complaints were handled in line with the hospital's complaints policy. If a child, young person, parent or carer wanted to make an informal complaint, they would be directed to a senior staff member. Patients would be advised to make a formal complaint if their concerns could not be resolved informally.
- We saw information on how to make a complaint on display in the reception area of the hospital.
- There were no complaints reported in the children and young people's services

Are services for children and young people well-led?

Inadequate 

We found that children and young people services were inadequate with regards to being to be well-led.

There was no vision or strategy for the service.

We found there were no risks identified on the risk register for the children and young people's service.

There was no one person who had clear responsibility for leading the service for children and young people.

There was no monitoring of registered nurses skills and competencies which led to staff with no paediatric training caring for children.

Senior managers confirmed that they did not identify children and young people within the completed audits. This meant that we could not be assured that risks were assessed, monitored and mitigated against.

There was no system in place to support nursing staff supervision. The director of nursing told they were aware of the shortfall and were looking at various models to implement this.

Children and young people were not engaged through survey feedback. Senior managers told us they were in the process of introducing a "smiley face" questionnaire for the service.

The service held a monthly paediatric forum group which provided them with information on their service.

Governance processes had a focus on risk and quality and we saw the Business Unit plan 2014-15 for the hospital. However, the business plan did not identify the objectives for the children and young people service.

Within the service there was a culture of support and respect for each other. Staff told us they were able to speak openly about issues and concerns with the director of nursing and felt this was positive for making improvements to the service.

Vision, strategy, innovation and sustainability and strategy for this this core service

- The Business Unit plan 2014 -15 identified the new vision for the hospital which was to provide the best possible patient outcomes and experience by delivering quality services and care. However, the Business plan did not have any clear strategy or plan for the children and young peoples' service
- Staff said they were not aware of the hospital's vision and strategy. Senior managers confirmed that the vision may not have been cascaded to all staff at the time of our inspection.
- We requested to see the strategy for the children and young people's services. Senior managers confirmed there was not a specific strategy in place but the business strategy outlined the development and future growth of all services.

Governance, risk management and quality measurement for this core service

- Staff told us they received information from the monthly paediatric forum group which provided them with information on their service. The group was attended by senior managers, RMOs and surgeons.
- We reviewed the risk register but found there were no risks identified specifically for the children and young people's service.
- We reviewed the minutes of the CG and MAC meetings, but there was no evidence, apart from review of practising privileges, that items relating to or affecting children's services were discussed.

Leadership/culture of service

- The registered nurses (child branch) reported to the acting ward manager when on the ward. The children and young people's services designated lead was on

Services for children and young people

long term leave which meant there was no specific person leading the children's services. The registered nurses (child branch) said the director of nursing was available when required.

- Although the director of nursing was visible and approachable, there was no one person who had clear responsibility for leading the service for children and young people.
- Staff we spoke with said they did not consider their role accountable other than their bedside responsibility. They said they were not encouraged to lead and monitor staffs competencies when working with children and young people. This meant there was a risk that staff may not have the skills required to support the care and treatment of children and young people.
- The registered nurses said that other nursing staff rarely wished to work with children, as they were concerned that their skills were not adequate to care for children.

Culture within the service

- Staff said that morale within the service was good and they received support from the director of nursing.
- Staff said the director of nursing was proactive and listened to ideas to improve the service provided. An example included the amendment to contact forms used in the outpatient department.
- Staff said they worked well together as a team and were proud to work for the hospital.






Public and staff engagement

- Staff said they were able to share ideas and discuss any issues or concerns during team meetings. They told us if they were unable to attend they could include agenda items for discussion. We saw the minutes were displayed in the staff office.
- At the time of our inspection the senior managers told us they did not have a specific children and young people's satisfaction questionnaire. They told us they were in the process of introducing a "smiley face" questionnaire for the service. We were shown an example of the documentation, in draft form, they wished to implement.
- Staff recommended the hospital as a place to work or receive treatment. Staff told us there was good communication between senior managers and staff.

Innovation, improvement and sustainability

- The service was very small and had been set up to respond to local needs. There were no plans to expand the service.
- Staff told us the hospital had created an environment where all members of staff were recognised and rewarded regarding the improvements to quality. Staff said they were thanked by the director of nursing for the work they carried out.

Outpatients and diagnostic imaging

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

Information about the service

BMI Three Shires Hospital provides an outpatient service for various specialties to both private and NHS patients. This includes, but is not limited to, dermatology, gynaecology, ophthalmology and urology. The outpatient department also provides a minor operation service and has 11 consultation rooms.

35% of patients seen in the outpatients department are NHS patients.

Diagnostic imaging services are available on site at BMI Three Shires Hospital; however this service is provided under a Joint Venture Agreement with a separate company and was not part of this inspection.

We spoke with 31 patients, one relative and 10 members of staff, including nurses, healthcare assistants, consultants and support staff.

Summary of findings

Safety concerns were not consistently identified or addressed quickly enough. Cleanliness, hygiene and infection prevention and control risks were not adequately assessed and managed.

Potential risks to patients due to the environment and equipment were not adequately identified, including equipment on the resuscitation trolleys.

Systems, processes and standard operating procedures were not always reliable or appropriate to keep patients safe.

Monitoring whether safety systems were implemented was not effective. We found incidences of out of date medicine and FP10 prescription pads that were stored inappropriately.

There was limited evidence of how practice was audited against current evidence-based guidance, standards and best practice. Participation in external audits and benchmarking was limited.

Not all staff had the right qualifications, skills, knowledge and experience to do their job. Staff were supported to participate in training and development. There were gaps in support arrangements for staff, such as supervision.

Multi-disciplinary teams worked well together to provide effective care. Nursing staff did not always have the complete information they needed before providing care and treatment.

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Consultants had their own patient records and were able to access diagnostic results without any delays. Consent to care and treatment was obtained in line with legislation and guidance, including the Mental Capacity Act 2005 (MCA) by the consultants.

There was a lack of awareness by nursing staff regarding the MCA and why they would need to know this information. Not all staff had received MCA and Deprivation of Liberty Safeguards (DoLS) training.

Feedback from patients was positive about the way staff treated them. Patients were treated with dignity, respect and kindness during all interactions with staff. Patients were involved in their care and in making decisions, with any support needed. They received information in a way that they could understand, including the risks and benefits of potential surgery. Patients' privacy and confidentiality was respected at all times.

Services were planned and delivered in a way that met the needs of the local population. Access to care was managed to take account of patient needs, including those with urgent needs. Waiting times and cancellations were managed predominately by medical secretaries. Data on waiting times and cancellations was not collated. Services ran on time; however patients were kept informed of any disruption/delays to their care or treatment. Complaint information or how to raise a concern was available for patients. Complaints and concerns were always listened to, taken seriously and responded to in a timely way.

The strategy for outpatient services was not underpinned by detailed, realistic objectives and plans. Some staff had limited knowledge regarding the vision for the hospital. The arrangements for governance did not always operate effectively. Risks and issues were not always dealt with appropriately or in a timely way. Not all leaders had the necessary experience and knowledge to lead the service effectively, although staff satisfaction was good. Staff felt supported, valued and able to contribute to the development of the service. There was a limited approach to obtaining the views of patients. Feedback was not always reported or acted upon in a timely way. Improvements were not always identified or action not always taken.

Are outpatients and diagnostic imaging services safe?

Requires improvement 

The safety of outpatient services required improvement.

Safety concerns were not consistently identified or addressed quickly enough. There was limited use of systems to record and report safety concerns, incidents and near misses. Some staff were not clear with regards to the process to do this.

The approach to assessing and managing day-to-day risks to patients was sometimes focused on clinical risks and did not take a holistic view of patient needs. Cleanliness, hygiene and infection prevention and control risks were not adequately assessed and managed. Potential risks to patients due to the environment and equipment were not adequately identified, including on the resuscitation trolleys.

Systems, processes and standard operating procedures were not always reliable or appropriate to keep patients safe. Monitoring whether safety systems were implemented was not robust. We found incidences of out of date medicine and FP10 prescription pads were stored inappropriately.

Staff were not fully aware of the new Duty of Candour regulation ensuring patients always received a timely apology when something went wrong.

Safeguarding systems were in place and most staff knew how to respond to safeguarding concerns.

Staffing levels were adequate for the service provision. Additional healthcare assistants had recently been recruited and advertisements were in place for the remaining vacancies.

The risks associated with anticipated events and emergency situations were recognised and systems were in place to deal with these.

Incidents

- There had been no 'Never Events' in outpatient services between January 2014 and December 2014. A never event is a serious incident that is wholly preventable as

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guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and should have been implemented by all healthcare providers.

- There had been no serious incidents reported for outpatient services between January 2014 and December 2014.
- Most staff we spoke with were aware of how to report an incident. The sister was able to describe what the last clinical and non-clinical incident was that occurred in the department and what actions had taken place. For example, a patient visiting the department became unwell, staff rang a doctor in the hospital who attended and admitted the patient onto one of the wards. We were informed that if an incident was investigated, the outcome would be filtered to staff through the chain of command. For example, from the outpatient services manager to the sister and then to registered nursing staff and healthcare assistants.
- There were a total of two clinical and four non-clinical incidents reported between January 2015 and June 2015 for outpatient services. These predominately related to patients becoming unwell in the department and immediate action was taken to ensure that the patient received appropriate care and treatment.
- During our unannounced inspection on 27 June 2015, staff confirmed that incident forms had been completed for an out of date Lidocaine ampoule and the paediatric bag valve mask that was past its expiration date on the paediatric resuscitation trolley, both of which we found during the announced inspection. We found these reports to be detailed and were awaiting review from the sister. In regards to the Lidocaine, as part of the initial investigation, nursing staff had confirmed that no out of date medication was administered to any patients. Improvements identified included introducing a new policy for the medication checks and reissuing the resuscitation policy.
- The outpatient services manager was able to describe what the new Duty of Candour regulation was. However, most staff we spoke with were unaware of what Duty of Candour meant. This meant we could not be assured that all staff were aware of the new regulation regarding being open and honest.

Cleanliness, infection control and hygiene

- Staff were observed and noted to be 'bare below the elbow' in line with the hospitals' infection control policy.

- All examination rooms, the treatment room and minor operations room had hand sanitiser dispensers.
- We inspected all 11 consulting rooms and adjoining examination rooms and noted that four did not have all required personal protective equipment, for example, aprons. Another had one apron hanging from the back of the door and it was unclear if this was being re-used. During an unannounced inspection, we noted that one apron was still hanging from the back of the door. We raised this with staff who told us that there should be an apron dispenser in each of the rooms and they should be disposed of once used. This meant that we could not be assured that staff were wearing disposable aprons in line with relevant guidance, including the Royal College of Nursing; Essential Practice for Infection Prevention and Control, Guidance for Nursing Staff.
- In one of the dirty utility rooms, we saw that there was no personal protective equipment (PPE) available and we observed one staff member enter the sluice room with a urine specimen without wearing any appropriate PPE. When we returned the next day, we noted that PPE (gloves and aprons) had been put into the sluice room.
- We were unable to see clearly when equipment was last cleaned. The pulse oximeter (a non-invasive method for monitoring a patient's oxygen saturation) in the treatment room was visibly unclean. Staff informed us that housekeepers, nursing staff and healthcare assistants were responsible for cleaning different types of equipment. For example, nursing staff and healthcare assistants were responsible for cleaning medical equipment including pulse oximeters. We reviewed the daily checklists which indicated all rooms should be checked for cleanliness and appropriate PPE should be available. Daily tasks also included checking the treatment room, plaster room, procedure room, clean utility, nurses' office and toilets. Lists were signed for completion; however the lists lacked detail as to what was expected during these checks, for example equipment cleaning.
- Housekeepers kept a book for the cleaning of toys in waiting area B which was completed on a weekly basis, records confirmed this was carried out.
- Within the sluice room near the minor operation room, we saw one cupboard that had urine spilt underneath the worktop, down the inside of the cupboard door and onto the shelves within the cupboard. We notified a staff member immediately. We checked later in the inspection if the cupboard had been cleaned and found

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that most of the urine had been cleaned, however it had not been cleaned from the shelves or under the worktop. This meant that we were not assured that cleaning was carried out appropriately to reduce the risk of infection.

- Paper towels were disposed of into a cardboard box in one of the sluice rooms. We were informed that the cardboard box should not be used for this and should be removed from the room. The most recent waste management audit undertaken in August 2014 indicated that appropriate segregation of waste was not always carried out in outpatients. Although the audit identified low numbers (10% non-healthcare waste, 5% healthcare waste and 5% waste in sharps containers), we could not be fully assured that all learning had taken place as a result of the audit.
- We found the procedures room to be generally unclean. There was blood on the pillow of the patient treatment bed. This was raised immediately with staff who cleaned the pillow straight away. Daily check lists were completed to indicate that rooms had been cleaned, however we could not be assured that these check lists were sufficient to ensure appropriate cleaning to reduce the risk of infection and potential cross contamination.
- One staff member was unsure what the main risk was in the department; however they informed us that all staff had been told not to carry out clinical procedures in consultation room nine as the room was fully carpeted. This was against Department of Health (DoH) guidelines (Health Building Note 00-09: Infection Control in the Built Environment).
- We raised that there was no sharps disposal bin in consultation room nine with the sister. We were informed that the room should have a sharps disposal bin and that the room was predominately used for audiology appointments and pre-operative assessments. We did note that in all other consultation / examination rooms a sharps disposal bin was in place. This was required to ensure that sharps, for example needles were disposal of appropriately.
- We also found a broken drawer handle in consultation room four, which had sticky tape at the back to rectify the problem. However, the sticky tape was peeling away from the handle, which meant this could not be cleaned properly and potentially allow bacteria to multiply.
- The floor in the procedures room where minor operations were carried out did not have continuous coved skirting between the floor and wall to allow easy

cleaning and prevent accumulation of dust and dirt. The carpet had been replaced in consultation room five with laminate flooring. However, there was no coving between the floor and wall and the sealant that had been used in the joints was not continuous. We noted that the coving was peeling away from the wall in one of the sluice rooms, and in the corridor between the nurse's office and treatment room coving and a wall panel were also peeling away. During the unannounced inspection, we noted that the coving between the floor and wall in the toilet opposite main reception had peeled away from the wall. This meant that not all of the environment was maintained in accordance with DoH guidance (Health Building Note 00-09: Infection Control in the Built Environment).

- We requested copies of the infection control audits undertaken in the outpatient department. We were provided with an annual audit work programme which identified compliance with the Healthcare Associated Infections Code of Practice and was not specific to outpatients. The draft minutes from the Hospital Infection Prevention and Control Meeting in June 2015 stated 'Hand Hygiene audits for all areas are to be spread out over the year – targeting a different area each month.' There was no indication when these audits were to commence. This meant we could not be assured that appropriate audits were undertaken in relation to cleanliness, infection control and hygiene to ensure best practice was carried out and patients were safe from the risk of infection.

Environment and equipment

- We inspected the adult and paediatric resuscitation trolleys which were located in the main waiting area of the outpatient department. Resuscitation guidance was visible and up to date in both folders that were on the trolleys. There were also two separate books for checking the trolleys and we found inconsistencies throughout both books. During the six week period between 11 May 2015 and our inspection, we found that the one trolleys had been checked 22 days out of 28 and the other checked 19 days out of 28 and had been signed by a member of staff. We also saw that these checks were not carried out on a Saturday although outpatient clinics were provided on a Saturday.
- The automated external defibrillator (AED) on the adult resuscitation trolley was visibly clean and had a recent portable appliance test (PAT). An AED is a portable

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electronic device that delivers a quantity of electrical energy to the heart during life threatening cardiac arrhythmias and ventricular fibrillation. However, we found several items of equipment that were stored incorrectly on the trolley and we were unable to determine how long equipment had been stored out of its packaging. This included the suction unit where the Yankeur catheter and tubing were both opened and connected. These items should remain in sealed packaging before use to ensure the equipment is clean and safe to use on patients. ECG electrode dots were not stored in the foil packaging on both the adult and paediatric trolleys. These should not be stored outside of the foil packaging for more than 30 days to protect integrity, however there was no evidence to say how long they had been removed from the packaging. The blade was connected to the laryngoscope handle and all packets were torn and open, including for the spare blade on both the adult and paediatric trolleys. Staff informed us that this was purposefully done to check the laryngoscope; however, blades should remain in sterile packaging. A reusable tourniquet was also found on the trolley, which should have been disposable. A paediatric bag valve mask on the paediatric trolley was out of date; the expiration date was April 2012. We raised our concerns with staff immediately and found the concerns to be rectified by the next day. During our unannounced inspection, we noted that an incident form had been completed in relation to the paediatric bag valve mask.

- This meant that although checks were in place, we could not be assured that these were carried out in accordance with the hospital's policy or efficiently to identify all concerns. This posed a safety risk to patients in the possible event of a life threatening situation as the equipment was not effectively checked or appropriately stored.
- Within the outpatient department stores cupboard, we found two 20g cannulas had passed their expiration dates of February 2015 and March 2015. This was raised with staff immediately. The next day we found that the cannulas had been replaced. This meant that there was a potential that unsafe and unsuitable equipment could be used in the treatment of patients posing a safety risk.
- Weighing scales in all consultation rooms were not calibrated and the marker was higher than 0kg without a person standing on them. For example, one set of weighing scales started at 4kg. This meant that there

was a potential to record a patient's weight incorrectly and their body mass index (BMI) which is used to check a patient's healthy weight and highlight any potential risks to their health.

- Computers in all consultation rooms had a PAT sticker which indicated that they were next due for testing in February 2009. We looked at various portable medical equipment and were unable to identify if a PAT test had been carried out for all equipment. The bladder scanner had a green sticker with a recent PAT test. However, a pair of surgical clippers in the stores cupboard, a magnifier lens in examination room four, a blood pressure monitor and magnifier lens in the treatment room did not have a green sticker to indicate they had recently been tested. We requested records of PAT testing and noted that there was a list of all computers, printers, telephones and extension leads in the outpatient department that had been tested and was in date. However, the records did not include portable medical equipment within the outpatient department. This meant that we could not be assured that electrical equipment in the department was safe or fit for use.
- We were unable to locate service or maintenance stickers on any of the examination beds that were in the outpatient department. The hospital confirmed that patient trolleys within the department were monitored by Facilities Services through the Maintenance Management System. We were sent two documents to show the pre-planned maintenance that took place in June 2014 for patient beds and patient trolleys in the hospital. However, the beds and trolleys checked did not demonstrate that those in outpatients had also been checked. This meant we were not assured that appropriate maintenance had been carried out to ensure they were safe and fit for use.
- The water fountain near waiting area B was leaking at the joins in the pipes. We raised this with staff immediately as the water was leaking onto the electrical wires. Staff were unsure how long the leak had been present although a water stain was present on the wall. The maintenance department was notified by outpatient staff and the water fountain was put out of use until the problem had been rectified. This posed a potential fire hazard.
- The sink in the toilets between waiting areas B and C was not fixed appropriately to the wall. We noticed that

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it was leaning away from the wall and if a patient, relative or member of staff was to fall or lean on the sink, it could have come away from the wall injuring the person.

- We were informed that health and safety environmental audits were carried out on a monthly basis. We reviewed the audits that were carried out between March 2015 and May 2015, which included general housekeeping, machinery/tools/equipment, first aid, PPE, COSHH (Control of Substances Hazardous to Health) and Shelving and Racking. All three audits identified all aspects to be compliant, however we noted that not all PPE was available in relevant rooms and one shelf was broken in a cupboard in one of the sluice rooms. This meant that although audits were carried out, not all risks were adequately identified.
- Nursing staff informed us that consultants should not bring in their own equipment; however one staff member confirmed that three consultants did. Following our visit, we wrote to the hospital to request assurances around the checks made on consultants own equipment. It was confirmed that three consultants had permission to use their own equipment and relevant maintenance and service records had been obtained. This meant relevant checks were carried out in line with the hospitals' Management of Medical Devices Policy, although not all staff in the outpatients department were aware of this.

Medicines

- A process was in place to check medication expiration dates as they were stocked in the department. The expiration dates were recorded on a sheet which was then monitored. If the date had been reached, the medication in the department would be checked and any left unused would be removed. We were also informed that two additional checks were carried out within the year. We saw records of the most recently stocked medications with expiry dates; however it was unclear when this was carried out.
- In one of the unattended examination rooms, we found a blue bag which contained Lidocaine, Kenalog and Bupivacaine (these medications are used for injections for pain relief). These forms of medication should be stored in a locked cupboard when not in use, one of the ampoules of Lidocaine also had an expiration date of February 2015. On top of the bag were details of two

patients and we were unsure if any other out of date medication had been used. We raised this with the Director of Nursing who checked the waste disposal and informed us that the medication used was in date.

- During our unannounced inspection, nursing staff informed us that a meeting was to be held to discuss the potential of including a second check of medication before it is administered by a consultant as a result of the out of date Lidocaine, as well as a weekly check of all blue bags containing medication. This would reduce the potential risk of out of date medication being used.
- We inspected all 11 consulting rooms and found in one of the rooms 11 FP10 prescriptions in the bottom of an unlocked filing cabinet. FP10 prescriptions should be securely locked away to prevent theft and abuse. We raised this immediately with staff and the prescription pads were locked away.
- We noted that the fridge which stored medication that required to be refrigerated was locked and visibly clean. Records of temperature checks were recorded on a daily basis. Staff confirmed that the process was to "reset" the temperature on a daily basis before recording the temperature. This was to ensure that the correct temperature was obtained and medication was stored appropriately.

Records

- Consultants provided plaster technicians with patient details for the following week so that referral notes could be viewed before seeing the patient. We reviewed the book which contained the referrals and noted that they were organised and stored appropriately.
- Consultant patient records were stored in the medical secretary's office safely and appropriately. Records were also scanned onto the computer system, which meant they could easily be access for appointments.
- We found patient records stored in an unlocked filing cabinet within the treatment room, patient identifiable data was also left on the side in one of the sluice rooms. The window to this room was open and a path ran alongside the window. This meant patient identifiable data was not protected at all times.
- We entered one of the consulting rooms that was not in use and found patient medical records that had been left on top of the desk. One set of records had a sticker on top of them which stated "Urgent must go back to ward". We were also able to access one of the medical secretaries' offices from a consultation room. The office

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was locked from the corridor, but not the consultation room and patient records were stored on the shelving. This meant that patient records were not always appropriately stored to protect patient confidentiality.

- We reviewed nine patient records and noted that a generic form was used for outpatient appointments. This recorded any co-morbidities, the patients' body mass index and any allergies if known. We also saw that consultants indicated the type of anaesthetic required if an operation was needed. All forms we reviewed were signed and dated by the appropriate consultant.

Safeguarding

- Safeguarding records confirmed that 92% of outpatient staff had received level one and level two safeguarding children training and 96% had received level one and level two safeguarding vulnerable adults training. One staff member explained that safeguarding training was completed using an eLearning programme which included different scenarios and a video to help identify possibilities of abuse.
- One staff member when asked was unsure what safeguarding was; however another staff member was able to describe in detail the different types of abuse and the actions they would take if they had any concerns. This meant we could not be fully assured that even though staff had received training that it was adequate and staff would be able to protect vulnerable patients.

Mandatory training

- Staff informed us that they had completed mandatory in-house training. This included, but was not limited to, wound care, infection prevention and control and fire safety. A mandatory training matrix for BMI Healthcare was in place which detailed the training course, the frequency of the training and which roles it was applicable to.
- Mandatory training information for the outpatient services included consulting rooms and outpatients by departments. 93% of nursing staff and 83% of staff overall in outpatients had completed all applicable mandatory training. The target set by the hospital for completion rates of mandatory training was 85%.

Assessing and responding to patient risk

- Staff informed us that if a patient was to deteriorate whilst in the outpatient department, the resident

medical officer, or a consultant in clinic would be called, to assess the patient. Nursing staff were able to provide examples of where a patient had become unwell in the department and after a doctor had assessed them, the patient was admitted to one of the wards. Incidents reported also demonstrated immediate action taken by staff to assess and respond to patient risk.

- Clerical staff also confirmed that if a patient was to collapse in a waiting area or at reception, they would use the panic button behind the reception desk to alert medical and nursing staff to the emergency. This meant in the event of a patient becoming unwell or collapsing, appropriate action was taken to assess and respond to the patients' needs without putting them at risk of deterioration.

Nursing staffing

- Records provided to the CQC before the inspection indicated that the hospital had very low occasional use of agency staff for nurses and no use of agency healthcare assistants working in the outpatient department between January 2014 and December 2014. A member of staff confirmed that in the past 12 months, one agency nurse had been used to provide cover for absences. However, as the agency staff member had no previous experience of an outpatient department it was decided not to use them. This meant patients could be assured that staff were familiar with the service provided and the needs of the patients.
- The sister informed us that they had recently recruited two bank healthcare assistants and were advertising for one permanent healthcare assistant and one registered nurse. The appointment of additional healthcare assistants was to alleviate the pressures on registered nursing staff to act as a chaperone in outpatient appointments and utilise their skills elsewhere in the department. This included plans to increase the utilisation of the minor operations room. The appointment of the additional registered nurse would also allow the sister to carry out any administrative duties that were required as part of their role.
- The minor operations rooms was usually used twice a week and procedures were booked two to three weeks in advance to ensure there was appropriate staffing cover.
- We observed a morning handover in the outpatient department. Staff informed us that this was an informal handover once all staff had arrived in the department

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for their shift so they knew who was on duty and which tasks and clinics were allocated to each person. We were also informed that a member of staff attended the hospital huddle and fed back to the rest of the team. This included information on staffing levels for the day.

Medical staffing

- Consultants attended the outpatient department on set days at set times. This meant that the department knew in advance of which consultant was attending and was able to allocate nursing staff appropriately to the clinics.
- We were informed that consultants were generally on time to start their clinics. However, some consultants, if they were working at another hospital and for example, their theatre list overran, meaning they would be delayed, they would ring BMI Three Shires Hospital to notify them. This information was not monitored, therefore we were unable to see how often this occurred and the impact it had on patients.

Major incident awareness and training

- Major incident training was included in staff induction training, this included fire training. Training data demonstrated that 75% staff in the consulting rooms and 92% staff in outpatients had received fire safety training. There was no target for completion of mandatory training.
- Staff we spoke with were familiar with the process that they were to follow in the event of a major incident. One staff member explained in detail the action they would take if the fire alarm was alerted.
- A business continuity plan was in place in the event of an IT system failure.

Are outpatients and diagnostic imaging services effective?

Not sufficient evidence to rate 

The effective domain for outpatient services was inspected; however this domain is not currently rated.

There was limited evidence of how practice was audited against current evidence-based guidance, standards and best practice.

It was recognised that a pain score system was in place in the hospital; however the outpatient services did not assess pain.

There was no monitoring of patient outcomes of care and treatment. Participation in external audits and benchmarking was limited.

Not all staff had the right qualifications, skills, knowledge and experience to do their job. The learning needs of staff were not fully understood. Staff were supported to participate in training and development. There were gaps in the management and support arrangements for staff, such as supervision.

Multi-disciplinary teams worked well together to provide effective care.

Nursing staff did not always have the complete information they needed before providing care and treatment. Consultants had their own patient records and were able to access diagnostic results without any delays.

Consent to care and treatment was obtained in line with legislation and guidance, including the Mental Capacity Act 2005 (MCA) by the consultants. There was a lack of awareness by nursing staff regarding the MCA and why they would need to know this information. Limited numbers of staff had received MCA and Deprivation of Liberty Safeguards (DoLS) training.

Evidence-based care and treatment

- The outpatient services manager received all updates on National Institute for Health and Care Excellence (NICE) guidelines and best practice, which was then cascaded to staff. We were also informed that best practice guidance from the local NHS hospital was also followed. However, there was no evidence of how practice was audited against best practice guidance or NICE guidelines to ensure they were followed effectively.
- A staff member informed us that they had been given the minor operations booking policy to review. Part of the review process was to ensure the policy was in line with relevant NICE guidance and best practice guidance. The process meant that staff had 30 days to review the policy. An example of this given was to ensure a registered children's nurse was available in the hospital when a patient aged between three and 16 years was booked for a procedure in the outpatient department.

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- A folder was kept in the staff office with relevant local policies and procedures, all staff we spoke with were aware of how to access this folder. This was despite policies being available on the intranet. We saw that some of these paper policies had past their review date. Staff were unable to find up-to-date local guidance and a member of the management team showed staff where to locate them on the computer.

Nutrition and hydration

- Staff informed us that patients were able to have diet and fluids if needed and sandwiches could be provided to diabetic patients. Staff were also able to provide tea and biscuits to patients undergoing minor operations in the procedure room before they went home. Staff confirmed that this was common practice and there was not a policy in place. This meant patients nutrition and hydration needs were met as required when attending the outpatient department.

Pain relief

- Staff informed us that the hospital used a pain assessment tool which measured pain on a scale of 0-3; however this was not used in the outpatient department. Staff confirmed that they did not assess pain. This meant that we could not be assured that patients were given adequate pain relief when undergoing minor operations and procedures in the outpatient department.

Patient outcomes

- We asked what national and local audits were carried out to monitor patient outcomes. Staff were unable to tell us how patient outcomes were monitored and how this information would be used to improve patient services.
- We requested a copy of the local audit plan for outpatient services and was informed that it was included in the main hospital audit plan. There was no specific audits to outpatient services. This meant we were unable to assess how the hospital monitored and compared patients' care and treatment outcomes with other services.

Competent staff

- The consultants' responsible officer was predominately in the NHS. For those that did not remain in NHS employment, their responsible officer was in BMI

Healthcare or the responsible officer if the doctor worked at another private healthcare company. A responsible officer is a senior doctor who ensures that doctors are appraised annually and where there are concerns about a doctor's fitness to practise they are investigated and referred to the General Medical Council (GMC).

- All doctors who had practising privileges were at consultant level and were registered with the GMC. This meant patients could be assured that they were treated by competent and registered practitioners.
- We spoke with a consultant who confirmed that they had received their appraisal and revalidation through their NHS role and that this information was checked by BMI Three Shires when required.
- Nursing staff were encouraged to undertake additional internal and external training. One senior healthcare assistant was due to commence their assistant practitioner training which they had requested to do. This meant staff were supported in their learning needs and development of their role to deliver effective care and treatment.
- Two staff members carried out bladder scanning within the outpatient department. One staff member had been shown by the manufacturer's training representative how to use the machine; however a competency review had not been carried out to ensure staff were able to use the machine effectively. We asked to review staff competencies and noted that most outpatient equipment competency records had been completed which included how to switch the equipment on and off and basic maintenance. The sister was unaware of any other competencies or training for outpatient staff that assisted in minor procedures on children, with the exception of paediatric basic life support. This meant we could not be assured that staff had received a review of all applicable competencies to ensure they could deliver an effective and safe service to patients.
- We were informed that all appraisals for staff in the department had been completed. The figures provided for up to date appraisals completed was not broken down to department level, however the hospital completed appraisal rate was 78%. We noted that nursing staff did not receive clinical supervision. A senior sister informed us they had regular one to one's with

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their line manager, however this did not include clinical supervision. This meant we could not be assured that all staff were supported effectively and appropriate mentoring and coaching was available.

Multidisciplinary working (related to this core service)

- Staff felt that they had good working relationships with other colleagues, including consultants. We were also informed that there was good communication with most medical secretaries.
- Ward staff were able to book appointments for patients to be seen by a nurse in the treatment room during the hours that the outpatient department was closed. Nursing staff informed us that this worked well and patients were allocated to the next available clinic time. We observed this in practice. This meant different teams in the hospital worked together to deliver effective care and treatment.
- The hospital had a 'Spot' contract in place with a nearby NHS hospital (Spot contracts mean that BMI Three Shires Hospital was able to alleviate capacity pressures from the NHS hospital where they were able to). This meant that the two hospitals worked together to plan ongoing care and treatment to ensure patients were seen in outpatients within an appropriate timeframe.
- When required, a multidisciplinary team meeting was arranged to review and agree a plan of care for Oncology patients.

Seven-day services

- The outpatient department at BMI Three Shires was open Monday to Friday from 7:45am to 9pm and on a Saturday from 8am to 1pm.
- Staff confirmed that when the outpatient department was closed and patients had any queries, for example regarding wound management, ward staff would book an appointment for the patient to be seen in the next available clinic to see a nurse in outpatients. We observed this during the unannounced inspection.

Access to information

- Staff were aware of the process to request medical records in the event that they were not available when a patient arrived for their appointment. This process was in line with the hospital policy reviewed.
- Before our inspection visit, we were informed that less than one percent of patients were seen in outpatients without the full medical record being available. BMI

Three Shires confirmed that from January 2015 to the date of the inspection, there had been no incidences when a patient had been seen in outpatients without a full medical record.

- A staff member informed us that NHS patients were seen at times without medical records by nursing staff in the treatment room. The HRUG meeting minutes from 02 March 2015 confirmed that: '40% of C & B folders are still held in the NHS Office. This is having a knock on effect when outpatients are coming back for stitch removal etc. and the files are not available for the appointment. It was suggested that if a file was needed the operation note could be copied and sent for the appointment. This was agreed this was unsafe practice.' Subsequently the hospital advised this was an error in the minutes, as it was in fact 40 sets of notes not 40%. However, this meant that patient records were not always available and accessible when a patient attended outpatients to see a nurse.
- BMI Three Shires informed us that hospital medical records were not to be removed from site by a consultant. Staff informed us that consultants had their own medical records, which their medical secretary would store. If the consultant did not have a medical secretary on site, the consultants' records were removed; however, the hospital record remained in the hospital. The outpatient services manager confirmed that consultants were required as part of their practising privileges to evidence their Information Commissioner's Office (ICO) registration. Records we reviewed confirmed this.
- Following a consultation, patient information was sent to the patients' GP in the form of a letter the next day. A consultant informed us that it was difficult to contact GPs by telephone therefore written communication was preferred.
- Staff confirmed that consultants were able to access diagnostic results electronically as they used the same electronic system as the neighbouring NHS hospital which provided some of the hospitals' diagnostic tests. This prevented any delays in potential decisions and the consultant was able to review this information when seeing the patient.
- We noticed that there were various information leaflets available in the main waiting area of the outpatient department. This included, but was not limited to, BMI Pain Management, women's health and urology. Information leaflets also included services that were

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provided by BMI Healthcare and not specifically to BMI Three Shires Hospital. This meant that patients were able to access additional relevant information according to their needs.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- A consultant explained the consent process and confirmed that they used the two stage process. This meant that the procedure was explained to the patient during the initial consultation and a leaflet was given which included all the risks, benefits and the process of the procedure. On the day of surgery, the patient confirmed they understand the procedure, that they had read the leaflet and signed the consent form. We reviewed nine medical records which included correctly completed consent forms.
- The consultant also confirmed that training for the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS) was completed as part of their NHS role.
- Nursing staff we spoke with had limited knowledge regarding MCA and DoLS and were not aware why this information would be needed. We discussed that if a patient living with dementia was seen in the outpatient department, if appropriate support would be provided by staff. Staff informed us that they would not see any patients living with dementia.
- Training records confirmed that 83% (five out of six applicable staff) in the consulting rooms and 50% (two out of four applicable staff) in outpatients had received training for MCA and DoLS. We were not assured that all relevant staff received training and would be able to provide effective care and treatment if a patient had mental capacity issues. We raised this with the Executive team.

Are outpatients and diagnostic imaging services caring?

Good 

Care in outpatient services was good.

Feedback from patients was positive about the way staff treated them. Patients were treated with dignity, respect and kindness during all interactions with staff.

Patients were involved in their care and in making decisions, with any support needed. They were communicated with and received information in a way that they could understand, including the risks and benefits of potential surgery.

Patients' privacy and confidentiality was respected at all times.

Staff helped patients to cope emotionally with their care and treatment. Patients were supported to maintain and develop their relationships with those close to them, their social networks and community.

Compassionate care

- We spoke with 30 patients who informed us that they felt well cared for.
- One relative told us that they were very happy with the "Prompt care" and that they "Would recommend to family and friends" and a patient told us they had received "Wonderful care".
- We observed good interactions between staff and patients, staff were friendly and polite.
- Reception staff respected patients' confidentiality. When patients arrived into the department, we noted that all patients were asked, "Does all the information we have for you remain the same?" This meant patient identifiable data was not disclosed near other patients.

Understanding and involvement of patients and those close to them

- Patients told us that they were involved in decisions around their care and treatment and that they had sufficient time to ask questions if they needed to.
- Completed comment cards received during our inspection also stated that an explanation of all treatment received was provided.
- One patient told us that the risks and benefits had briefly been explained to them; however they had had the same surgery before and were happy to have surgery again. Another patient told us that all the risks and benefits were explained to them before having their outpatient procedure. This meant patients were provided with all relevant information to make an informed decision regarding treatment and were involved in their care.

Emotional support

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- Patients informed us that they were given appropriate and timely support regarding the care and treatment they received. One patient also informed us about access to support networks in the community. Staff confirmed that this information would be provided to patients by the consultants.

Are outpatients and diagnostic imaging services responsive?

Good 

Outpatient services were found to be good for responsiveness.

Services were planned and delivered in a way that met the needs of the local population. The importance of flexibility, choice and continuity of care was reflected in the services.

Care and treatment was coordinated with other services and other providers.

Reasonable adjustments were made most of the time and action was taken to remove barriers when patients found it hard to use or access services.

Premises were appropriate for the services being delivered.

People could access the right care at the right time. Access to care was managed to take account of patient needs, including those with urgent needs.

Waiting times and cancellations were managed predominately by medical secretaries. Services ran on time. Patients were kept informed of any disruption to their care or treatment.

Complaint information or how to raise a concern was available for patients. Complaints and concerns were always taken seriously, responded to in a timely way and listened to.

Service planning and delivery to meet the needs of local people

- The outpatient department was clearly signposted from the entrance of the hospital and was a short walk from the main reception on the ground floor. This meant that the department was easily accessible for all patients.

- Patients informed us that access to the services was quick and that the location of the hospital was easy to get to with adequate car parking. One example was a patient who received an appointment for the next day.
- 35% of patients seen in the outpatients department were NHS patients. This included patients who had chosen to attend BMI Three Shires Hospital through choose and book system and also through a 'Spot' contract that the hospital had with the nearby local NHS hospital. (Spot contracts mean that BMI Three Shires Hospital was able to alleviate capacity pressures from the NHS hospital where they were able to.)
- The local clinical commissioning group (CCG) set criteria within the contract with BMI Three Shires for NHS patients. This included, but was not limited to, patients not having a body mass index (BMI) of more than 40 and patients with no complex social issues. Nursing staff within the outpatient department triaged referrals received through choose and book system to ensure the criteria was met.
- This meant local commissioners and other providers were involved in planning services to deliver the needs of the local people, ensuring appropriate capacity was available for the demand in services.

Access and flow

- Data demonstrated that throughout 2014/15, BMI Three Shires met their contractual target of 95% for non-admitted pathways in 18 weeks each month with the exception of October 2014 (90%). Recent data for May 2015 also demonstrated that the hospital was meeting their contractual target for all specialties for non-admitted pathways.
- Medical secretaries monitored the number of patients that did not attend (DNA) their appointment. If a patient DNA the medical secretaries tried to make contact by telephone to rearrange another appointment. DNA rates for private patients were not monitored centrally.
- Receptionists informed us that they also tried to make contact with the patient if it was about 10 minutes past their appointment time in case they were delayed for any reason. Receptionists informed us that they would ring the patient from one of the offices, to preserve confidentiality and we observed this.
- The receptionist notified the central NHS team in the hospital if a NHS patient did not attend. This information was monitored centrally in line with the hospitals' contract with the local commissioners. Data

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demonstrated that, with the exception of follow up appointments from May 2014 to July 2014, there was below 5% of patients that DNA their appointment each month for new and follow up appointments.

- We were informed that cancellations of appointments and or clinics were mainly cancelled by the patient and rarely by the consultant. We were unable to review this data as the hospital confirmed that data on clinic cancellations was not collated and that clinics would only be cancelled by consultants due to other commitments.
- We observed the clinics to be generally running on time and patients did not have to wait long once they had arrived in the department.
- During our unannounced inspection, nursing staff informed us that consultant clinics had been cancelled for that morning. However, a consultant arrived for a morning clinic around 9am. We were told that the consultant's secretary had not informed them that the clinic had been re-instated. Although we noted that nursing and healthcare assistants were available to assist as required and reception staff were able to reinstate the clinic accordingly to ensure patients were booked in on arrival.
- We requested to see data for the waiting times for a first appointment; however the hospital confirmed that this information was not collated.

Meeting people's individual needs

- The hospital had access to Language Line in the event that a patient required assistance with translation, however there was no facility to support patients that required sign language. Staff also informed us that patients were encouraged to bring a relative with them to assist during consultations for translating. We asked staff if we could see the hospitals' policy for translation services, however they were unaware if one was in place.
- Medical secretaries and the NHS team within the hospital predominately booked patient appointments. Appointments were 30 minutes or 10 minutes long depending on whether the patient had a new appointment, a follow up appointment or a planned procedure to take place. This meant patients could be assured that their needs would be met and their appointment would not be rushed.

- Nursing staff within the department confirmed that no patients' arrived for their appointment by ambulance transport.
- The outpatient department was located on the ground floor with accessible toilet facilities for disabled patients. We observed one patient who arrived in a wheelchair and staff assisted the patient from the main reception to ensure they were comfortable and able to access the department.

Learning from complaints and concerns

- The majority of patients we spoke with informed us that they were unaware of the complaints process. However, they did tell us that they had been given this information and had not read the documentation. This meant that, if needed, patients had access to information to support them in raising any concerns or complaints.
- Staff we spoke with were aware of the complaints process and informed us that they tried to resolve any patient concerns immediately to prevent the concerns escalating to a complaint.
- One staff member explained that appointment cards were written out for all patients, although the majority of appointments booked by outpatient reception staff were for follow up appointments. This was action taken by the department as a result of a complaint.

Are outpatients and diagnostic imaging services well-led?

Requires improvement 

Outpatient services required improvement for well-led.

The strategy for outpatient services was not underpinned by detailed, realistic objectives and plans. Some staff had limited knowledge regarding the vision for the hospital.

The arrangements for governance did not always operate effectively. Risks and issues were not always dealt with appropriately or in a timely way.

Not all leaders had the necessary experience or knowledge to lead the outpatients service effectively.

Staff satisfaction was good. Staff felt supported, valued and able to contribute to the development of the service.

Outpatients and diagnostic imaging

There was a limited approach to obtaining the views of patients. Feedback was not always reported or acted upon in a timely way.

Improvements were not always identified or action not always taken.

Vision, strategy, innovation and sustainability and strategy for this service

- A new vision had been recently implemented by BMI and senior management confirmed that this may not have cascaded fully to all staff members at the time of our inspection.
- Most staff were unsure what the hospital vision was. However, one staff member explained that they had their name badges changed a year ago in line with the vision. This changed the slogan from 'the consultants' choice' to 'serious about health, passionate about care'.
- We requested to see strategy for outpatient services. Senior managers confirmed that a specific strategy was not in place; however a business strategy encompassed the development of all services. We reviewed the Business Unit Plan 2014/2015 which identified outpatient cardiology diagnostics as an area of opportunity. However, there was no further information regarding this or any other specific information to outpatient services.

Governance, risk management and quality measurement for this service

- We reviewed the hospital risk register and noted that there were no risks highlighted for the outpatient department. This was confirmed by the outpatient services manager.
- We saw a risk assessment completed in April 2015 in relation to the carpet in consulting rooms. The risk assessment stated 'Replace carpets with hard non-permeable flooring to comply with DoH health building note 00-09 (March 2013), when carpet requires replacement due to wear or staining. Review at annual environmental IC&P audits.' The deadline for completion stated that it was on the 'Annual IPC Action Plan and Refurbishment Plan 2015'. We asked when the carpet was to be removed and were told that all carpets would be removed throughout time. We noted that the risk assessment did not identify other risks surrounding the flooring in various rooms within the outpatient

department and that deadlines for actions to be completed were not defined. This meant we could not be assured that there was sufficient governance systems in place to assess, monitor and mitigate risks.

- Of the audits that were carried out, we noted that these did not always adequately identify potential risks to patients. This further demonstrated that we could not be assured that risks could be adequately assessed, monitored and mitigated against.
- We reviewed a number of policies and protocols that were held within the department and found them to be past their review date. This included hand hygiene policy, protocol for Hepatitis B exposure, segregation of clinical waste, standard infection control precautions and dealing with spills of blood and other bodily fluids. During our unannounced inspection, we asked staff if they could locate electronic copies of the policies to ensure they had been updated. With the exception of the segregation of clinical waste policy, staff were unable to locate electronic copies. The segregation of clinical waste policy remained out of date. However, before we left the outpatient services manager was able to show us all policies and protocols that had been reviewed were on the electronic system and were in date. This meant policies and protocols had been updated, although staff were unsure how to access these documents and relied on the hard copies that were out of date that may not have reflected current and best practice.
- The standard operating procedure in relation to portable appliance testing (PAT) that was sent electronically was different to the one shown to us by the maintenance department. One procedure stated that a green sticker should be fixed to the equipment after testing and another stated that a sticker with a barcode should be used or a sticker that gave the asset number and date of testing (examples of the two stickers were in the procedure). We were unclear which procedure was in use as we were unable to see a review date and practice seen for the testing of equipment was not consistent.
- Hospital management confirmed that a new Management of Medical Devices Policy had been published in April 2015 which transferred the accountability of monitoring equipment to each hospital. It was acknowledged that since the transfer of responsibility the asset register was an area for improvement and the tool itself was not necessarily

Outpatients and diagnostic imaging

reflective of current maintenance levels. Monitoring systems were in place and clear actions had been commenced to assist with the implementation of the new policy.

Leadership/culture of service

- Staff told us that they felt there was good leadership within the service and the organisation.
- All staff we spoke with were aware of the Executive Director and Director of Nursing and informed us that they were visible and approachable.
- The outpatient services manager was a qualified radiographer who maintained their clinical work and also managed the imaging services as well as the outpatient services. We were informed that they were proud of the infrastructure they had implemented within the department and that the hospital was policy driven. An identified area for improvement was for staff to take ownership of the department.
- The outpatient services manager confirmed that there were no risks for outpatient services on the hospital risk register. Due to the number of concerns identified throughout our inspection in relation to the environment and infection prevention and control, we were not assured by leaders within the outpatient services that they were fully aware of their roles and accountabilities for the quality of the service.

Culture within the service

- Staff informed us that they felt supported and valued in their role and that the organisational leaders were visible within the department.
- Staff felt that their immediate line managers were proactive and listened to ideas to improve the service provided to patients. An example given was the introduction of rolling rota system for staff off duty; this meant staff were able to identify which staff were available when consultants requested appointments for minor operations.

Public and staff engagement

- Staff informed us that they felt able to share their ideas and opinions to develop and improve the outpatient

services. Monthly team meetings were held and minutes we reviewed from April 2015 indicated that there were three attendees. The meeting included informing staff that procedures were not to be carried out in consultation room nine until the carpet had been replaced. However, the minutes did not record when this would be.

- Staff informed us that if they were unable to attend the meeting they could put forward items for discussion and the minutes were then displayed in the staff office.
- The Friends and Family Postcard results from April 2015 demonstrated that 90.2% of patients were extremely likely to recommend the service and 9% were likely to recommend the service to friends and family if they needed similar care or treatment.
- Staff explained that patient feedback was received; however they were unsure how this information was used to shape or improve the service. Although all staff we spoke with demonstrated a great understanding in making sure all patient needs were met and patients informed us that they were very happy with the service received.

Innovation, improvement and sustainability

- Staff informed us that plans were in place to improve the examination rooms in line with infection prevention and control risks. A risk assessment had been completed for this, which indicated carpets were to be replaced due to wear or staining and no definitive date was provided for this action to take place.
- We were also informed regarding potential plans to commence carpal tunnel decompression surgery in the procedures room. A reconfiguration of the department was required, which was due to start in the near future. One of nursing staff also confirmed that the air flow of the room was suitable for day case procedures. The Business Unit Plan 2014/15 confirmed that the room was fully compliant for day case procedures.
- There was a lack of robust governance processes in place to review the quality of the service provision and implement improvements.

Termination of pregnancy

Safe	Not sufficient evidence to rate ●
Effective	Not sufficient evidence to rate ●
Caring	Not sufficient evidence to rate ●
Responsive	Not sufficient evidence to rate ●
Well-led	Not sufficient evidence to rate ●

Information about the service

BMI Three Shires Hospital has 53 beds, most of which are private patient rooms with ensuite facilities. The hospital offers a range of surgical procedures, including gynaecology, orthopaedics and general surgery.

The hospital provides surgical termination of pregnancies up to a gestation period of 14 weeks. Contraception post procedure is also offered.

Between the period of January 2014 and December 2014, the hospital carried out four surgical terminations of pregnancy. There were none undertaken in 2015 up to the time of our inspection.

Medical terminations of pregnancy are not carried out at this hospital.

Summary of findings

BMI Three Shires Hospital provides a termination of pregnancy (TOP) service in Northampton for privately funded patients who were over the age of sixteen.

The hospital offers surgical TOP procedures up to a gestation period of 14 weeks. Contraception was prescribed if needed.

In 2014, four women had pregnancies terminated at this hospital.

Records were completed as required in accordance with The Abortion Act 1967, The Abortion Regulations 1991 and DoH Required Standard Operating procedures (RSOPS).

We carried out this inspection as part of a comprehensive inspection of the hospital.

Termination of pregnancy

Are termination of pregnancy services safe?

Not sufficient evidence to rate

There had been no incidents reported with regards to termination of pregnancy in the past year.

The hospital complied with The Abortion Act 1967, (as amended) The Abortion Regulations 1991, the

Abortion (Amendment) (England) Regulations 2002 and some of the DoH Required Standard Operating procedures (RSOPS).

Incidents

- Staff were aware of how to report an incident
- There had been no incidents reported with regards to termination of pregnancy in the past year.

Cleanliness, infection control and hygiene

- Pregnancy remains, following a termination of pregnancy, were labelled appropriately in accordance with the hospital's management of specimens policy, and sent to the local trust. We saw the trust's policy, which confirmed the process to ensure that the pregnancy remains were disposed of in a manner that reflected Human Tissue Authority (HTA) Guidelines.
- There was no evidence to confirm that the woman's wishes were sought or considered with regards to the disposal of the pregnancy remains.

Records

- We reviewed the records of the four procedures carried out in 2014. These were well completed, including those required in accordance with The Abortion Act 1967, (as amended) The Abortion Regulations 1991, the Abortion (Amendment) (England) Regulations 2002 and the DoH Required Standard Operating procedures (RSOPS).
- We saw in each set of notes that there was a:
- copy of the clinic letter detailing the discussion on the reason for abortion.
- copy of the ultrasound scan results in order that the gestational age of the foetus was correct.
- a fully completed HSA1 form, signed and dated by two doctors and giving the reason for the termination of pregnancy.

- We saw evidence in the notes that the HSA4 (notification) form had been sent to the Chief Medical Officer at the DoH, by the surgeon, as required under The Abortion Regulations 1991, as amended.
- There was no evidence that any of these forms had been signed in advance of the woman seeking advice
- The hospital used paper records; we saw that records were stored confidentially. We saw that, for example, admission lists and operating theatre lists were also stored confidentially.

Safeguarding

- The hospital had safeguarding policies and procedures available to staff on the intranet.
- Staff received training through electronic learning and had a good understanding of their responsibilities in relation to safeguarding of vulnerable adults. They were able to explain how to respond to and escalate a concern.
- There had been no safeguarding concerns reported within 2014, up to June 2015.
- The hospital policy stated that young women from the age of 16 years could be admitted for termination of pregnancy. There were no procedures in place to ensure that the young woman would be cared for by a team who had received the appropriate level of children's safeguarding training. However, of the four records we saw of women who had undergone a termination of pregnancy, none of the women were under the age of 18 years.
- Staff had received training about the Mental Capacity Act (MHA) to ensure they were competent to meet patients' needs and protect their rights where required.

Mandatory training

- Staff explained they received mandatory training to provide safe care. Some of this was completed through e-learning and some through on-site training, for example, manual handling. Staff described a range of topics included in their training such as information security and infection prevention and control. The compliance with mandatory training was 79% against a target of 85%.
- There was no training specifically with regards to termination of pregnancy.

Assessing and responding to patient risk

Termination of pregnancy

- All women who underwent termination of pregnancy were fully pre-assessed in advance of their procedure and underwent appropriate blood tests, for example to ascertain their blood group to identify if an Anti-D immunoglobulin injection was required post procedure.
- The practicing privileges agreement required the designated consultant to be contactable at all times when they had inpatients within the hospital. Furthermore, they needed to be available to attend within an appropriate timescale according to the risk of medical or surgical emergency. This included making suitable arrangements with another approved practitioner to provide cover in the event they were not available, for example whilst on holiday.
- Each patient room and bathroom had emergency call bells to be used to alert staff when urgent assistance was required, these were routinely tested to ensure they were fit for purpose.
- The National Early Warning system (NEWS) tool was used to identify the deteriorating condition of patients. This system alerted nursing staff to escalate, according to a written protocol, any patient whose routine vital signs fell out of safe parameters.
- Audits of NEWS records completed in April 2015 identified 36% of records were incomplete. This was due to a time not being recorded when the document was signed by the nurse completing the score. Actions proposed included further training but we did not see any evidence of further training during the inspection.
- Audits of the correct use of the checklist '5 steps to safer surgery' was undertaken by the trust data collectors. To support compliance the local trust had provided the use of a training CD showing the use of the checklist in action for the training of new staff.
- If a patient became unwell after treatment, there were arrangements for the patient to be seen promptly by a doctor, the RMO, and if necessary reassessed by the admitting consultant or anaesthetist where required.
- In accordance with the DoH RSOPs, women were given a phone number, which they could use to contact the hospital in case of emergency. This meant the women had access to medical advice if they were concerned or there was an emergency
- Women were advised both at preadmission and on admission to the hospital that they should be taken home following the procedure, by a competent adult and have a competent adult in attendance for 24 hours post procedure.

Medical staffing

- At BMI Three Shires Hospital, one Consultant provided termination of pregnancy services. The consultant worked for the hospital under a practising privileges agreement. This meant their competency to carry out these procedures was assessed annually by the MAC.

Are termination of pregnancy services effective?

Not sufficient evidence to rate

Care was provided in line with national and statutory guidelines.

Women were offered appropriate pain relief, prophylactic antibiotics and post-abortion contraceptives.

The hospital performed audits recommended by Royal College of Obstetricians and Gynaecology (RCOG) such as infection control, consent to treatment, discussions about options for abortion and contraception. There were no specific audits carried out with regards to termination of pregnancy.

Pregnancy and gestation was confirmed by ultrasound.

The hospital did not offer a full counselling service but could refer women to other counselling services. However, there was no evidence to confirm that these would be trained pregnancy counsellors, in line with DoH RSOP.

Evidence-based care and treatment

- Out of the four sets of records we reviewed, three recorded discussions regarding contraceptive advice. This was in line with DoH RSOP. However, it was unclear if the hospital was able to supply all reversible methods of contraception, including Long Acting Reversible methods (LARC) which are the most effective, or whether the woman was referred to an external provider for contraception. Testing for STIs was offered, according to the hospital policy, but there was no evidence in the records that we saw that this had been discussed with the women.
- There were no audits undertaken of HSA1 and HSA4 forms completion rates.

Pain relief

Termination of pregnancy

- There was a full range of pain relief available. We saw from the patients' records that pain relief was prescribed and administered appropriately.
- The hospital had trained pain relief link nurses to provide support to the clinical team and ensure best practice. They met quarterly with other pain link nurses and head of nursing to review practice and share learning. Physiotherapists and pharmacists were also involved.
- The surgical pathway prompted staff to assess and record if pain was being managed effectively. This commenced in the pre-assessment clinic where actions to deal with pain management were discussed.

Competent staff

- The hospital's standard operating procedure, Termination of Pregnancy Policy stated that staff training would be given as required and that all staff had access to written procedures for information and reference. We requested to see any additional policies or procedures that the hospital had in place; however the hospital was unable to evidence this.
- On review of training available to staff, there were no courses that related to caring for and supporting women undergoing an abortion. Although staff we spoke with were knowledgeable about providing the appropriate support to women, with the limited number of procedures carried out, we could not be assured that staff competencies were reviewed effectively to ensure they were able to provide the appropriate level of support and care.

Seven-day services

- Consultants were on call 24 hours a day for patients in their care.
- There was 24 hour RMO cover in the hospital to provide clinical support to surgeons, staff and patients.
- The hospital had on-call arrangements for theatres, radiology and physiotherapy services.

Access to information

- On review of the records for the procedures carried out in 2014, we noted that although a pre-procedure blood test had been carried out, this sometimes occurred on the day of admission. This meant that staff had to

telephone the haematology department at the local trust for the results before the procedure could be carried out. This meant that the relevant information was not always available in a timely manner.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- The records we reviewed contained consent forms signed by the patient and consultant. Possible risks and complications were also recorded and the records demonstrated that these had been discussed with the patient.

Are termination of pregnancy services caring?

Not sufficient evidence to rate

Staff treated women with compassion and respect. Consultations were held in private rooms.

All women had a chance to speak with a nurse on their own to establish that the woman was not being pressurised to make a decision. Aside from this, women could be accompanied by a friend or family member.

Women's choices were respected. Their preferences for sharing information with their partner or family members were established and reviewed throughout their care.

Compassionate care

- Staff told us they asked women about their preferences for sharing information with their partner or family members.

Understanding and involvement of patients and those close to them

- During the initial assessment, the consultant explained the one available method for termination of pregnancy (surgical) that took place at the hospital. If the surgical method was inappropriate and unsafe to the woman at her gestational period, she would be referred to another centre where alternative methods were offered.
- If women needed time to make a decision, this was supported by the staff and women were offered an alternative date for further consultation.
- Women could ask for a chaperone to be present during consultations and examinations.

Termination of pregnancy

- The statutory HSA4 form used to inform the Chief Medical Officer of abortions was anonymised and used for statistical purposes by the Department of Health in order that data can be published. We did not see any evidence that staff ensured that women were made aware that data was used in this way.

Emotional support

- Nursing staff told us that there were occasions where women changed their mind about terminating their pregnancy, once they got into the hospital. In these instances, a staff member would sit with the woman to listen and ensure that they had enough time to make their own decision
- There were arrangements in place for women to receive counselling should this be required.
- The policy did not state how women who were vulnerable were identified. There was no risk assessment in place to do so and there was no evidence that vulnerable women were identified.

Are termination of pregnancy services responsive?

Not sufficient evidence to rate

The culture of the hospital was caring and supportive to women despite there only being a small number of terminations taking place.

Access and flow

- Between 01 January 2014 and 31 December 2014, the hospital carried out four surgical terminations. These were carried out within the first trimester of pregnancy. The termination of pregnancy policy did not contain information to state what the upper gestational age was. However, the Director of Nursing confirmed that they would not accept anyone over 14 weeks pregnant, nor anyone under 16 years of age.
- The termination of pregnancy policy did not specify that there were any procedures in place for women who may have had particular needs, for example a learning disability.

Meeting people's individual needs

- We saw from patient's records that women were given advice on contraception, which was prescribed, or other devices inserted/implanted as appropriate.
- There was no evidence that women were made aware, either verbally, or in writing, that there were options for disposal or pregnancy remains.

Learning from complaints and concerns

- There had been no complaints made in the previous year with regard to termination of pregnancy.

Are termination of pregnancy services well-led?

Not sufficient evidence to rate

The hospital management team were highly visible. There was a statement of the hospitals values, based on quality and safety. Staff were aware of the new values recently introduced but these were not yet embedded.

There was no strategy or vision with regards to this service.

Vision, strategy, innovation and sustainability and strategy for this this core service

- There was no strategy or vision with regards to this service.
- We did not see the certificate of approval (issued by the Department of Health) displayed within the hospital.

Governance, risk management and quality measurement for this core service

- Governance and risk throughout the hospital was managed via the clinical governance committee and the Medical Advisory Committee. We revised the minutes of both these committees and saw that there had been nothing raised or discussed with termination of pregnancy. Furthermore, when the DoH revised and re-published RSOPs in May 2014, there was no evidence that these had been reviewed and reported through either committee.
- The hospital maintained a register of women undergoing a termination of pregnancy, in line with the requirement of regulation 20 of the Care Quality Commission (Registration) Regulations 2009. This was

Termination of pregnancy

completed in respect of each person at the time the termination was undertaken and was retained for a period of three years beginning on the date of the last entry.

- The assessment process for termination of pregnancy legally requires that two medical practitioners agree that at least one, and the same ground for a termination of pregnancy as set out in the Abortion Act 1967 (as amended) has been met and each sign a form (HSA1 form) to indicate their agreement. This is in accordance with The Abortion Act 1967. We saw in three sets of notes that there was a:
 1. Copy of the clinic letter detailing the discussion on the reason for abortion.
 2. Copy of the ultrasound scan results in order that the gestational age of the foetus was correct.
 3. A fully completed HSA1 form, signed and dated by two doctors and giving the reason for the termination of pregnancy.
- The Department of Health requires for all providers undertaking termination of pregnancies to notify them of prescribed data for each abortion performed, using the notification form HSA4. We saw evidence in the notes that the HSA4 (notification form) had been sent by the consultant to the Chief Medical Officer at the DoH, as required under The Abortion Regulations 1991 (as amended).

Outstanding practice and areas for improvement

Outstanding practice

We saw several areas of outstanding practice including:

- Excellent multidisciplinary working across the hospital, to ensure that patients received appropriate and timely care.
- A caring and responsive approach to patients after their surgery.
- The daily hospital 'Huddle' for exchanging information.

Areas for improvement

Action the provider **MUST** take to improve However, there were also areas of poor practice where the provider needs to make improvements.

- The provider must ensure that there is adequate supply personal protective equipment in all consultation/examination rooms.
- The provider must ensure that all medical equipment is clean and fit for purpose.
- The provider must ensure that cleaning responsibilities are defined and detailed cleaning schedules and processes are in place.
- The provider must ensure that blood and other bodily fluid spillages are dealt with effectively.
- The provider must ensure relevant audits are carried out robustly to identify, monitor and mitigate against risk.
- The provider must ensure that checks regarding resuscitation equipment is carried out thoroughly and are stored appropriately.
- The provider must ensure that all equipment and medical devices are serviced, tested and maintained as required or replaced if past its expiration date to ensure the equipment is safe for use.
- The provider must ensure that the process to identify out of date medication is effective.
- The provider must ensure that all FP10 prescription pads are stored safely and appropriately.

- The provider must ensure that governance systems in place are effective and identify risks in the outpatient department. This includes implementing appropriate monitoring systems and actions to mitigate the risk.

Action the provider **SHOULD** take to improve

In addition the provider **should**:

- The provider should ensure that all staff are aware of what an incident is and the reporting process.
- The provider should ensure that safeguarding training is effective and all staff are aware of the actions needed if they had safeguarding concerns.
- The provider should ensure that patient information is stored appropriately and securely.
- The provider should ensure that all staff have access to the relevant patient records when required.
- The provider should consider the effectiveness of storing hard copies of policies and protocols as these were out of date.
- The provider should ensure that staff have appropriate competencies and supervision in relation to their role.
- The provider should ensure that staff receive appropriate training, in particular mental capacity act and deprivation of liberty safeguards, to ensure their understanding if a patient has mental capacity issues.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
<p>Surgical procedures</p> <p>Treatment of disease, disorder or injury</p>	<p>Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment</p> <p>Regulation 12. (2) (a)(b)(c)(d)(e)(g)(h) Care and treatment must be provided in a safe way for service users.</p> <p>How the regulation was not being met:</p> <p>The provider did not operate effective systems to assess, monitor and mitigate the risks relating to the health, safety and welfare of service users.</p> <p>The provider did not operate effective systems designed to prevent, detect and control the spread of infection and did not maintain appropriate standards of cleanliness and hygiene in relation to equipment in outpatients.</p> <p>Staff did not always follow infection prevention and control guidance in all services, for example handwashing and shoe cleanliness in theatre.</p> <p>People who use services and others were not protected against the risks associated with the unsafe management of medicines in the outpatient department as the hospital did not have an effective system in place to ensure out of date medicines and equipment were used.</p> <p>Care and treatment should be carried out by staff who have the competence and skills to do safely</p> <p>In children's services, there was no assurance the RMOs had appropriate training or experience to deal with a child or young person.</p> <p>In children's services, height and weight was not always recorded prior to treatment commencing. This meant that medicine doses could not always be calculated accurately.</p>

This section is primarily information for the provider

Requirement notices

Regulated activity

Surgical procedures
Treatment of disease, disorder or injury

Regulation

Regulation 17 HSCA (RA) Regulations 2014 Good governance

Regulation 17(2)(a)(b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Good governance

How the regulation was not being met:

The provider did not operate effective systems to assess, monitor and mitigate the risks relating to the health, safety and welfare of service users.

Risks were not always identified, monitored and mitigated.

Incident reports were not always completed.

Equipment maintenance records were not complete.

The risk register was not reflective of service risks.

Resuscitation equipment was not checked thoroughly

This meant that the provider did not have appropriated systems and processes in place that enables them to identify and assess risks.