BMI The Beaumont Hospital

Quality Report

Old Hall Clough
Chorley New Road
Lostock
Bolton
BL6 4LA
Tel: 01204 404404
Website: www.bmihealthcare.co.uk/beaumont

Date of inspection visit: 2-3 and 17 September 2015
Date of publication: 11/01/2016

This report describes our judgement of the quality of care at this location. It is based on a combination of what we found when we inspected and a review of all information available to CQC including information given to us from patients, the public and other organisations

Ratings

Overall rating for this location	Good
Are services safe?	Good
Are services effective?	Good
Are services caring?	Good
Are services responsive?	Good
Are services well-led?	Good

Summary of findings

Letter from the Chief Inspector of Hospitals

BMI The Beaumont Hospital is a private hospital that opened in 1984 and is part of BMI Healthcare. We carried out an announced inspection of BMI The Beaumont Hospital on 2 and 3 September 2015. We also carried out an unannounced visit on 17 September between 6pm and 7.30pm to check how patients were cared for out of hours. We carried out this inspection as part of our comprehensive inspection programme of independent healthcare hospitals.

Overall, we have rated BMI The Beaumont Hospital as good.

Are services safe at this hospital/service

Incidents, accidents and near misses were recorded and investigated appropriately. Incidents were discussed during daily 'comms cell' meetings and at monthly staff meetings so shared learning could take place. Staff were familiar with the term 'Duty of Candour' (meaning they should act in an open and transparent way in relation to care and treatment provided). Policies were in place to ensure the principles and requirements of the duty of candour process were followed. There were systems in place in the event of a patient deteriorating. The hospital had a transfer agreement in place so patients could be transferred to a local acute trust if needed. Staff had received mandatory training in safeguarding adults and children. They were aware of how to identify potential abuse and report safeguarding concerns. The director of clinical services was the named safeguarding lead for the hospital. The areas we inspected had a sufficient number of trained nursing staff with an appropriate skills mix to meet patients' needs. Staffing levels were monitored using the BMI Healthcare nursing dependency and skill mix tool. The theatres did not have a full establishment of trained permanent staff (there were 11 nursing staff vacancies). However, staffing levels were maintained through the use of regular bank and agency staff. Nursing staff handovers occurred three times a day and included discussions around patient needs, their medication and their present condition. There was appropriate medical cover. A resident medical officer (RMO) was based at the hospital 24 hours per day over a two week period. The RMOs had received appropriate induction training and had access to relevant trust policies, such as the policy for patient transfer. They were appropriately trained in Immediate Life Support (ILS) and Advanced Life Support (ALS) for adults and children. Surgical procedures and outpatient consultations were carried out by a team of surgical and medical staff who were mainly employed by other organisations (usually in the NHS) in substantive posts and had practising privileges with the Beaumont Hospital.

Are services effective at this hospital/service

Patients received care and treatment in line with national guidelines such as National Institute for Health and Clinical Excellence (NICE) and the Royal Colleges. The rate of unplanned readmissions and unplanned patient transfers to other hospitals was within expected levels when compared to national averages and other independent hospitals. The hospital participated in national audit programmes such as performance reported outcomes measures (PROMs) and the National Joint Registry. Results showed patient outcomes were in line with the national average. Audit findings were reviewed and monitored at routine clinical governance and medical advisory committee meetings. Staff were aware of the legal requirements of the Mental Capacity Act (MCA) 2005 and Deprivation of Liberties Safeguards (DoLS). Staff sought consent from patients prior to delivering care and treatment and understood what actions to take if a patient lacked the capacity to make informed decisions. Consultants working at the hospital were employed under practising privileges (authority granted to a physician or dentist by a hospital governing board to provide patient care in the hospital) that were monitored by the Medical Advisory Committee (MAC). Any changes to policies were reviewed by a consultant with the relevant expertise and discussed and ratified during MAC meetings. Staff appraisals had been identified as an area for improvement by the management team. We were told appraisals were now more robustly

Summary of findings

recorded using an appraisal system but historically the formal reporting of appraisals had not been updated on the hospital database consistently, leading to poor evidence that appraisals were being conducted on a regular basis. Whilst improvements had already been seen, the registered manager and director of clinical services were fully aware that the current position in this area remained a 'work in progress'.

Are services caring at this hospital/service

Staff treated patients with dignity and respect. Patients were kept involved in their care and treatment and staff were clear at explaining their treatment to them in a way they could understand. Patient feedback from the NHS Friends and Family Test showed most patients were positive about recommending the surgical services to friends and family. The hospital also asked patients to complete a patient satisfaction survey. This was administered by an independent third party organisation. Results from the survey for 2015 consistently showed high levels of patient satisfaction in all areas surveyed including overall quality of care and nursing care. Surgical patients had an allocated nurse who was able to support their understanding of care and treatment and ensure that they were able to voice any concerns or anxieties.

Are services responsive at this hospital/service

There were clear inclusion and exclusion criteria in place to determine which patients could be treated safely at the hospital. As part of the pre-operative assessment process, patients with certain medical conditions were excluded from receiving treatment at the hospital. This meant the majority of patients treated at the hospital were considered to be "low risk". Vulnerable adults, such as patients with learning disabilities and those living with dementia were identified at referral and appropriate steps were taken to ensure they were appropriately cared for. In most cases, this meant they were usually referred to NHS establishments. There was sufficient capacity to provide care and treatment for patients undergoing surgery at the hospital. The hospital met the target for 90% of admitted NHS patients beginning treatment within 18 weeks of referral for each month between April 2014 and July 2015. Waiting times for outpatient appointments were within the national guidelines. Daily 'comms cell' meetings took place to monitor staffing and capacity issues so that patients could be managed and treated in a timely manner. Staff demonstrated an awareness of the religious needs of patients and facilities such as prayer rooms were available for patients from different faiths. Complaints were responded to in a timely manner. Complaints were discussed during daily 'comms cell' meetings and at monthly staff meetings so shared learning could take place.

Are services well led at this hospital/service

There was a clear governance structure in place with committees for medicines management, infection control and health and safety feeding into the clinical governance committee and medical advisory committee (MAC). There was a robust policy and process in place for reviewing consultant practising privileges every 12 months by the MAC with oversight by the registered manager. There were clearly defined and visible leadership roles at corporate, hospital and department level. The hospital's vision and values were visible throughout the hospital and staff had a good understanding of these. The governance strategy and quality improvement plan 2015/16 included specific performance targets and actions relating to patient safety, clinical effectiveness and patient experience. One of the areas identified for improvement was the hospital's endoscope cleaning and decontamination process. At the time of inspection the service was not JAG accredited because scopes were decontaminated in a small decontamination room that did not have clear segregated clean and dirty areas in accordance with best practice guidelines. Whilst practice was safe, the layout of equipment was not in line with best practice guidelines due to the size of the room. Investment in this area was a priority for the hospital to enable it to achieve JAG accreditation. Improvement plans to refurbish the room, increase the size and have separate dirty and clean areas was in place and was due to be completed prior to accreditation during 2016.The risk register highlighted key risks to the service. Actions taken to control or minimise the risks were detailed but where there was a residual risk it was not always clear what action was still required or was being taken to further mitigate or minimise the risk. In some instance the status of the risk was recorded as "outstanding controls/actions" but it did not detail what they were or the timeframe for completion. The risk register was reviewed quarterly as part of the senior management team meetings but we were told that these meetings were not recorded.

Summary of findings

Our key findings were as follows:

Overall service leadership

- There were clearly defined and visible leadership roles at corporate, hospital and department level.
- Senior staff provided clear leadership and motivation to their teams.
- The theatres staff spoke positively about the recently appointed theatre manager. They told us the theatre manager had shown good leadership and had made positive improvements in planning and organisation within the theatres.

Cleanliness and infection control

- There had been no cases of Methicillin-Resistant Staphylococcus Aureus (MRSA) bacteraemia infections, Methicillin-Sensitive Staphylococcus Aureus (MSSA) bacteraemia infections or Clostridium difficile (C. diff) infections at the hospital between April 2014 and March 2015.
- All admitted patients underwent MRSA screening. Patients identified with an infection could be isolated in their rooms to support the management of cross infection risks.
- There were no surgical site infections following knee replacement surgery at the hospital between April 2014 and March 2015. The hospital had reported one surgical site infection following hip replacement surgery during this period.
- Hospital records showed there had been a total of 16 surgical site infections following surgery (all surgical procedures) between October 2014 and July 2015. Each incident was investigated to look for improvements. There were no recurring themes or trends that could attribute to the infection rates.
- All the areas we visited were visibly clean and tidy. Staff were aware of current infection prevention and control guidelines. Cleaning schedules were in place with clearly defined roles and responsibilities for cleaning the environment and cleaning and decontaminating equipment.
- There were arrangements in place for the handling, storage and disposal of clinical waste, including sharps. There were hand wash sinks and hand gels available in all areas of the hospital. We observed most staff following hand hygiene and 'bare below the elbow' guidance. However, some staff did not always carry out hand hygiene practices in between contact with patients. This was not in line with best practice guidance and may increase the risk of cross infection between patients.
- Staff were observed wearing personal protective equipment, such as gloves and aprons, while delivering care. Gowning procedures were adhered to in the theatre areas.
- The trust had employed a number of infection control link nurses to provide training and to liaise with staff so patients that acquired infections could be identified and treated promptly.

Staffing levels

- The areas we inspected had a sufficient number of trained nursing and support staff with an appropriate skills mix to meet patients' needs.
- Staffing levels were monitored using the BMI Healthcare nursing dependency and skill mix tool. The theatres did not have a full establishment of trained permanent staff (there were 11 nursing staff vacancies). However, staffing levels were maintained through the use of regular bank and agency staff.
- A recent initiative had seen a restructure of the theatre team to introduce lead practitioners that the hospital hoped would stimulate recruitment success. In addition, the recruitment of newly qualified nurses with a desire to work on the wards and theatres who could be mentored and trained internally was an area of focus going forward for the hospital.
- In outpatients, the staff rota showed how many staff were needed for the different clinics based on the nature of the clinic and the acuity of the patients in conjunction with the consultant. This was reviewed weekly to provide safe staffing levels when extra clinics were needed.

Nutrition and hydration

Summary of findings

- Patient records included an assessment of patients' nutritional requirements.
- Patients told us they were offered a choice of food and drink and spoke positively about the quality of the food offered.
- Patients with difficulties eating and drinking were placed on special diets. Special meals were also prepared for patients with diabetes.
- Staff understood people's cultural needs. For example, staff could provide 'halal' or 'kosher' meals if requested

There were areas of practice where the provider should make improvements.

The provider should:

- Ensure that all staff follow hand hygiene best practice processes in all areas of the hospital.
- Ensure all staff receive a regular appraisal to support and promote development.
- Continue to prioritise recruitment of theatre staff.
- Ensure the risk register clearly identifies any outstanding actions required to mitigate risks and expected date of completion.

Professor Sir Mike Richards
Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Surgery	Good	We rated surgical services at The Beaumont Hospital overall as 'Good'. Patient safety was monitored and incidents were investigated to assist learning and improve care. Patients received care in visibly clean and suitably maintained premises and appropriate equipment was available to meet their needs. Medicines were stored safely and given to patients in a timely manner. Patient records were completed appropriately. The staffing levels and skills mix was sufficient to meet patients' needs and staff assessed and responded to patient risks. Patients received care and treatment by competent staff that worked well as part of a multidisciplinary team. Patients received care and treatment in line with national guidelines such as National Institute for Health and Clinical Excellence (NICE) and the Royal Colleges. The rate of unplanned readmissions and unplanned patient transfers to other hospitals was within expected levels when compared to national averages and other independent hospitals. Staff sought consent from patients prior to delivering care and treatment and understood what actions to take if a patient lacked the capacity to make their own decisions. Patients spoke positively about their care and the way they were treated by staff. Patient feedback from the NHS Friends and Family Test showed most patients were positive about recommending the surgical services to friends and family. Patients admitted for surgery were seen promptly and received the right level of care. The service consistently achieved the 18 week referral to treatment standards for admitted patients. There were systems in place to support vulnerable patients. Complaints about the service were investigated and lessons learnt were shared with staff. There was a clear governance structure in place with committees such as clinical governance, infection control, health and safety and medicines management feeding into the medical advisory committee (MAC) and hospital

Summary of findings

management team. There was effective teamwork and clearly visible leadership within the department. Staff were positive about the culture and the support they received from the managers.

Outpatients and diagnostic imaging

Good

We rated the Outpatients and Diagnostic Imaging service (OPD) at The BMI Beaumont Hospital as 'Good' overall. Safe systems were in place for reporting incidents, duty of candour and safeguarding issues. Staff knew about current infection prevention and control guidelines, however, hand hygiene wasn't always carried out in line with best practice guidelines. Sufficient equipment was available and well maintained, appropriately checked and decontaminated regularly with checklists in use. Records were safely stored, structured, legible and up to date. Staff attended mandatory training courses with good compliance rates. Staffing levels were sufficient to meet the needs of patients and staff were aware of how to escalate key risks that could affect patient safety.

Patients received care and treatment in line clinical care pathways and local and national guidance. Patients were assessed for pain relief and provided with medication or treatment where appropriate. Staff undertook clinical audits such as patient consent and quality assurance for equipment in radiology by certified national organisations. Most staff confirmed they had received yearly appraisals; however, the overall rate was low. We observed effective multi-disciplinary working and staff sought consent from patients appropriately. Staff were enthusiastic and respectful whilst providing care. We observed positive interactions between staff and patients. All patients spoke highly of the care they had received regardless of how they were referred or funded. Waiting times for outpatient appointments were within the national guidelines. The diagnostic and imaging department provided scans on the same day for patients who had attended clinics. This reduced waiting times in the long term and meant patients didn't have to return another day. Interpreters could be booked for patients whose first language was not English, if required. Wheelchair access was available throughout the hospital. Information on how to raise compliments and complaints was displayed in the waiting areas.

Summary of findings

The BMI vision was embedded in the departments and staff embraced the values in the work they undertook. There were clearly defined and visible local leadership roles in each speciality within the outpatients and diagnostic imaging areas. Senior staff provided visible leadership and motivation to their teams. The services were appropriately represented at executive level and there was appropriate management of quality, governance and risks at a local level.

Summary of findings

Contents

Good

BMI The Beaumont Hospital

Services we looked at
Surgery; Outpatients and diagnostic imaging.

Summary of this inspection

Background to BMI The Beaumont Hospital

BMI The Beaumont Hospital in Bolton, Lancashire, is a private hospital that opened in 1984 and is part of BMI Healthcare. It is registered for 32 beds, which are positioned across 20 rooms. Currently there are 25 beds available for use. The registered manager is Mr. Wyn Davies who has been in post since 01 September 2013.

The hospital offers a wide range of procedures from routine investigations to complex surgery for inpatient and day-case patients aged 16 years and over. The hospital accepts children aged three to 16 for outpatient consultations. No invasive procedures (such as phlebotomy) are provided at the hospital for children and young people below the age of 16 and this is explained to parents or guardians at the time of the booking. Limited imaging and physiotherapy services are also available for children aged 12 or above.

The hospital has three theatres; two major theatres one of which has laminar flow and is used for orthopaedic procedures. The other is a minor operations theatre used for local anaesthetic procedures and endoscopy. The hospital also offers a well-equipped physiotherapy department supporting the hospital's significant orthopaedic activity.

Theatre Sterile Supply Unit (TSSU) services have been taken off-site to a corporate hub to ensure compliance with regulatory requirements for decontamination. The hospital's imaging department provides for most core modalities through a mixture of static and mobile solutions. More complex tests such as MRI and CT scans were provided by an external provider on certain days of the week at The Beaumont Hospital site. These facilities combined with on-site support services, enable consultants to undertake a wide range of procedures from routine investigations to complex surgery.

We carried out this inspection using our comprehensive inspection methodology. As part of our inspection we looked at surgery services and outpatient and diagnostic imaging services.

Our inspection team

Our inspection team was led by:

Inspection Lead: Emily Harrison, Inspection Manager, Care Quality Commission

The team included two CQC inspectors and a variety of specialists: Director of Nursing and Clinical Services (Independent Healthcare), Matron for Theatres, Outpatients Nurse.

How we carried out this inspection

To get to the heart of patients' experiences 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?

Before visiting, we reviewed a range of information we held about BMI The Beaumont Hospital.

The announced inspection of BMI The Beaumont Hospital took place on 2 and 3 September 2014. We also carried out an unannounced inspection on 17 September 2015 to see how patients were cared for out of hours.

As part of our inspection we spoke with a range of staff at different grades including: nurses of all grades, consultants, clinical lead nurse for outpatients, the infection control lead nurse, physiotherapists, radiographers, clinic coordinators, the employee compliance coordinator, the physiotherapy manager and

Summary of this inspection

team leader, reception staff. Catering staff, healthcare assistants, housekeepers, the ward manager, the theatre manager, the registered manager and the director of clinical services.

We spoke with 13 patients and received comments from people who contacted us to tell us about their experiences. We observed care and treatment and looked at 21 patient medical records. We also reviewed other relevant records held by the hospital such as complaints, incidents and relevant policies.

We would like to thank all staff and patients for sharing their views and experiences of the quality of care and treatment at BMI The Beaumont Hospital.

Information about BMI The Beaumont Hospital

BMI The Beaumont Hospital in Bolton, Lancashire, is a private hospital that opened in 1984 and is part of BMI Healthcare. It is licensed for 32 beds, which are positioned across 20 rooms. Currently there are 25 beds available for use.

In the 12 month period from April 2014 – March 2015 there were 5,763 visits to theatre. The most common surgeries were:

445 Facet joint injections

323 Injections into joints without x-ray control

212 Arthroscopic menisectomies

178 Vasectomies

165 Inguinal hernia repairs.

Diagnostic colonoscopy was the most common procedure performed in this timeframe. NHS funded inpatient day cases made up the majority of inpatient activity. Young people aged 16 to 17 years made up less than 1% of all inpatient activity. The hospital did not provide inpatient treatment to children below the age of 16 years.

NHS funded outpatient (first attendance and follow up) cases accounted for the majority of day case activity. Outpatient follow up appointments made up the majority of all activity carried out at the hospital (50%). Children aged 3 to 15 years made up less than 0.5% of outpatient activity.

Detailed findings from this inspection

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Surgery	Good	Good	Good	Good	Good	Good
Outpatients and diagnostic imaging	Good	Not rated	Good	Good	Good	Good
Overall	Good	Good	Good	Good	Good	Good

Notes

1. We will rate effectiveness where we have sufficient, robust information which answer the KLOE's and reflect the prompts.

Good

Surgery

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

Information about the service

The Beaumont Hospital provided day surgery and inpatient treatment for NHS funded and private patients across a range of surgical services, including cosmetic surgery, urology, ophthalmology, orthopaedics, pain management, ear, nose and throat (ENT), endoscopies and general surgery. There were 737 overnight patients and 4,539 day case patients admitted to the hospital between April 2014 and March 2015.

The hospital did not carry out any invasive surgical procedures on patients less than 16 years of age. Young people aged 16 years and above could be admitted for day surgery or one night stay for certain surgical procedures, such as ear, nose and throat (ENT) or orthopaedic surgery. Surgery was only performed following the completion of a formal risk assessment as part of the pre-assessment process. Records showed that between April 2014 and March 2015 there were five overnight patients and nine day surgery patients in the 16 to 17 year old age group that were treated at the hospital and these were all private patients.

The Rivington ward (general surgery ward) was open over 24 hours, seven days and had 15 overnight beds and 10 day case beds. There were three operating theatres where surgical procedures were carried out between 8am to 8pm during weekdays and 8am to 6pm on Saturdays. One theatre had laminar flow and was used for orthopaedic procedures. The other two theatres consisted of a major theatre and a minor operations theatre suitable for local anaesthetic and endoscopy procedures. There were two recovery bays in the theatre areas.

We visited The Beaumont Hospital as part of our announced inspection on 2 and 3 September 2015. As part of the inspection, we inspected the pre-operative treatment room, the three operating theatres, the theatre recovery area (with two recovery bays) and the Rivington ward. We also visited the Rivington ward as part of our unannounced inspection on 17 September 2015 to see how patients were cared for out of hours.

As part of our inspection we spoke with a range of staff at different grades including ward and theatre nurses, consultants, catering staff, healthcare assistants, housekeepers, the ward manager, the theatre manager and the director of clinical services. We spoke with seven patients, observed care and treatment and looked at 10 patient medical records. We received comments from people who contacted us to tell us about their experiences, and we reviewed performance information about the hospital.

Good

Surgery

Summary of findings

We rated surgical services at The Beaumont Hospital overall as 'Good'. Patient safety was monitored and incidents were investigated to assist learning and improve care. Patients received care in visibly clean and suitably maintained premises and appropriate equipment was available to meet their needs. Medicines were stored safely and given to patients in a timely manner. Patient records were completed appropriately. The staffing levels and skills mix was sufficient to meet patients' needs and staff assessed and responded to patient risks. Patients received care and treatment by competent staff that worked well as part of a multidisciplinary team.

Patients received care and treatment in line with national guidelines such as National Institute for Health and Clinical Excellence (NICE) and the Royal Colleges. The rate of unplanned readmissions and unplanned patient transfers to other hospitals was within expected levels when compared to national averages and other independent hospitals. Staff sought consent from patients prior to delivering care and treatment and understood what actions to take if a patient lacked the capacity to make their own decisions. Patients spoke positively about their care and the way they were treated by staff. Patient feedback from the NHS Friends and Family Test showed most patients were positive about recommending the surgical services to friends and family.

Patients admitted for surgery were seen promptly and received the right level of care. The service consistently achieved the 18 week referral to treatment standards for admitted patients. There were systems in place to support vulnerable patients. Complaints about the service were investigated and lessons learnt were shared with staff. There was a clear governance structure in place with committees such as clinical governance, infection control, health and safety and medicines management feeding into the medical advisory committee (MAC) and hospital management team. There was effective teamwork and clearly visible leadership within the department. Staff were positive about the culture and the support they received from the managers.

Are surgery services safe?

Good

Patient safety was monitored and incidents were investigated to assist learning and improve care. Patients received care in visibly clean and suitably maintained premises and were supported with the right equipment. Medicines were stored safely and given to patients in a timely manner. Patient records were completed appropriately. The staffing levels and skills mix was sufficient to meet patients' needs and staff assessed and responded to patient risks.

The hospital's target of 90% training completion had been achieved for surgery ward staff. However, the training completion rate for theatre staff was 78.7%. This meant that although most theatre staff had completed their mandatory training, the hospital's own target had not been achieved. The recently appointed theatre manager had identified this issue and was taking appropriate action to secure improvement. Some staff had not adhered to hand hygiene processes but these were low numbers and there was no evidence of harm to patients. Where poor compliance was identified, this was fed back to individual staff members to aid their learning.

Incidents

- The strategic executive information system data showed that there had been one 'never event' reported by the hospital since April 2014 relating to surgery. A never event is a serious, wholly preventable patient safety incident that should not occur if the available preventative measures have been implemented by healthcare providers.
- The incident occurred when a swab was left inside a patient after tonsillectomy surgery (removal of tonsils) in June 2014. This incident was investigated and remedial actions were put in place to prevent recurrence, such as the use of swab counters and additional training for staff. Compliance with this practice was audited on a monthly basis. The hospital reported one serious incident relating to surgery during December 2014 where an expired surgical implant component was used on a patient. The investigation highlighted this was due to human error and there was no adverse impact on the

safety and welfare of the patient. The component was sourced from another hospital and remedial actions included holding stocks of the surgical component at the hospital.
- Staff were aware of the process for reporting any incidents and identified risks. All incidents, accidents and near misses were recorded using paper based incident report (IR1) forms and an electronic incident reporting system. All incidents raised using IR1 forms were then uploaded to the electronic system.
- Incidents were reviewed and investigated by the appropriate manager (depending on the area the incident took place) to look for improvements to the service. Serious incidents were investigated by staff with the appropriate level of seniority, such as the director of clinical services.
- Incidents were discussed during daily 'communication cell' meetings and at monthly staff meetings so shared learning could take place.
- Staff told us they received feedback directly if they made an individual error, such medication record errors, to aid their learning and that they were supported by their managers.
- Staff across all disciplines were aware of their responsibilities regarding duty of candour legislation. Policies were in place to ensure the principles and requirements of the duty of candour process were followed.

Safety thermometer

- The NHS Safety Thermometer is an improvement tool for measuring, monitoring and analysing patient harms and 'harm free' care. It looks at risks such as falls, pressure ulcers, bloods clots and catheter acquired urinary tract infections.
- Information relating to the Safety Thermometer was clearly displayed in the ward and theatre areas we inspected.
- Staff carried out risk assessments to identify patients at risk of falls and acquiring pressure ulcers and venous thromboembolism (VTE- when a blood clot breaks loose and travels in the blood)) as part of the assessment carried out before patients were admitted for surgery.
- There had been eight patient falls reported by the hospital between October 2014 and July 2015. Patients identified at risk of falls were placed on care plans and were monitored more frequently by staff to reduce the risk of falls.
- There had been one case of hospital-acquired VTE reported between April 2014 and March 2015. The incident occurred during June 2014. We saw the incident was investigated and appropriate remedial actions were taken such as ensuring the use of anti-embolism stockings to reduce the risk of blood clots.
- The hospital carried out VTE risk assessments for all patients. The hospital consistently achieved its target for VTE risk assessments to be completed for at least 95% of NHS funded patients.

Cleanliness, infection control and hygiene

- There had been no cases of Methicillin-Resistant Staphylococcus Aureus (MRSA) bacteraemia infections, Methicillin-Sensitive Staphylococcus Aureus (MSSA) bacteraemia infections or Clostridium difficile (C.diff) infections at the hospital between April 2014 and March 2015.
- All admitted patients underwent MRSA screening. Patients identified with an infection could be isolated in their rooms to support the management of cross infection risks.
- There were no surgical site infections following knee replacement surgery at the hospital between April 2014 and March 2015. The hospital had reported one surgical site infection following hip replacement surgery during this period.
- Hospital records showed there had been a total of 16 surgical site infections following surgery (all surgical procedures) between October 2014 and July 2015. Each incident was investigated to look for improvements. There were no recurring themes or trends that could attribute to the infection rates.
- We looked at the investigation reports for two surgical site infections that occurred during February and March 2015 and saw remedial actions had been taken to minimise recurrence, such as additional training for staff in hand hygiene and aseptic non-touch technique procedures.
- The preoperative assessment area, ward and theatres were visibly clean and safe. Staff were aware of current infection prevention and control guidelines. Cleaning schedules were in place with clearly defined roles and responsibilities for cleaning the environment and cleaning and decontaminating equipment.

- There were arrangements in place for the handling, storage and disposal of clinical waste, including sharps. There were enough hand wash sinks and hand gels. We observed most staff following hand hygiene and 'bare below the elbow' guidance.
- Hand hygiene and 'bare below the elbow' compliance was monitored through a monthly audit by observing at least 10 staff in the ward and theatre areas. Audit results for the ward and theatre areas showed compliance ranged between 75% and 100% between April and September 2015. Where poor compliance was identified, this was fed back to individual staff members to aid their learning.
- The director of clinical services told us they had completed a review of hand hygiene audits and will be amending the reporting template to include two additional sections; one to include who the non-compliances have been reported to and on what date and the other to indicate the outcome of the escalation process so that there is evidence of lessons learnt and closure of any actions.
- The director of clinical services also confirmed that staff had been made aware of the requirement to complete the hand hygiene observational audits each month in each clinical department and to discuss the outcome and details of the audit with the departmental manager so they are fully aware of any issues identified.
- Staff were observed wearing personal protective equipment, such as gloves and aprons, while delivering care. Gowning procedures were adhered to in the theatre areas.

Environment and equipment

- The preoperative assessment area, ward and theatre areas were visibly clean, well maintained and free from clutter.
- Equipment was visibly clean and well maintained. Staff told us that all items of equipment were readily available and any faulty equipment was repaired or replaced in a timely manner.
- Equipment servicing was managed by a centralised maintenance team that arranged for equipment to be serviced by external contractors. Equipment such as hoists, operating theatre equipment and blood pressure monitors included labels showing they had been serviced and when they were next due for servicing.
- Reusable surgical instruments were sterilised in a dedicated sterilisation unit by an external contractor. Staff in the theatres told us they always had access to the equipment they needed to meet patients' needs.
- Single use sterile instruments were stored appropriately and kept within their expiry dates. The theatres' equipment store had sufficient storage space and items such as surgical procedure packs, implants and consumable items were appropriately stored in a tidy and organised manner.
- Reusable endoscopes (which are used to look inside a body cavity or organ) were cleaned and decontaminated in a dedicated decontamination room. The facility had not yet achieved joint advisory group for gastrointestinal endoscopy (JAG) accreditation. At the time of inspection the service was not JAG accredited because scopes were decontaminated in a small decontamination room that did not have clear segregated clean and dirty areas in accordance with best practice guidelines. Whilst practice was safe, the layout of equipment was not in line with best practice guidelines due to the size of the room. Investment in this area was a priority for the hospital to enable it to achieve JAG accreditation. Improvement plans to refurbish the room, increase the size and have separate dirty and clean areas was in place and was due to be completed during 2016. The hospital was working towards JAG accreditation for endoscopy services with the audit scheduled for April 2017.
- We saw that scopes were decontaminated in a small decontamination room that did not have clear segregated clean and dirty areas in accordance with best practice guidelines. There were plans to replace the equipment and refurbish the facilities with segregated clean and dirty areas by the end of December 2015. A risk assessment had been completed to minimise the risk to patient safety by providing training to staff working in the decontamination room and by having arrangements with the decontamination equipment manufacturer to repair or replace faulty equipment in a timely manner.
- There was a system in place to ensure safety alerts relating to patient safety, medicines and medical devices were cascaded to staff across the surgical services and responded to in a timely manner. Records

showed 100% of Medicines and Healthcare products Regulatory Agency (MHRA) alerts had been completed within required timescales between October 2014 and July 2015.
- Emergency resuscitation equipment was available across all areas and checked on a daily basis by staff.

Medicines

- The hospital had a pharmacist and pharmacy technician during weekdays. The pharmacist was available on-call outside of normal working hours and at weekends. The hospital had an on-site pharmacy so that medicines required for patients were readily available.
- Medicines, including controlled drugs, were securely stored. Staff carried out daily checks on controlled drugs and medication stocks to ensure that medicines were reconciled correctly.
- Medicines that required storage at temperatures below 8ºC were appropriately stored in medicine fridges. Fridge temperatures were checked daily to ensure medicines were stored at the correct temperatures.
- A pharmacist reviewed all medical prescriptions, including antimicrobial prescriptions, to identify and minimise the incidence of prescribing errors. The ward staff confirmed a pharmacist carried out daily reviews on the ward.
- We looked at the medication charts for three patients and found these to be complete, up to date and reviewed on a regular basis.

Records

- The hospital used paper based patient records which were securely stored in each area we inspected.
- We looked at the records for seven patients. All of the records were well structured, legible and up to date.
- Patient records included appropriate risk assessments for things such as patient falls, venous thromboembolism (VTE), pressure care and nutrition and they were completed correctly.
- Patient records showed that nursing and clinical assessments were carried out before, during and after surgery and these were documented correctly.

Safeguarding

- Staff received mandatory training in the safeguarding of vulnerable adults and children as part of their induction followed by annual safeguarding refresher training.
- Hospital data showed that 96% of staff across the hospital had received safeguarding vulnerable adults training and 98% of staff had received training in safeguarding children.
- Staff were aware of how to identify potential abuse and report safeguarding concerns. Information on how to report safeguarding concerns was clearly displayed in the areas we inspected. The director of clinical services was the named safeguarding lead for the hospital.
- There had been no reported safeguarding incidents relating to surgery at the hospital during the past 12 months.

Mandatory training

- Staff received annual training in key topics such as children's and adult life support training, information governance, safeguarding of vulnerable adults, safeguarding children, equality and diversity, fire safety, infection control, health and safety and moving and handling training.
- Mandatory training was delivered on a rolling annual programme and monitored on a monthly basis. The mandatory training was delivered either face-to-face or via e-learning.
- Records showed that 91.9% of staff across the hospital had completed their mandatory training at the end of August 2015 and the hospital's target of 90% training completion had been achieved. However, the training completion rate for theatre staff was 78.7%. This meant that although most theatre staff had completed their mandatory training, the hospital's own target had not been achieved. The recently appointed theatre manager had identified this issue and was taking appropriate action to secure improvement.

Assessing and responding to patient risk

- An emergency telephone line was available for staff to call in case of emergency or a deteriorating patient. A first responder team would attend the patient. There was a resident medical officer (RMO) on site 24 hours a day. As part of their practising privileges (the right to practice in a hospital), consultants were responsible for the care and treatment of their patients at all times. As a result, they were accessible by telephone 24 hours a day, seven days a week for advice and guidance when required. Alternatively consultants had to arrange appropriate alternative named cover if they were unavailable.

Good

Surgery

- Staff were aware of how to escalate key risks that could impact on patient safety, such as staffing and bed capacity issues and there was daily involvement by the ward and theatre managers and the director of clinical services to address these risks.
- Prior to undergoing surgery, staff carried out preoperative risk assessments to identify patients at risk of harm. Patients at high risk were placed on care pathways and care plans were put in place to ensure they received the right level of care.
- Patients were assessed by an anaesthetist and surgeon on the day of surgery to identify patients with underlying medical conditions or those deemed at risk of developing complications after surgery and a decision was made as to whether they could be operated on at the hospital.
- Staff used early warning score systems and carried out routine monitoring based on the patient's individual needs to ensure any changes to their medical condition could be promptly identified.
- The hospital had a transfer agreement in place so patients could be transferred to a local acute trust if needed. Where a patient's health deteriorated, staff were supported with medical input to stabilise patients prior to transfer. Theatres did not stock equipment for transfer but did have the ability to continue to ventilate patients in theatre. This was a recognised decision as it was felt that such instances were so rare, it was difficult to maintain staff competence. At the time of our inspection the Greater Manchester Critical Care network had agreed to include the hospital in its transfer policy. This meant the service would have access to the relevant expertise with a clear, formal process in place should a patient require emergency transfer.
- We observed two theatre teams undertake the 'five steps to safer surgery' procedures, including the use of the World Health Organization (WHO) checklist. The theatre staff completed safety checks before, during and after surgery and demonstrated a good understanding of the 'five steps to safer surgery' procedures.
- A monthly audit to monitor adherence to the WHO checklist was carried out by reviewing at least five completed records and observing the checklist being performed during surgical procedures in the theatres department.

Nursing staffing

- The ward had a sufficient number of trained nursing and support staff with an appropriate skills mix to ensure that patients were safe and received the right level of care.
- Staffing levels were monitored using the BMI Healthcare nursing dependency and skill mix tool. The expected and actual staffing levels were displayed on notice boards in each area we inspected and these were updated on a daily basis.
- The ward and theatre managers told us that the staffing establishments were set in advance based on planned procedures and patient acuity. Staffing levels were increased if a patient requiring additional support was identified during their pre-operative assessment.
- The staffing levels on the ward consisted of at least three nurses and one healthcare assistant (HCA) during the morning and evening shifts and at least two nurses during the night. As part of our unannounced inspection on 17 September we found there were two registered nurses and two healthcare assistants on duty on the late shift for two patients.
- The staffing establishment on the ward was 18 nurses and four HCA's at the time of the inspection. There were only two nurse vacancies in the ward area. Two healthcare assistants had recently been appointed which meant there were no HCA vacancies on the ward.
- The theatres did not have a full establishment of trained permanent staff. However, staffing levels were maintained through the use of bank and agency staff to ensure that patients were safe and received the right level of care. The theatre manager told us the majority of agency staff working in the theatres were regular agency staff that had undergone induction training and were familiar with the theatre department's policies and procedures. A record was maintained for all regular agency staff that indicated induction had been completed.
- Within the theatres, there were 11 nursing staff vacancies. The theatre manager told us recruitment to these posts was ongoing and the vacancies had been advertised. At the time of our inspection, suitable candidates had been identified for two of the vacancies.
- There was low usage of agency staff for inpatient ward nurses and support workers (less than 15%) between April 2014 and March 2015.
- Nursing staff handovers occurred three times a day and included discussions around patient needs, their medication and their present condition.

- Records showed that 100% of professional registrations for staff (such as Nursing and Midwifery Council and General Medical Council registrations) had been verified at the end of July 2015.

Surgical staffing

- Medical cover on the wards was provided by two resident medical officers (RMO) that worked alternate shifts every two weeks. During their shift, the RMO was based at the hospital 24 hours per day over the two week period. The RMO was on duty between 7.30am and 10pm daily and was available on-call during out-of-hours.
- During their shift, the RMO was responsible for providing medical cover on the ward. Their duties included the monitoring of patients in the ward areas and prescribing medicines. The RMO was also responsible for taking blood samples and inserting / removing patient cannulas and catheters as the nursing staff were not trained to carry out these duties.
- The RMO told us they received induction training and were provided with hospital policies applicable to their role, such as the policy for patient transfer. They also told us they received good support from the ward staff and could contact the on-call consultant or anaesthetist responsible for a particular patient if further advice or support was needed.
- Ward staff told us the RMO cover was sufficient to meet patient needs because the majority of patients were deemed low risk and did not have complex medical needs.
- Surgical procedures were carried out by a team of consultant surgeons and anaesthetists who were mainly employed by other organisations (usually in the NHS) in substantive posts and had practising privileges with the Beaumont Hospital. The process for review of practising privileges also ensured consultants were practising within their scope of practise. Any requests to carry out additional procedures had to be approved by the medical advisory committee to ensure they were safe and appropriate.
- The consultants and anaesthetists were responsible for their individual patients during their hospital stay. Patient records showed consultant reviews were carried out on a daily basis.
- The RMO and ward staff had a list of contacts for all the consultants and anaesthetists for each patient and told us they could be easily contacted when needed.

Major incident awareness and training

- There was a business continuity plan that listed key risks that could affect the provision of care and treatment and staff were aware of how to access this information when needed.
- The ward and theatre staff had written guidelines to follow in the event of a major incident, such as a fire or power failure.
- There was a hospital-wide resuscitation team in place for dealing with medical emergencies. The team was led by the RMO and included a team of nurses and supporting staff that were trained in immediate life support for adults and children.

Are surgery services effective?

Good

Patients received care and treatment according to national guidelines such as National Institute for Health and Clinical Excellence (NICE) and the Royal Colleges. Surgery services participated in national audits. Findings from performance reported outcomes measures (PROMs) and the National Joint Registry showed the majority of patients had a positive outcome following their care and treatment. The rate of unplanned readmissions and unplanned patient transfers to other hospitals was within expected levels when compared to national averages and other independent hospitals.

Care and treatment was provided by suitably trained, competent staff that worked well as part of a multidisciplinary team. We found that none of the theatre staff had completed their appraisals during 2014. However, the theatre manager was working to address this during 2015. Consultants working at the hospital were employed under practising privileges (authority granted to a physician or dentist by a hospital governing board to provide patient care in the hospital). Practising privileges were reviewed every two years by the site management team. Staff sought consent from patients prior to delivering care and treatment and understood what actions to take if a patient lacked the capacity to make their own decisions.

Evidence-based care and treatment

- Patients received care according to national guidelines such as National Institute for Health and Clinical Excellence (NICE) and Royal College of Surgeons guidelines.
- Staff in the ward and theatres used enhanced care and recovery pathways, in line with national guidance.
- Staff used integrated care pathways for surgical procedures such as for hip or knee replacement and these were based on national guidelines.
- Policies and procedures reflected current guidelines and staff told us they were easily accessible via the hospital's intranet.

Pain relief

- Patients were assessed pre-operatively for their preferred post-operative pain relief. Staff used a pain assessment score to assess the comfort of patients both as part of their routine observations and at a suitable interval of time after giving pain relief.
- Patient records showed that patients received the required pain relief and they were treated in a way that met their needs and reduced discomfort.
- Patients were given an information leaflet to take home which provided information on how to manage pain symptoms following discharge from the hospital.
- Patients told us they received good support from staff and their pain relief medication was given to them as and when needed.

Nutrition and hydration

- Patient records included an assessment of patients' nutritional requirements.
- Patients told us they were offered a choice of food and drink and spoke positively about the quality of the food offered.
- Patients with difficulties eating and drinking were placed on special diets. Special meals were also prepared for patients with diabetes.
- Staff understood people's cultural needs. For example, staff could provide 'halal' or 'kosher' meals if requested.

Patient outcomes

- There had been no patient deaths reported at the hospital between April 2014 and June 2015
- The hospital participated in national audit programmes such as performance reported outcomes measures (PROMs) and the National Joint Registry. Audit findings were reviewed and monitored at routine clinical governance and medical advisory committee meetings.
- The national joint registry (NJR) data showed that hip and knee mortality rates at the hospital were in line with the national average.
- Performance reported outcomes measures (PROMs) data between April 2013 and March 2014 showed that the percentage of patients with improved outcomes following groin hernia, hip replacement and knee replacement procedures was similar to the England average.
- There had been 17 unplanned patient readmissions to the hospital within 28 days of discharge between April 2014 and March 2015. The rate of unplanned readmissions was 'similar to expected' when compared to the other independent acute hospitals during this period.
- The number of unplanned patient transfers to another hospital was similar to the England average between April 2014 and June 2015. There had been five transfers of surgical patients to other hospitals during this period. In each case, a consultant had made the decision to transfer the patients for valid clinical reasons such as patients becoming unwell after surgery.

Competent staff

- Newly appointed staff underwent an induction process for up to three weeks and their competency was assessed prior to working unsupervised.
- Staff told us they received annual appraisals. Records showed that 50% of inpatient ward nurses, 33% of healthcare assistants and 58% of allied health professionals had completed their annual appraisals during 2014.
- None of the theatre staff had completed their appraisals during 2014. The recently appointed theatre manager had carried out one to one meetings with each member of staff and had a schedule in place to complete all staff appraisals during 2015.
- This had been identified as an area for improvement by the management team. The registered manager told us there had been three theatre managers in 18 months

and this had contributed to sporadic completion of appraisals in theatres. However, the post had recently been recruited to and it was hoped that this would lead to stability and a more formalised approach.
- An action plan for theatres was in place that included dates for appraisals to take place up to the end of 2015. At the time of inspection, the theatre manager had completed one to one supervisions with all staff.
- We were also told that appraisals were now more robustly recorded using an appraisal system. Historically the formal reporting of appraisals had not been updated on the hospital database consistently, leading to poor evidence that appraisals were being conducted on a regular basis. Whilst improvements had already been seen, the registered manager and director of clinical services were fully aware that the current position in this area remained a 'work in progress'. There were 137 consultants working at the hospital that were employed under practising privileges (authority granted to a physician or dentist by a hospital governing board to provide patient care in the hospital).
- All consultant surgeons and anaesthetists were required to maintain current practicing privileges in line with the BMI practicing privileges policy. An employee compliance coordinator monitored information stored for each consultant to ensure practising privileges were reviewed in a timely manner. Each individual consultant was responsible for keeping their information up to date and current.
- Practising privileges were reviewed by the chairperson of the medical advisory committee (MAC). This included a review of appraisals, General Medical Council (GMC) registrations and medical indemnity insurance.
- We spoke with two consultants, who told us they underwent peer appraisal and revalidation at the NHS acute trust they were based at and this information was provided to this hospital to ensure they kept up-to-date records about the consultant. Records were closely monitored. Any delay in submission of evidence of appraisal and revalidation was flagged by the employee compliance coordinator with oversight, and if necessary, intervention from the registered manager.
- Staff were positive about on-the-job learning and development opportunities and told us they were supported well by their line managers.

Multidisciplinary working

- There was effective daily communication between multidisciplinary teams within the ward and theatres. Staff told us they had a good relationship with consultants and the resident medical officer (RMO).
- Patient records showed that there was routine input from nursing and medical staff and allied health professionals, such as physiotherapists.
- Theatre staff carried out 'safety huddles' on a daily basis to ensure all staff had up-to-date information about risks and concerns.
- There was daily communication between the pre-operative assessment staff and ward and theatre staff so patient care could be coordinated and delivered effectively.

Seven-day services

- Routine surgery was performed in the theatres during weekdays and on Saturdays. The Rivington ward accommodated overnight patients seven days per week and staffing levels were suitably maintained during out-of-hours and weekends.
- The RMO provided out-of-hours medical cover for the inpatient ward 24 hours a day, seven days per week.
- Patients were seen daily by their consultant, including on weekends. The hospital's practising privileges policy required consultants to remain available at all times during the patient's stay at the hospital or to arrange appropriate alternative named cover if they were unavailable. Staff confirmed they had never had any difficulty contacting a surgeon if and when required.
- The RMO and ward staff had a list of contacts for all the consultants and anaesthetists for each patient and told us they could be easily contacted when needed.
- There was an on-call rota for key staff groups, including senior managers, pharmacy, physiotherapy and imaging (such as X-rays). An on-call emergency theatre team was also available out of hours in case a patient needed to return to theatre unexpectedly.

Access to information

- The hospital used paper based patient records. We looked at 10 patient records in total. The records were complete, up to date and easy to follow. They contained detailed patient information from admission and surgery through to discharge. This meant that staff could access all the information needed about the patient at any time.

- We saw that information such as audit results, performance information and internal correspondence were displayed in all the areas we inspected. Staff could access information such as policies and procedures from the hospital's intranet.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff had the appropriate skills and knowledge to seek consent from patients. Staff were clear on how they sought verbal informed consent and written consent before providing care or treatment.
- The consultants sought consent from patients undergoing surgery during the initial consultation and again on the day of surgery. Patient records showed that verbal or written consent had been obtained from patients and that planned care was delivered with their agreement. Consent forms showed the risks and benefits were discussed with the patient prior to carrying out a surgical procedure.
- Staff were aware of the legal requirements of the Mental Capacity Act (MCA) 2005 and Deprivation of Liberties Safeguards (DoLS). Records showed 88% of staff across the hospital had completed mandatory training in MCA and DoLS at the end of August 2015.
- Patients that lacked capacity were identified during their pre-operative assessment and staff could seek advice from other professionals, such as social workers or local mental health services in order to complete capacity assessments.
- Staff told us the majority of admitted patients had the capacity to make their decisions. Where patients lacked the capacity to provide informed consent, staff made decisions about care and treatment in the best interests of the patient and involved the patient's representatives and other healthcare professionals.

Are surgery services caring?

Good

We spoke with seven patients and they all spoke positively about their care and the way they were treated by staff. Staff treated patients with dignity and respect. Patients were kept involved in their care and treatment and staff were clear at explaining their treatment to them in a way they could understand. Patient feedback from the NHS Friends and Family Test showed most patients were positive about recommending the surgical services to friends and family.

Compassionate care

- Patients were treated with dignity, compassion and empathy. We observed staff providing care in a respectful manner. Staff spoke with patients in private to maintain confidentiality.
- We spoke with seven patients. All the patients said they thought staff were kind and caring and gave us positive feedback about ways in which staff showed them respect and ensured that their dignity was maintained. The comments received included: "Staff are very respectful and friendly" and "Staff are fantastic, can't fault them".
- The NHS Friends and Family Test is a satisfaction survey that measures patients' satisfaction with the healthcare they have received. The test data for all patients between October 2014 and July 2015 showed the hospital had consistently high scores (greater than 90%) and the response rates varied between 20% and 50%. This showed that most patients were positive about recommending the hospital to their friends and family.
- The hospital also carried out an annual patient satisfaction survey and the patient feedback was compared with the provider's other hospitals.
- The survey results from July 2015 showed the responses were positive with patient satisfaction scores above 90% in relation to management of pain, medication side effects, accommodation and the quality of nursing and medical staff. The survey showed patients were less positive about the variety and choice of food offered, with a satisfaction score of 82.5%.

Understanding and involvement of patients and those close to them

- Patient records included pre-admission and pre-operative assessments that took into account individual patient preferences.
- Patients told us they were kept informed about their treatment and staff were clear at explaining their treatment to them in a way they could understand. They also spoke positively about the information they received verbally and also in the form of written materials, such as information leaflets specific to their treatment.

Good

Surgery

Emotional support

- Patients told us the staff were calm, reassuring and supportive and this helped them to relax prior to undergoing surgery.
- Patients had an allocated nurse who was able to support their understanding of care and treatment and ensure that they were able to voice any concerns or anxieties.
- There were information leaflets readily available that provided patients and their relatives with information about chaplaincy services and bereavement or counselling services.

Are surgery services responsive?

Good

Patients were assessed prior to undergoing surgery and staff were proactive in meeting patient needs. There was daily planning by staff to ensure patients were admitted and discharged in a timely manner. There was sufficient capacity in the wards and theatres to ensure patients admitted for surgery could be seen promptly and receive the right level of care.

There were systems in place to support vulnerable patients. Surgery services met the target for 90% of admitted NHS patients beginning treatment within 18 weeks of referral for each month between April 2014 and July 2015. Complaints about the service were investigated and lessons learnt were shared with staff.

Service planning and delivery to meet the needs of local people

- Patients had an initial consultation to determine whether they needed surgery, followed by a pre-operative assessment. Where a patient was identified as needing surgery, staff were able to plan for the patient in advance so they did not experience delays in their treatment when admitted to the hospital.
- As part of the pre-operative assessment process, patients with certain medical conditions were excluded from receiving treatment at the hospital. For example, Patients with an American Society of Anesthesiologists (ASA) physical status score of 3 and above were excluded. The majority of patients admitted to the hospital had an ASA score of 1 or 2 i.e. patients that were generally healthy or suffered from mild systemic disease. This meant the majority of patients treated at the hospital were considered to be "low risk".
- Patients with complex pre-existing medical conditions or a body mass index (BMI) of greater than 40 were also excluded from undergoing treatment at the hospital.
- However, there was no clear written policy or treatment criteria for patients living with dementia or patients with a learning disability.
- There was sufficient capacity to provide care and treatment for patients undergoing surgery at the hospital. Daily 'communication cell' meetings took place to monitor staffing and capacity issues so that patients could be managed and treated in a timely manner.
- Staff demonstrated an awareness of the religious needs of patients and facilities such as prayer rooms were available for patients from different faiths.

Access and flow

- Staff told us approximately 80% of patients treated at the hospital were NHS funded patients. The remainder were private insured and self-paying patients. The majority of NHS funded patients were referred to the hospital by their general practitioner (GP) via the NHS 'choose and book' system.
- The inspection did not highlight any concerns relating to the admission, transfer or discharge of patients from the ward or theatres. The patients we spoke with did not have any concerns in relation to their admission, waiting times or discharge arrangements.
- There was daily communication between the pre-operative assessment staff and ward and theatre staff to manage patient flow.
- Discharge planning was covered during pre-assessment to determine how many days patients would need on the ward as well as ascertaining whether patients were likely to require additional support at home when they were discharged.
- Patient records showed staff had completed a discharge checklist that covered areas such as medication and communication to the patient and other healthcare professionals, such as GPs, to ensure patients were discharged in a planned and organised manner.
- The hospital met the target for 90% of admitted NHS patients beginning treatment within 18 weeks of referral for each month between April 2014 and July 2015.

Good

Surgery

- Day case patients that were assessed as not being fit for discharge following surgery were kept on the ward for overnight care if needed. Records showed that 56 day case patients were transferred to the ward for overnight care between April 2014 and March 2015. This accounted for 1.2% of all day case patients during this period and showed that the majority of day case patients were treated and discharged the same day.
- There were 5,763 visits to the operating theatre between April 2014 and March 2015. Hospital data showed there had been 59 operations cancelled on the day of surgery between October 2014 and July 2015, which demonstrated that a relatively small proportion of operations were cancelled at the hospital.
- The theatre manager told us cancellations occurred due to clinical reasons as well as non-clinical reasons such as patients that did not attend. The theatre manager told us they planned to review the reasons for cancellations to look for improvements to the service.

Meeting people's individual needs

- Information leaflets about the services were readily available in all the areas we visited. Staff told us they could provide leaflets in different languages or other formats, such as braille if requested.
- Staff could access a language interpreter if needed.
- Staff received mandatory training in equality and diversity. Records showed 100% of ward staff and 95% of theatre staff had completed this training at the end of August 2015.
- The pre-operative assessment identified patients living with dementia or a learning disability. This allowed the staff to decide whether they could support these patients appropriately or refer them to another healthcare provider that could better meet their needs. However, it was not clear what screening tool or assessment criterion was used to support staff in making this decision. The hospital did not have a dementia link nurse.
- Staff told us patients with significant mental health issues would not be admitted to the hospital due to the complex nature of their needs.
- The hospital did not provide surgical services for obese (bariatric) patients. Patients identified as obese were offered services at another of the provider's hospitals.

Learning from complaints and concerns

- Information on how to raise complaints was visibly displayed in the areas we inspected.
- Patients told us they did not have any concerns but would speak with the staff if they wished to raise a complaint. Staff understood the process for receiving and handling complaints.
- The complaints policy stated that complaints would be acknowledged within two working days and investigated and responded to within 20 working days for routine complaints.
- Where the complaint investigation had not been completed within 20 working days, staff were required to send a holding letter explaining why a response had not been sent, followed by further holding letters every 20 days until the complaint was resolved.
- Where patients were not satisfied with the response to their complaint, they were given information on how to escalate their concerns with the independent sector complaints adjudication service (ISCAS).
- The hospital received 29 written complaints between April 2014 and March 2015. This included complaints for outpatients and surgical services. The main reasons for complaints were 'communication/information to patients' (seven complaints) and 'clinical treatment' (four complaints). There were two complaints relating to cancelled or delayed appointments from patients that were admitted overnight.
- We looked at the records for two complaints and saw that these were appropriately documented and had been responded to in a timely manner.
- Complaints were discussed during daily 'communication cell' meetings and at monthly staff meetings so shared learning could take place.

Are surgery services well-led?

Good

The hospital's vision and values were visible in the wards and theatres and staff had a good understanding of these. There was a clear governance structure in place with committees for clinical governance, infection control, health and safety and medicines management feeding into the medical advisory committee (MAC) and hospital management team. Staff were positive about the culture and the support they received from the managers.

Good

Surgery

Vision, strategy, innovation and sustainability for this core service

- The corporate vision was 'we aspire to deliver the highest quality outcomes, the best patient care and the most convenient choice of our patients as the UK leader in independent healthcare'.
- The governance strategy and quality improvement plan 2015/16 included specific performance targets and actions relating to patient safety, clinical effectiveness and patient experience.
- The vision and values were clearly displayed and had been shared with staff across the ward and theatre areas and staff had a good understanding of these.

Governance, risk management and quality measurement for this core service

- There was a clear governance structure in place with committees for medicines management, infection control and health and safety feeding into the clinical governance committee and medical advisory committee (MAC).
- Minutes for the last three MAC meetings demonstrated that key governance areas were discussed including incidents, complaints and practising privileges. However, we noted the MAC chair had been in post longer than the terms of reference indicated they should be. Whilst this had not had any demonstrable impact, it was not in line with best practice. We raised this with the provider at the time of the inspection.
- The ward and theatre managers logged identified risks on local risk registers. Key risks were placed on the hospital-wide corporate risk register.
- The hospital wide risk register highlighted key risks to the service. Actions taken to control or minimise the risks were detailed but where there was a residual risk (low and moderate risk) it was not clear what action was still required or was being taken to further mitigate or minimise the risk. In some instance the status of the risk was recorded as "outstanding controls/actions" but it did not detail what they were or the timeframe for completion. The clinical services director told us that the risks register was reviewed quarterly at senior management team meeting but that these meetings were not formally recorded.
- There was an infection prevention and control lead nurse who was responsible for coordinating audits, reviewing serious incidents and providing training to staff. Activity and outcomes were monitored through monthly clinical governance meetings.
- In each area we inspected, there were routine staff meetings to discuss day-to-day issues and to share information on complaints, incidents and audit results.
- Routine audit and monitoring of key processes took place across the ward and theatre areas to monitor performance against objectives. Information relating to performance against key quality, safety and performance objectives was monitored and shared with staff through performance dashboards that were displayed on noticeboards.

Leadership/culture of service

- The overall lead for the surgical services at the hospital was the director of clinical services.
- The surgical ward was led by a ward manager. The theatre manager was responsible for the day to day management of the theatres and had been in post for four weeks at the time of our inspection. The registered manager explained why there had been a turnover in theatre managers and that there had been challenges finding the right person.
- The theatres staff spoke positively about the recently appointed theatre manager. They told us that the theatre manager had shown good leadership and had made positive improvements in planning and organisation within the theatres.
- All the staff we spoke with were highly motivated and positive about their work and described the managers as approachable, visible and provided them with good support. Staff told us there was a friendly and open culture.
- Staff sickness rates in the wards and theatres were generally low (below 10%) between April 2014 and March 2015. Staff turnover was also low (below 20%) during this period. It should be noted that the ward and theatre teams consisted of a small number of staff so any sickness / absence would be perceived as a high percentage. In terms of actual staff numbers however, these rates were generally low.

Public and staff engagement

Good

Surgery

- The hospital participated in the BMI Healthcare staff survey. However, the survey had not taken place in 2014 due a period of consultation with staff regarding the terms and conditions of their contracts. A further survey was planned for early 2016.
- The hospital ran a staff recognition scheme to encourage staff to formally recognise and thank their colleagues who had 'gone the extra mile'
- The hospital also carried out a patient satisfaction survey and the patient feedback was compared with the provider's other hospitals. This was administered by an independent third party organisation. Results from the survey for 2015 to date, consistently showed high levels of patient satisfaction in all areas surveyed including overall quality of care and nursing care.
- The hospital displayed "You said – We did" information to show what action had been taken in response to patient feedback.

Innovation, improvement and sustainability

- One of the areas identified for improvement was the hospital's endoscope cleaning and decontamination process.
- At the time of inspection the service was not JAG accredited. Investment in this area was a priority for the hospital to enable it to achieve JAG accreditation.
- A recent initiative had seen a restructure of the theatre team to introduce lead practitioners that the hospital hoped would stimulate recruitment success. In addition, the recruitment of newly qualified nurses with a desire to work on the wards and theatres who could be mentored and trained internally was an area of focus going forward for the hospital.

Good

Outpatients and diagnostic imaging

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

Information about the service

The outpatients and diagnostic imaging services at The Beaumont Hospital covered a wide range of specialties including neurology, orthopaedics, ear nose and throat (ENT), general medicine, physiotherapy, urology, cosmetic surgery and general surgery. The diagnostic and imaging department carried out x-rays and ultrasound scans. More complex tests such as MRI and CT scans were provided by an external provider on certain days of the week at The Beaumont Hospital site.

The service mostly saw adults; however children over the age of three were also accepted as patients for consultations but no invasive treatments were carried out. The service was open from 8am to 9pm Monday to Friday with some additional clinics on Saturdays. The hospital recorded 28,421 patient attendances between April 2014 and March 2015 of which the majority (17,309) were NHS funded patients.

The outpatients department included a number of consultation and treatment rooms, a physiotherapy department with a gym and the diagnostic and imaging suite. Patients were referred by their GP, through consultants' private practice or as self-referrals. NHS services were commissioned by local clinical commissioning groups.

As part of our inspection we spoke with six patients and a range of staff including consultants across different specialities, the senior staff nurse, clinical lead nurse for outpatients, the infection control lead nurse, healthcare assistants, physiotherapists, radiographers, clinic coordinators, the physiotherapy manager and team leader, and reception staff. We observed care and looked at 11 patient medical records.

Summary of findings

We rated the Outpatients and Diagnostic Imaging service (OPD) at The BMI Beaumont Hospital as good overall. Safe systems were in place for reporting incidents, duty of candour and safeguarding issues. Staff knew about current infection prevention and control guidelines, however, hand hygiene wasn't always carried out in line with best practice guidelines. Sufficient equipment was available and well maintained, appropriately checked and decontaminated regularly with checklists in use. Records were safely stored, structured, legible and up to date. Staff attended mandatory training courses with good compliance rates. Staffing levels were sufficient to meet the needs of patients and staff were aware of how to escalate key risks that could affect patient safety.

Patients received care and treatment in line clinical care pathways and local and national guidance. Patients were assessed for pain relief and provided with medication or treatment where appropriate. Staff undertook clinical audits such as patient consent and quality assurance for equipment in radiology by certified national organisations. Most staff confirmed they had received yearly appraisals; however, the overall rate was low. We observed effective multi-disciplinary working and staff sought consent from patients appropriately. Staff were enthusiastic and respectful whilst providing care. We observed positive interactions between staff and patients. All patients spoke highly of the care they had received regardless of how they were referred or funded.

Good

Outpatients and diagnostic imaging

Waiting times for outpatient appointments were within the national guidelines. The diagnostic and imaging department provided scans on the same day for patients who had attended clinics. This reduced waiting times in the long term and meant patients did not have to return another day. Interpreters could be booked for patients whose first language was not English, if required. Wheelchair access was available throughout the hospital. Information on how to raise compliments and complaints was displayed in the waiting areas.

The BMI vision was embedded in the departments and staff embraced the values in the work they undertook. There were clearly defined and visible local leadership roles in each speciality within the outpatients and diagnostic imaging areas. Senior staff provided visible leadership and motivation to their teams. The services were appropriately represented at executive level and there was appropriate management of quality, governance and risks at a local level.

Are outpatients and diagnostic imaging services safe?

Good

Staff knew the types of incidents to report and could demonstrate how these would be recorded, escalated and reviewed. There was evidence of learning from incidents being shared. Staff were familiar with 'Duty of Candour' (meaning they should act in an open and transparent way in relation to care and treatment provided) and were aware of how to ensure patients were safeguarded from abuse. The areas we inspected were visibly clean and safe. Staff were aware of current infection prevention and control guidelines. However, we observed that hand hygiene practices were not always followed.

Sufficient equipment was available that was well maintained, appropriately checked and decontaminated regularly with checklists in use. Records were safely stored, structured, legible and up to date. Staff attended mandatory training courses with good compliance rates. Staffing levels were sufficient to meet the needs of patients and staff were aware of how to escalate key risks that could affect patient safety.

Incidents

- Incidents were reported using an electronic reporting system. Staff knew the types of incident they needed to report and could demonstrate how these would be recorded and escalated.
- Incidents were reviewed and investigated by staff with the appropriate level of seniority to look for improvements to the service.
- Learning from incidents had been shared at meetings and changes in practice had been made where required.
- There had been no notifications to the CQC in relation to Ionising Radiation (Medical Exposure) Regulations (IR(ME)R) in the last 12 months.
- Staff were familiar with the term 'Duty of Candour' (meaning they should act in an open and transparent way in relation to care and treatment provided) and told us they would also inform the patients or their carers if incidents occurred. Policies were in place to ensure the principles and requirements of the duty of candour process were followed.

Good

Outpatients and diagnostic imaging

Cleanliness, infection control and hygiene

- The areas we inspected were visibly clean and tidy. Cleaning schedules were in place with clearly defined roles and responsibilities for cleaning the environment and decontaminating the equipment.
- Staff were aware of current infection prevention and control guidelines. Arrangements were in place for the handling, storage and disposal of clinical waste, including sharps.
- Staff followed the 'bare below the elbow' guidance and used appropriate protective personal equipment, such as gloves and aprons, whilst delivering care. Hand hygiene audits for the service showed a high level of compliance. However, we observed at least six staff who did not always carry out hand hygiene practices in between contact with patients. This was not in line with best practice guidance and may increase the risk of cross infection between patients.
- The hospital had employed a number of infection control link nurses to provide training and to liaise with staff so patients that acquired infections could be identified and treated promptly.
- No healthcare-associated infections such as Methicillin Resistant Staphylococcus Aureus (MRSA), clostridium difficile (C.diff) or, Methicillin Sensitive Staphylococcus Aureus (MSSA) were attributed to the outpatients and diagnostic imaging department for the 12 months preceding the inspection.

Environment and equipment

- The building was in good condition, well maintained, free from clutter and provided a suitable environment for treating patients.
- Equipment was well maintained, appropriately checked and decontaminated regularly with checklists in use for daily, weekly and monthly monitoring.
- Staff told us they always had access to the equipment and instruments they needed to meet patients' needs and confirmed any faulty equipment was either repaired or replaced promptly.
- The hospital used single-use, sterile instruments where possible. The single use instruments we saw were within their expiry dates.
- The organisation maintained an electronic asset register which was updated every time equipment was removed or added. This was audited yearly to ensure all equipment was appropriately maintained, serviced and calibrated in line with the manufacturer's guidance.
- Clinical equipment, such as the ultrasound scanner, had been subject to regular and recent audit. Any concerns were recorded and rectified before patient use and staff were reminded of procedures. Monthly audits were carried out on health and safety and infection control issues.
- The diagnostics department carried out care and treatment in line with the Ionising Radiation (Medical Exposure) Regulations (IR(ME)R). Local radiation protection rules were evident on the walls in the imaging rooms.
- The imaging department had assessed exposure to radiation and staff wore radiation detection badges that were sent externally to be analysed routinely to ensure safe levels were maintained.
- All diagnostics and imaging equipment had routine quality assurance and calibration checks in place to ensure the equipment was working effectively.
- The physiotherapy department had a gymnasium area with fitness equipment and room for classes such as Pilates to be carried out. All the equipment had the appropriate servicing and cleaning regimes in place.
- Emergency resuscitation equipment was available in all the areas we inspected and was checked on a daily basis by staff.

Medicines

- Up to date policies and procedures were accessible to staff who were aware of the appropriate medicines management processes.
- Medicines were stored, managed, administered and recorded securely and safely.
- Medicines that required refrigeration were stored correctly and temperatures were checked and recorded routinely.
- The outpatients department didn't hold any stock of controlled drugs.
- The on-site pharmacy had sufficient stock for the number of treatments being carried out. Staff told us the outpatient prescriptions were turned around immediately.

Records

Good

Outpatients and diagnostic imaging

- Patient records were stored securely in all areas either in locked cabinets or rooms with keypads.
- Patient records were requested by the admin and clerical staff around 48 hours before a clinic to allow sufficient time to identify any gaps or issues.
- Records were taken back to the medical records storage area after the clinics by the clinic coordinators.
- The consultants did not consider there were any problems with accessing patients' notes for their clinics.
- We reviewed 10 sets of patient records. The notes were legible, comprehensive and contained all the relevant information including letters to the patient's General Practitioner (GP). Records showed that risks and benefits to care and treatment had been explained. All records had a summary records sheet with a brief history of any previous consultations or treatments.
- Consultants worked on a sessional basis and often practiced in a number of locations not connected with BMI. If they needed to transfer notes or store patient sensitive information on their own premises they were required to be personally registered with the Information Commissioner's Office (ICO) (a publically accessible online register, which meant they had to comply with The Data Protection Act 1998). We spoke to two consultants who confirmed they had the appropriate ICO registration, even though they didn't remove any notes from the hospital. Records showed ICO registration was checked and monitored by the hospital.
- Any letters requiring further review were emailed to consultants via secure email.
- Patient records were stored electronically in the diagnostic and imaging departments. We reviewed six records and found them to be comprehensive and well managed.
- The imaging department received clinical history from the referring consultant. Images were passed to referring hospitals via a secure portal. The BMI policy for the retention of records stipulated x-rays were retained for eight years after conclusion of treatment or the death of the patient.
- For children, the policy states: "Retain until the patient's 25th birthday or 26th if young person was 17 at conclusion of treatment, or 8 years after death. If the illness or death could have potential relevance to adult conditions or have genetic implications, the advice of clinicians should be sought as to whether to retain the records for a longer period."

Safeguarding

- Safeguarding policies and procedures were accessible to staff. Staff were aware of the actions to follow and how to escalate safeguarding concerns. There was a named lead for safeguarding to support this process.
- Staff completed an e-learning training module as part of their mandatory training for safeguarding. At the time of inspection, 98% of required staff had completed safeguarding adults training and 96% of required staff had completed safeguarding children training.

Mandatory training

- Mandatory training content and frequency differed for clinical and non-clinical staff and included training in safeguarding of vulnerable adults and children, equality and diversity, information security and infection control.
- As part of their mandatory training, all staff attended basic life support training annually. Staff were currently completing paediatric immediate life support (PILS). All the staff in the diagnostic and imaging department and in the physiotherapy department had completed this training but only 67% of general nursing staff had undertaken this training to date. It was expected that all identified staff would have completed this training by the end of December.Role specific training was also provided for staff and included areas such as radiation protection training for the imaging staff.
- Training was delivered via a structured programme with face to face sessions and e-learning modules.
- Compliance with mandatory training was high. Data up until 28 August 2015 showed 99% of staff in the diagnostic imaging department, 100% of staff in the physiotherapy department and 90% of the general nursing staff had completed their mandatory training.
- There was a process in place to ensure staff not employed directly by BMI had received the appropriate mandatory training. For clinicians that were employed in substantive posts by other organisations (usually in the NHS) and had practising privileges (the right to practice in a private hospital) mandatory training was usually undertaken at their primary employer and was monitored by The Beaumont Hospital to ensure it had taken place.

Assessing and responding to patient risk

- An emergency bleep system was available for staff to call in case of emergency or a deteriorating patient. An

emergency response team led by the resident medical officer (RMO) would attend to the patient. The hospital utilised two RMOs who worked on a weekly rotation and were based on site 24 hours a day for that whole week before handing over to the next RMO. The RMOs utilised by this hospital were appropriately trained in Immediate Life Support (ILS) and Advanced Life Support (ALS) for adults and Advanced Paediatric Life Support for children.

- Emergency resuscitation equipment was available throughout the outpatient areas and included defibrillators for adults and children as an example.
- Systems to promote safety were in place and well managed for example, alarm systems, key coding access to consulting corridors, fire alarm procedures and checked fire extinguishers.
- The physiotherapy department conducted risk assessments on patients before they could use the equipment.
- Designated staff from the physiotherapy department were on call in the evenings, overnight and at the weekends in order to provide post-operative assessments such as for falls.
- Risk assessments were in place where necessary in all departments.
- The diagnostic and imaging service had patient safety questionnaires for patients to complete before any scans. Staff told us they wouldn't perform scans that may involve radiation for vulnerable patients such as pregnant women.
- Consultants could access a chaperone when required for example whilst performing an intimate examination of the opposite sex. A register was kept with all staff trained to be a chaperone but it was mainly covered by the healthcare assistants.

Nursing staffing

- The staff rota showed how many staff were needed for the different clinics based on the nature of the clinic and the acuity of the patients in conjunction with the consultant. This was reviewed weekly to provide safe staffing levels when extra clinics were needed.
- Nurses were on shift from 7:30am to 9pm Monday to Friday with Saturday timings dependant on the clinics running. Staffing was dictated by the number of patients attending the clinics. There was always a senior nurse on each shift with support from a number of nurses and a healthcare assistant. The rota showed a minimum of four nurses were scheduled on clinic days.
- Cover for staff leave or sickness was provided by bank staff made up of the existing nursing team.
- The policy was only to see children for consultation over the age of three years (no invasive procedures). The hospital didn't see many children on a routine basis with only 393 attendances between April 2014 and March 2015 which was 1% of the total attendances. In each case the situation was risk assessed prior to a child attending a clinic to ensure it was safe and appropriate.
- Staffing levels met the calculated levels as per the rota during our inspection and the hospital was fully staffed.
- All staff confirmed there were sufficient staff to deliver care safely and we observed this to be the case.

Medical staffing

- Medical staff were mainly employed by other organisations (usually in the NHS) in substantive posts with practising privileges with The Beaumont Hospital.
- Specific consultants had planned clinics every week and medical staffing was based on the number and type of clinics that were operating on any given day.
- If a consultant couldn't attend a clinic, appointments would be rearranged.
- There was a Resident Medical Officer (RMO) within the hospital 24 hours a day with immediate telephone access to the responsible consultant if required. Under the conditions of their practising privileges, consultants working at the hospital had to be accessible 24 hours a day, seven days a week. Alternatively consultants had to arrange appropriate alternative named cover if they were unavailable. Staff confirmed they were able to contact consultants when required and had not experienced any problems.

Allied Health Professional Staffing

- The physiotherapy department consisted of three senior physiotherapists, one women's health physiotherapist and six bank staff who worked from 7:30am to 8pm Monday to Friday with cover out of hours for the inpatient ward.

Major incident awareness and training

- The hospital was part of a large group of privately owned hospitals. A business continuity plan identified

Good

Outpatients and diagnostic imaging

responses to manage any risks in case of a disaster or a major event where the hospital's ability to accommodate staff or patients or provide essential services was severely compromised.
- Actions specific to the outpatients and diagnostic imaging included services such as outpatient bookings, physiotherapy services and diagnostic imaging to be redirected to an alternative hospital owned by the same group.
- Staff were fully aware of the emergency procedures for a major incident such as a fire or adverse weather conditions.

Are outpatients and diagnostic imaging services effective?

Not sufficient evidence to rate

Staff followed policies, procedures and clinical care pathways in line with local and national guidance. Patients were assessed for pain relief and provided with medication or treatment where appropriate. Staff undertook clinical audits such as patient consent and quality assurance for equipment in radiology was carried out by certified national organisations.

Staff, including those not directly employed by the hospital, had received regular one to one supervisions. Most staff confirmed they had received yearly appraisals; however, records showed the overall completion rate was low. There was effective multi-disciplinary working amongst all of the teams in the hospital. Staff had the appropriate skills and knowledge to seek consent from patients and explained how they sought informed consent during consultations.

Evidence-based care and treatment

- Care and treatment was provided in line guidance from the National Institute for Health and Care Excellence (NICE) and the Royal Colleges.
- Clinical staff were aware of national and local guidelines relevant to their specialist areas.
- Clinical care pathways had been developed in line with best practise and were put into action as soon as the patient entered the department, for example ophthalmology and physiotherapy pathways.
- The hospital followed the World Health Organisation (WHO) and Royal College of Radiologists guidelines for interventional radiology. The guidelines were easy to access and displayed for reference.
- Guidance was regularly discussed at governance meetings, disseminated and the impact that it would have on staff practice was discussed. For example, radiation protection processes in line with the updated IR(ME)R guidance was discussed and the policy was updated as a result.

Pain relief

- Patients were assessed for pain relief during assessments and supported in managing pain through prescriptions with the appropriate medication.
- Complimentary pain relief therapies were also available via the physiotherapists such as acupuncture, Pilates and massage via the physiotherapists.
- Electrotherapy (electrical stimulation used to directly block transmission of pain signals along nerves) was also available by prior booking in the physiotherapy suite.

Patient outcomes

- Staff were encouraged to undertake a clinical audit to assess how well NICE and other guidelines were adhered to. All of these audits resulted in staff education and changes in practice to improve patient care.
- The audit plan outlined when, how often and who would conduct audits in the various areas such as consent, health & safety, medical records and equipment quality assurance checks. We saw that audits had been carried out in line with the audit plan. For example, we noted the equipment in the gym had been checked according to schedule to ensure it was functioning in a safe manner.
- The diagnostic imaging department had a yearly audit schedule in place and ensured all staff participated in them. Dose audits were conducted in line with IR(ME)R regarding the protection of patients from the risks of unnecessary exposure to x-rays. The department was also audited externally from its commissioners to ensure the quality standards were being met. The reports we viewed were all positive.
- We looked at the July 2015 audit to determine if consent was taken appropriately in the physiotherapy department. The audit concluded all appropriate procedures were followed.

Good

Outpatients and diagnostic imaging

- We looked at a peer review audit to ensure acupuncture therapy was delivered appropriately. The staff trained in providing acupuncture reviewed each other's practice in line with the Acupuncture Association of Chartered Physiotherpaists (AACP). Results showed the staff were competent in all areas such as ensuring the patient details (referral diagnosis/history/key clinical features) were captured, providing a clinical diagnosis and then providing a management plan with clinical reasoning behind choosing acupuncture.
- The physiotherapy department used a survey which measured pain on a scale of one to 100 before and after treatment and included areas such as mobility, anxiety and self-care. An audit into the outcomes indicated that 88% of patients with spinal pain, 85% of patients with lower limb pain and 86% of patients with upper limb pain felt the pain had decreased after treatment.

Competent staff

- All staff completed competency assessments and an induction to the department when they first started.
- All staff received a departmental induction before they began to work unsupervised.
- Most of the staff told us they had received an annual appraisal and those that had worked for the hospital for less than one year were aware they would have one in the coming months.
- The target was for all staff in the outpatients department to have an appraisal. Data showed the appraisal rates were low (less than 49%) in 2013 and 2014 for care assistants working in inpatient departments, administrative and clerical workers (hospital-wide) and other support workers (hospital-wide). The appraisal rates were moderate (between 50% and 74%) for nurses working in inpatient departments in 2014 and allied healthcare professionals (hospital-wide) in 2013 and 2014. This had been identified as an area for improvement by the management team. We were told appraisals were now more robustly recorded using an appraisal system but historically the formal reporting of appraisals had not been updated on the hospital database consistently, leading to poor evidence that appraisals were being conducted on a regular basis. Whilst improvements had already been seen, the registered manager and director of clinical services were fully aware that the current position in this area remained a 'work in progress'.
- However, staff employed by The Beaumont Hospital confirmed they had regular one to one supervisions with their line manager and yearly appraisals had been scheduled for 2015.
- Staff told us they had opportunities to conduct further training if it was identified. Nurses were asked to sign a learning agreement which meant they could not leave their post for two years after undertaking a course relating to their work that was financially supported by the hospital. This meant the hospital benefitted from their new skills or knowledge.
- All nurses were encouraged to establish an interest in a particular area and many nurses chose to work when certain clinics were operating to gain further knowledge in that area.
- All diagnostic imaging staff were assessed on a range of competencies, such as ultrasound scanning, on an annual basis.
- There were procedures in place for granting and reviewing practising privileges (medical practitioners being granted the right to practice in a private hospital). The organisation had implemented a robust system with a checklist and guidelines as to who was responsible for providing the information to ensure they met the BMI employment criteria. The majority of these staff also worked in local NHS hospitals and as such received training and appraisals in those substantive posts. An employee compliance coordinator monitored information stored for each consultant to ensure practising privileges were reviewed in a timely manner. Each individual consultant was responsible for keeping their information up to date and current.
- Practising privileges were reviewed by the chairperson of the medical advisory committee (MAC). This included a review of appraisals, General Medical Council (GMC) registrations and medical indemnity insurance.
- We spoke to two consultants who confirmed they had received appraisals and revalidation of their practice with their substantive NHS employers. The BMI appraisal involved checking the NHS appraisals and participating in re-validation of their practice. Any delay in submission of evidence of appraisal and revalidation was flagged by the employee compliance coordinator with oversight, and if necessary, intervention from the registered manager.

Multidisciplinary working

Good

Outpatients and diagnostic imaging

- A multi-disciplinary team (MDT) approach was evident across all of the areas we visited. We observed collaboration and communication amongst all members of the MDT to support the planning and delivery of care in the outpatients and diagnostic imaging department.
- Daily meetings, involving the nursing staff, therapists and medical staff were conducted to ensure there were sufficient staffing levels for each clinic.
- Collaborative working with the surgical department meant each area knew the number and type of patient that would be receiving treatments and may need interventions.
- There were a number of service level agreements in place with nearby organisations which involved teamwork to ensure continuity of care for patients.

Seven-day services

- Various clinics were operating between 8am and 9pm Monday to Friday with clinics scheduled on Saturdays when the demand was high but mostly from 8am to 2pm.
- Under their practising privileges, consultants practising within the hospital were responsible for the care of their patients 24 hours a day, seven days a week. There was a Resident Medical Officer (RMO) within the hospital 24 hours a day with immediate telephone access to the responsible consultant.
- The physiotherapy department provided services five days a week with times to suit the patients. The physiotherapists were on call at the weekend to assist the ward areas for any assessments or to assist with discharge if required.
- The diagnostic imaging service was available through an on-call system outside of normal hours.

Access to information

- Patient records were easily accessible with information being requested at least 48 hours before the patient arrived. Nurses ensured this was collated and checked before the appointment.
- The radiology service used a picture archiving and communication system (PACS). This was a central off-site server that clinicians with appropriate secure access could view images from. Report results were available promptly from the radiology management computer system.
- The documentation in the physiotherapy department was either electronic, such as booking information and patient notes, or scanned in such as the GP referral letters and consent forms.
- All results were sent to the patient's referring GP to discuss with their patient. Results were not sent directly to patients. The records we reviewed showed letters were setn to patients' GPs in a timely manner (within 48 hours).
- Data and appointment lists were collated daily and printed off for everyone to ensure they knew which patients were attending.
- Information about the patient, such as scans or medical information, taken during the outpatient appointments was readily available across all the teams working in the hospital. For example, the surgical services could access scans taken pre-operatively to co-ordinate their surgery lists.
- Outpatient consultations within the hospital were consultant-led. All patients attending outpatients would either have an accompanying GP referral letter or their current medical records from a previous appointment or admission would be available at the hospital. For NHS patients a detailed referral letter would be available prior to their initial consultation at the hospital.
- If for any reason records were not available when a patient attended, the following steps were taken:

- The nurse in charge would access and retrieve the medical record from the on-site medical records department

- If there was no physical medical record on site, the nurse in charge would contact the consultant's secretary to access the patient's records.

- The consultant would retrieve their own patient records

- If there were no previous medical records or GP referral letter available, the consultant would complete a full previous medical history and presenting condition assessment as part of their consultation.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff had the appropriate skills and knowledge to seek consent from patients or their legal representatives. Staff were clear about how they sought informed verbal and written consent before providing care or treatment.

Good

Outpatients and diagnostic imaging

- Patient records showed verbal and written consent had been obtained from patients and planned care was delivered with their agreement. Consent forms were completed where appropriate prior to providing care and treatment, for example acupuncture in the physiotherapy department.
- Consultants discussed details of the surgery and recovery at the outpatient's appointment and told us this would be discussed again on the day of surgery.
- Staff understood the legal requirements of the Mental Capacity Act 2005 and deprivation of liberties safeguards.
- If patients lacked the capacity to provide informed consent, staff made decisions about care and treatment in the best interests of the patient and involved the patient's representatives and other healthcare professionals appropriately.

Are outpatients and diagnostic imaging services caring?

Good

Patients received caring and supportive care and treatment in an environment that afforded them privacy, dignity and confidentiality. Staff were enthusiastic and respectful whilst providing care. We observed positive interactions between staff and patients. All patients spoke highly of the care they had received regardless of how they were referred or funded.

Compassionate care

- All the patients we spoke with said the care they received was of a very good standard and we observed many positive interactions between staff and patients throughout our inspection.
- Staff greeted patients appropriately and in a friendly manner. Staff treated patients with dignity and respect whilst ensuring patient confidentiality was maintained.
- Patient comments included: "Staff are excellent, helpful and exceptional", "I give the hospital 10 out of 10" and "The staff are professional and caring".
- The Friends and Family Test (FFT) (a survey which asks patients whether they would recommend the service they have received to friends and family who need similar treatment or care) showed a high response rate between October 2014 and March 2015. The FFT results showed the outpatients department received a score of 100% frequently. This meant people would recommend the hospital.
- The hospital also asked patients to complete a patient satisfaction survey. This was administered by an independent third party organisation. Results from the survey for 2015 to date, consistently showed high levels of patient satisfaction in all areas surveyed including overall quality of care and nursing care.

Understanding and involvement of patients and those close to them

- All patients stated their appointment slots gave sufficient time to discuss their conditions in a relaxed, respectful, courteous and dignified manner.
- Patients felt involved in their care and treatment and consent was discussed appropriately. Consultants explained various approaches to meeting the patients' needs by discussing and offering alternative procedures where available.
- A patient receiving treatment in the physiotherapy gym told us all the treatment options, risks and benefits as well as prices had been explained to them thoroughly.

Emotional support

- Patients were supported throughout their treatments. We saw staff spending appropriate time talking to patients and responding to their questions in an appropriate manner.
- We observed a member of staff in the imaging department who took extra time with a distressed patient to provide the appropriate emotional support.
- All the treatment and consultation rooms were private and could be used to deliver any bad news which could adversely and seriously affect a patient's future.
- Staff told us consultants and nurses would work together to relay this information and provide any additional support where appropriate such as information about the condition.

Good

Outpatients and diagnostic imaging

Are outpatients and diagnostic imaging services responsive?

Good

Patients could be referred to the hospital in a number of ways and had many options to book appointments that suited them. Waiting times for outpatient appointments were within the national guidelines.

The diagnostic and imaging department provided scans on the same day for patients who had attended clinics. This reduced waiting times in the long term and meant patients didn't have to return another day. Interpreters could be booked when required for patients whose first language was not English. Wheelchair access was available throughout the hospital. Information on how to raise compliments and complaints was displayed in the waiting areas.

Service planning and delivery to meet the needs of local people

- The environment for patients was comfortable with plenty of seating areas. All areas were furnished to a high standard. The Taylor Suite had a waiting area designated for privately funded treatments. Patients referred via the NHS could wait in the Belmont Suite before being called.
- Patients accessed services via a GP referral through the NHS e-Referral Service (previously known as Choose and Book), via self-referral and self-funding or via their health care insurer. Patients were offered appointment times after work and at weekends to fit around their personal and work lives.
- Private patients phoned a central number to book appointments with times to suit their needs via a specific private patient's administrative team.
- Patients referred via the NHS used the electronic referral service which gives patients a choice of place, date and time for their first outpatient appointment in a hospital or clinic. Patients confirmed this worked well and told us there were no concerns as they were able to book slots to suit their needs.
- Patients reported to the receptionists who logged them in via an electronic booking system and directed them towards the appropriate clinics and waiting areas.
- The hospital had sufficient space and flexibility for the current number of patients being treated.
- There was sufficient free parking to meet patients' needs.
- All patients stated their appointment slots gave sufficient time to discuss their conditions.
- The physiotherapy and digital imaging areas had dedicated and private changing rooms with secure lockers for patients to use.
- MRI and CT scans were provided by an external provider on-site via mobile equipment on certain days.
- The diagnostic and imaging department provided scans on the same day for patients who had attended clinics. This reduced waiting times in the long term and meant patients didn't have to return another day.

Access and flow

- The hospital had scheduled clinics with set specialities on a weekly basis with open booking slots. This meant staff knew when they could book patients for specific specialities and ensured the appropriate support staff were present. If any slots were empty then consultants could move or rebook patients at their discretion.
- NHS patients were managed in line with other NHS patients who should start their treatment within 18 weeks of being referred by their GP. The Patient Referral to Treatment (RTT) pathway was monitored by BMI's information management team.
- The hospital met the RTT target of having at least 95% of non-admitted patients beginning treatment within 18 weeks of referral for each month from April 2014 to March 2015. Data showed the hospital achieved 100% in all 12 months.
- The physiotherapy department told us they could offer an appointment within 48 hours of referral if appropriate for the patient.
- Waiting times for patients once they had arrived in the department were short after being booked in at reception. Patients confirmed they didn't wait long before they were seen. No waiting times were displayed in the waiting areas but staff told us they would let patients know individually if there were any unforeseen delays.
- The service regularly monitored people who did not attend (DNA) their appointments. Actions had been taken to ensure all the patients attended their appointments at the right time. The service sent letters

at least a week in advance of appointment and then followed up by sending a text message 24 hours prior to the appointment. This had led to a significant drop in the number of DNA's for the outpatient service.
- Patients who didn't attend for any reason and were referred via the NHS could rearrange the appointment before they were discharged back to their GP via an automated process.
- If a clinic was cancelled at short notice, they would attempt to contact the patient and offer alternative times.
- During the inspection we observed all the clinics were running to schedule with no delays. The hospital monitored the clinic timings and patient attendances. This data was used to inform how future clinics would be scheduled.

Meeting people's individual needs

- The majority of patients attending the hospital were White British. A variety of information leaflets were available but were mostly in English. Staff told us they could provide leaflets in different languages or other formats, such as braille, if requested. Patients confirmed they had received information about their care and treatment in a manner they understood.
- Staff completed equality and diversity training as part of their mandatory training. We found staff to be culturally aware.
- Telephone or face to face interpreter services were available where English was not the patient's first language. Information gathered at the referral stage identified patients who would need interpretation services and translators were booked when the appointment was made. Staff told us they wouldn't use family members to translate for consent which was in line with best practice guidance.
- Wheelchair access was available via a ramp at the main entrance of the hospital with automated doors.
- Vulnerable adults, such as patients with learning disabilities and those living with dementia were identified at the referral stage and appropriate steps were taken to ensure they were appropriately cared for. Steps included providing suitable appointment times, for example, during less busy periods and ensuring carers or representatives were kept informed at all stages. Staff told us it was rare for such patients to be treated at the hospital as they were usually seen at NHS establishments.
- If patients required surgery, staff would decide as part of the pre-operative assessment, whether they could support these patients appropriately or would refer them to another healthcare provider that could better meet their needs. However, it was not clear what screening tool or assessment criterion was used to support staff in making this decision and the hospital did not have a dementia link nurse.

Learning from complaints and concerns

- Information on how to raise complaints or concerns was displayed in the waiting areas. Staff were aware of the complaints procedure and told us they would always talk to the patient if possible and ensure the matter was resolved.
- The hospital's aim was to provide written acknowledgement within two working days of receipt of a complaint and provide a full written response within 20 working days when the outcome of the investigation was known.
- The procedure included details for complainants to contact the Independent External Adjudication Service (ISCAS) if they wished to escalate their complaint.
- The latest complaints were discussed at team meetings and lessons learned from complaints were implemented and cascaded to staff to improve patient experiences.
- Between 1 April 2014 and 31 March 2015, 29 written complaints were received at The Beaumont Hospital. The main themes were around communication, financial costs, and the delay/cancellation of outpatient appointments. There were no particular trends, apart from patients not being made aware of additional charges for tests during consultation. This had been addressed with the consultants concerned and notices were placed in waiting areas and consulting rooms advising of additional charges. The outpatient nurses also advised patients of the charges whilst chaperoning.

Are outpatients and diagnostic imaging services well-led?

Good

Outpatients and diagnostic imaging

Good

The hospital's vision was embedded in the departments and staff embraced the values in the work they undertook. There were clearly defined and visible local leadership roles in each speciality within the outpatients and diagnostic imaging areas. Senior staff provided clear leadership and motivation to their teams.

Staff told us the overall ethos was centred on the quality of care patients received and spoke of an open culture where they could raise concerns or issues in relation to issues such as patient care which would be acted upon. The services were appropriately represented at executive level and there was appropriate management of quality, governance and risks at a local level.

Vision and strategy for this service

- The quality strategy articulated how the service would provide the best possible care, strive for continual improvement and live up to the BMI brand promise to be "serious about health, passionate about care". Its four core themes of safety, clinical effectiveness, patient experience and quality assurance provided staff with a platform to deliver consistent care.
- Staff were provided with a corporate induction that outlined the vision and values. Staff had a clear understanding and could articulate what the vision and values meant for their practice. Objectives were linked to the vision and values and staff had a good understanding of them.

Governance, risk management and quality measurement

- There was a clear governance structure in place with committees for medicines management, infection control and health and safety feeding into the clinical governance committee and medical advisory committee (MAC).
- Outpatients and diagnostic imaging services were appropriately represented at executive level by the director of clinical services.
- Risks were identified and well managed locally. We saw evidence of risk assessments undertaken in areas of concern. For example, we saw risk assessments for the use of equipment in the gym and for radiology in relation to pregnant women.
- The hospital wide risk register highlighted key risks to the service. Actions taken to control or minimise the risks were detailed but where there was a residual risk (low to moderate) it was not clear what action was still required or was being taken to further mitigate or minimise the risk. In some instance the status of the risk was recorded as "outstanding controls/actions" but it did not detail what they were or the timeframe for completion. The clinical services director told us that the risks register was reviewed quarterly at senior management team meeting but that these meetings were not formally recorded.
- Staff were aware of their departmental risks and issues such as information around complaints, incidents and audit results which were shared on notice boards around the department and also via meetings.
- Performance activity and quality measurement was recorded and reported centrally to allow comparison with the other BMI group of hospitals. The Beaumont Hospital was meeting targets set nationally in areas such as waiting times, cleanliness and infection control as well as staff sickness.
- Clinical governance was part of the Medical Advisory Committee (MAC) agenda. Any concerns or issues related to outpatient and diagnostic imaging services were discussed at the meeting.
- MAC meetings were held every three months. Minutes for the last three MAC meetings demonstrated that key governance areas were discussed including incidents, complaints and practising privileges. However, we noted the MAC chair had been in post longer than the terms of reference indicated they should be. Whilst this had not had any demonstrable impact at the time of inspection, it is not in line with best practice and was raised with the provider.
- There was an infection prevention and control lead nurse who was responsible for coordinating audits, reviewing serious incidents and providing training to staff. Activity and outcomes were monitored through monthly clinical governance meetings.
- The most senior member of staff on duty within each department attended the senior staff 'Comm cell' every morning. This meeting was an opportunity to share

information relating to the hospital and across each department. As well as general hospital business it included complaints, incidents, concerns and compliments. Each department had the opportunity to report on things relating to their area. The information from this meeting was then shared at departmental 'Comm cell' meetings.

- The outpatient department held a 'Comm cell' in the department each day. This was a joint meeting between clinical and non-clinical staff. The clinical staff held a further meeting prior to the afternoon clinics starting. Both meetings allowed staff to share any concerns or observations with the team. The outpatients' team took it in turns to lead the 'Comm cell' meeting.
- Each department had a 'Comm cell' board of information and statistics. The boards were uniform across the hospital and displayed amongst other things the department's activity, incidents and staffing. Any incidents and risks identified were recorded and displayed on the 'Communication cell' board along with a running record of the action being taken to address them and current status.
- Staff spoke very positively about the 'Communication cell' board and meetings and told us it gave them the opportunity to see at a glance how the department was doing. For example they could see compliments, concerns or updates, late running consultants/clinics, the number of patients seen.

Leadership and Culture within the service

- There were clearly defined and visible local leadership roles in each speciality within the outpatients and diagnostic imaging areas. Senior staff provided clear leadership and motivation to their teams.
- Staff told us the overall ethos was centred on the quality of care patients received and spoke of an open culture where they could raise concerns or issues in relation to issues such as patient care which would be acted upon. Staff felt the quality of care was a key aspect otherwise patients wouldn't return.
- Staff morale was good and we observed staff from all specialties worked well together. The team was visibly enthusiastic about the outpatient and diagnostic imaging services. Many of them had worked in the service for many years. Staff enjoyed working at the hospital and felt the company treated them with respect and valued their opinions.
- Staff retention was stable and turnover was low with 80% of staff having been employed over a year. This enabled continuity of care for patients.
- Staff sickness rates were generally low (less than 10%) between April 2014 and March 2015. It should be noted that the ward and theatre teams consisted of a small number of staff so any sickness / absence would be perceived as a high percentage. In terms of actual staff numbers however, these rates were generally low.

Public and staff engagement

- The hospital participated in the BMI Healthcare staff survey. However, the survey had not taken place in 2014 due a period of consultation with staff regarding the terms and conditions of their contracts. A further survey was planned for early 2016.
- The hospital ran a staff recognition scheme to encourage staff to formally recognise and thank their colleagues who had 'gone the extra mile'
- The hospital also carried out a patient satisfaction survey and the patient feedback was compared with the provider's other hospitals. This was administered by an independent third party organization. Results from the survey for 2015 to date, consistently showed high levels of patient satisfaction in all areas surveyed including overall quality of care and nursing care.
- The hospital displayed "You said – We did" information to show what action had been taken in response to patient feedback.

Innovation, improvement and sustainability

- Although the physical environment of the outpatient minor treatment room was a challenge and restricted the hospital's capability to provide the desired scope of activity, it posed no risk to the patients. A business plan had been developed to address this.

Outstanding practice and areas for improvement

Outstanding practice

Each department had a 'Comm cell' board of information and statistics. The boards were uniform across the hospital and displayed amongst other things the department's activity, incidents and staffing. Any incidents and risks identified were recorded and displayed on the 'Communication cell' board along with a running record of the action being taken to address them and current status.

Areas for improvement

Action the provider SHOULD take to improve

- The hospital should ensure that all staff follow hand hygiene best practice processes in all areas of the hospital.
- The hospital should ensure all staff receive a regular appraisal to support and promote development.
- The hospital should continue to prioritise recruitment of theatre staff.
- The hospital should ensure the risk register clearly identifies any outstanding actions required to mitigate risks and expected date of completion.