

The Duchy Hospital

Quality Report

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

Ratings

Overall rating for this location

Inadequate 

Are services safe?

Inadequate 

Are services effective?

Requires improvement 

Are services caring?

Good 

Are services responsive?

Good 

Are services well-led?

Inadequate 

Overall summary

The Duchy Hospital is operated by BMI Healthcare Limited. The hospital/service has 27 beds. Facilities include two operating theatres (both have laminar flow), X-ray, outpatient and diagnostic facilities. The hospital provides surgery and outpatients with diagnostic imaging services and we inspected both of these services. We did not inspect services for children or young people as the

hospital had ceased to provide these services for children under 16 on 31st August 2016. At the time of the inspection, they did provide services for young people over the age of 16.

We inspected this hospital using our comprehensive inspection methodology. We carried out the announced part of the inspection on 4-5 October 2016 with an unannounced visit to the hospital on the 19th October 2016. To get to the heart of patients' experiences of care

Summary of findings

and treatment, we ask the same five key questions of all services: are they safe, effective, caring, responsive to peoples' needs and well-led? Where we have a legal duty to do so, we rate services' performance against each key question as outstanding, good, requires improvement or inadequate. Throughout the inspection, we took account of what people said to us and how the provider understood and complied with the Mental Capacity Act 2005.

We rated surgery as inadequate and outpatients and diagnostic imaging as requires improvement and the hospital as inadequate overall.

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

We found areas of practice that the service provider needs to improve in both surgery and the outpatients and diagnostic imaging services.

In surgery:

- In the inpatient ward and theatre recovery area, sufficient numbers of suitably qualified, skilled and experienced nursing staff to meet patients' needs were not always available.
- In the theatre and outpatients department, the use of the five steps for safer surgery including the World Health Organisation (WHO) surgical safety checklist was not embedded. The WHO surgical safety checklist is a tool for the relevant clinical teams to improve patient safety.
- Actions based on recommendations around theatre escorts were not always implemented in an effective way.
- Pre-operative fasting guidance was not consistently delivered in line with national guidance and the best practice outcomes for patients.
- The inpatient environment had carpets present and patient bedrooms did not have access to a clinical hand washbasin to perform hand hygiene. This was a recognised risk on the hospital risk register. At the time of inspection, the hospital had a refurbishment plan that was due for completion in 2020, however some of

these plans, due to financial constraints, had been placed on-hold. However, since the inspection the provider has informed us that refurbishment work was now underway again in the service.

- The environment used to decontaminate endoscope equipment did not meet best practice guidance (Management and decontamination of flexible endoscopes Health technical memorandum (HTM) 01-06). There were plans to move this offsite.
- Based on the pre-inspection information request we identified inaccuracies in data held locally within the hospital and data held by the head office. This had the potential to affect any data used for benchmarking quality at the hospital compared with other BMI services.
- Not all risks that staff identified to us including business, staffing and infrastructure risks were recorded on the risk register.
- During our inspection, we saw a lack of cohesive leadership between the senior management team. Staff consistently told us that, although they felt supported by their immediate management, there was less support from senior management. In addition, they spoke about degrees of variance in their confidence in senior leadership and the responses they had received when raising concerns. Management had recognised there were issues and had involved external agencies to support relationship challenges within hospital teams.
- The majority of staff we spoke with told us that there were relationship difficulties between staff working in the operating theatre and inpatient ward areas.
- At a hospital level there was no clear ownership of the workforce and race equality standards (WRES). The organisation had a corporate workforce and race equality standards report. However, the report was for the organisation and not individual to the hospital.

In outpatients and diagnostic imaging services:

- The use of the five steps for safer surgery including the World Health Organisation (WHO) checklist was not embedded in the outpatient department.
- Patients who attended the outpatient department for a minor procedure under local anaesthetic, such as, cystoscopies (an invasive medical procedure used to examine the inside of the bladder) or excision of skin tags and moles did not have their observations recorded before or after the procedure.

Summary of findings

- There was no specialist ventilation in the minor procedure room. The room was used for a variety of procedures including: wound checks, excision of cysts and lesions including basal cell carcinomas (a type of skin cancer), removal of sutures, endoscopic biopsies and cystoscopies. Guidance from the Department of Health, The Health Technical Memorandum 03-01: Specialised ventilation for healthcare premises states endoscopy, day-case and minimum invasive suites, such as the minor procedure room, require a degree of specialist ventilation. Following our inspection, the hospital did a risk assessment and sought external assurance from a microbiologist regarding the use of the room. The evidence provided to us did not reference compliance with HTM03-01. The hospital continued to use the room for cystoscopies, although they have since advised that they no longer use the room for that purpose.
- The Radiology department had recently changed Radiation Protection Advisors. An action plan was in place and they were in the process of reviewing standard radiology protocols. The deadline for completion was December 2016.
- The hospital did not collect data on waiting times. However, staff in all departments told us the wait times for appointments were short. The radiology and outpatient managers both told us patients could get an appointment within a week.
- The outpatient department did not have a DNA policy. The hospital recorded the number of NHS patients who DNA their appointment however, they did not collect data or audit the number of privately funded patients who DNA their appointment. If a patient DNA their appointment, they were contacted and an alternative appointment was made

- We identified some risks in the departments that were not on the hospital's risk register. For example, the lack of ventilation in the minor procedure room did not appear on the hospital's risk register.
- Some clinical areas within outpatients had carpets. This was not in line with Health Building Note 00-09: Infection control in the built environment.

However, we found the following areas of good practice:

- The hospital environment was visibly clean.
- There were effective processes for recording practising privileges, compliance, indemnity and appraisals.
- Patients we spoke with were positive about their experience of care.
- We observed that staff delivering care to patients were caring and compassionate.
- There was good local level leadership on the inpatient ward and administration and outpatient department.
- The hospital had an out of hours rota for anaesthetists to provide 24 hour cover for patients post-operatively and there was a service level agreement for emergency transfer arrangements with the local NHS trust.

Following this inspection, we told the provider that it must take some actions to comply with the regulations and that it should make other improvements. We issued the hospital with five requirement notices that affected surgical and outpatients' services. Details are at the end of the report.

Ellen Armistead

Deputy Chief Inspector of Hospitals (North Region)

Summary of findings

Our judgements about each of the main services

Service

Rating Summary of each main service

Surgery

Inadequate



We rated this service as inadequate because:

In the inpatient ward and theatre recovery area, sufficient numbers of suitably qualified, skilled and experienced nursing staff to meet patients' needs were not always available.

In the theatre department, the use of the five steps for safer surgery including the World Health Organisation (WHO) checklist was not embedded. The WHO surgical safety checklist is a tool for the relevant clinical teams to improve patient safety. Actions based on recommendations from incidents were not always implemented in an effective way. Pre-operative fasting guidance was not consistently delivered in line with national guidance and the best practice outcomes for patients.

The environment used to decontaminate endoscope equipment did not meet best practice guidance (Management and decontamination of flexible endoscopes Health technical memorandum (HTM) 01-06). There were plans to move this offsite.

Based on the pre-inspection information request, we identified inaccuracies in data held locally within the hospital and data held at the head office. This had the potential to affect any benchmarking data used to review quality at the hospital compared with other BMI services. Not all risks that staff identified to us, including business, staffing and infrastructure risks, were recorded on the risk register.

During our inspection, we saw a lack of cohesive leadership between the senior management team. Staff consistently told us that, although they felt supported by their immediate management, there was less support from senior management. They spoke about degrees of variance in their confidence in senior leadership and the responses they had received when raising concerns.

Summary of findings

The majority of staff we spoke with told us that there were difficulties between staff working in the operating theatre and in patient ward areas. There was no clear ownership of the workforce and race equality standards (WRES) at a hospital level. The organisation had a corporate workforce and race equality standards report. However, the report was for the organisation and not individual to the hospital.

However,

The hospital environment was visibly clean.

We saw an effective process for recording practising privileges, compliance, indemnity and appraisals.

Patients we spoke with were positive about their experience of care.

We observed that staff delivering care to patients were caring and compassionate.

We saw good local level leadership on the inpatient ward.

The hospital had an out of hours rota for anaesthetists to provide 24- hour cover for patients post-operatively and there was a service level agreement for emergency transfer arrangements with the local NHS trust.

Outpatients and diagnostic imaging

Requires improvement



We rated outpatient and diagnostic imaging services at the hospital as requires improvement because:

In the outpatient department, the use of the five steps for safer surgery including the World Health Organisation (WHO) checklist was not embedded. The WHO surgical safety checklist is a tool for the relevant clinical teams to improve patient safety. Patients attending the outpatient department for a minor procedure under local anaesthetic, such as cystoscopies (an invasive medical procedure used to examine the inside of the bladder) or excision of skin tags and moles did not have their observations recorded before or after the procedure.

There was no specialist ventilation in the minor procedure room. Staff used the room for a variety of procedures including: wound checks, excision of cysts and lesions including basal cell carcinomas (a type of skin cancer), removal of sutures, endoscopic biopsies and cystoscopies. Guidance

Summary of findings

from the Department of Health, The Health Technical Memorandum 03-01: Specialised ventilation for healthcare premises states, endoscopy, day-case and minimum invasive suites such as the minor procedure room require a degree of specialist ventilation. Following our inspection, the hospital did a risk assessment and sought external assurance from a microbiologist regarding the use of the room. The evidence provided to us did not reference compliance with HTM03-01. The hospital continued to use the room for cystoscopies, although they have since advised that they no longer use the room for that purpose. The hospital did not collect data on waiting times. However, staff in all departments told us the wait times for appointments were short. The radiology and outpatient managers both told us patients could get an appointment within a week. The outpatient department did not have a DNA policy. The hospital recorded the number of NHS patients who DNA their appointment however, they did not collect data or audit the number of privately funded patients who DNA their appointment. If a patient DNA their appointment, they were contacted and an alternative appointment was made.

The Radiology department had recently changed Radiation Protection Advisors. An action plan was in place and they were in the process of reviewing standard radiology protocols. The deadline for completion was December 2016.

We identified some risks in the departments that were not on the hospital's risk register. For example, the lack of specialist ventilation in the minor procedure room did not appear on the hospital's risk register.

However:

The service had reported no never events or serious incidents and no incidents had been reported to the CQC in accordance with the Ionising Radiation (Medical Exposure) Regulations 2000 (IR (M) ER).

Medications, including contrast media used in radiology, were stored securely in appropriately

Summary of findings

locked rooms and fridges. Staff checked and recorded fridge temperatures daily. There was an effective process in place for monitoring the use of prescription charts.

All patients spoke positively about the care and treatment they had received and we observed staff acting in a compassionate manner. Staff treated patients with dignity and respect. Patients we spoke with said they received appropriate information and support about their care or treatment.

Summary of findings

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Inadequate 

The Duchy Hospital

Services we looked at

Surgery; Outpatients and Diagnostic Imaging.

Summary of this inspection

Background to The Duchy Hospital

The Duchy Hospital is operated by BMI Healthcare Limited. The hospital opened in 2008. The hospital was taken over from a Doctor by Nuffield Nursing Homes Trust in 1959 and then bought by BMI Healthcare in 2008. It is a private hospital in Harrogate, North Yorkshire and primarily serves the local communities. It also accepts patient referrals from outside this area.

The registered manager for the hospital had been in post since February 2012. She was seconded to the position of Regional Director of Nursing for the north region between February 2015 and December 2015 before returning to her position as registered manager for the hospital.

The hospital provides a range of surgical, outpatient and diagnostic imaging services to the NHS and other funded (insured and self-pay) patients and works predominately with consultants from local NHS hospitals.

Surgical services at the BMI Duchy Hospital provide day and overnight facilities for adults undergoing a variety of procedures. The hospital provided services for children, but on 31 August 2016 had stopped treatment for under sixteen year olds.

Our inspection team

The team that inspected the service was comprised of a CQC lead inspector, other CQC inspectors, and specialist advisors with expertise in surgery, radiology and outpatient services. Amanda Stanford, Head of Hospital Inspection, oversaw the inspection team.

Information about The Duchy Hospital

The Duchy hospital offered a range of elective and outpatient treatments for different specialities such as cosmetics, dermatology, ENT, general surgery, gynaecology, oral and maxilla facial, ophthalmology, orthopaedic and spinal surgery, urology, plastics and vascular.

Facilities at the hospital included one ward with 27 registered beds, two theatres both with laminar flow and, for patients recovering immediately post-surgery, a recovery area. Theatres were open 8.30am until 8pm, Monday to Friday. In exceptional circumstances, staff opened the department at 7.30am.

The outpatient department provided outpatient consultations and a range of diagnostic imaging services. The outpatient clinics covered approximately 16 different specialities, including orthopaedics, cardiology, dermatology, ophthalmology, urology and cardiology.

The outpatient department had 10 consulting rooms, a minor procedures room and a phlebotomy room. The hospital provided outpatient physiotherapy services and had three treatment rooms and a gymnasium.

Diagnostic imaging provided a range of services including X-ray, fluoroscopy, ultrasound and mammography. A mobile MRI scanner visited the hospital weekly on a Saturday. We did not inspect this unit as part of our inspection, as it is registered separately. The service did not have an on-site pathology service; a local NHS provider provided this.

The hospital is registered to provide the following regulated activities:

- Diagnostic and screening procedures (11 May 2011)
- Family planning (3 April 2014)
- Surgical procedures (11 May 2011)
- Treatment of disease, disorder, or injury (11 May 2011).

Summary of this inspection

Activity (July 2015 to June 2016)

There were 2,858 episodes of inpatient activity between July 2015 and June 2016. During this reporting period, there were a total of 1,045 overnight inpatients and 1,045-day case patients. Of these 33% were NHS funded and 67% were other funded (insured and self-pay).

There were 19,034 outpatient attendances in the reporting period; of these, 27% were NHS patients and 73% were other funded appointments.

The most common procedures performed accounted for 955 of the visits to theatre. The five most common procedures were:

- Multiple arthroscopic operations on the knee.
- Image guided injections into joint(s).
- Cataract surgery.
- Primary total hip replacement.
- Total prosthesis replacement of the knee joint.

The hospital had 91 doctors working under practising privileges. The hospital employed 4.2 whole time equivalent (WTE) theatre nurses, six WTE operating department practitioners (theatre) and 4.1 WTE care assistants for theatre and in-patients. An additional 33.1 WTE allied health professionals (including Radiographers) and administrative staff were employed.

Track record on safety (July 2015 to June 2016)

- During the reporting period, July 2015 to June 2016, there had been one never event within the hospital relating to a wrong optical lens implant. Never events are serious incidents, which are wholly preventable as guidance and safety recommendations are available that provide strong systemic protective barriers at a national level. Although each never event has the potential to cause harm or death, harm is not required to have occurred for an incident to be categorised as a never event.
- Information submitted by the hospital prior to the inspection reported a total of 123 clinical incidents in the reporting period, 91% of which (112 incidents) occurred in surgery or inpatients. Subsequently revised data provided by the hospital reported 142 clinical incidents but no breakdown was supplied by service type, degree of harm and quarter and so it was not possible to provide a breakdown analysis.

- During the reporting period, the hospital reported no incidences of hospital acquired Methicillin-resistant Staphylococcus aureus (MRSA), Methicillin-sensitive Staphylococcus aureus (MSSA) or Clostridium difficile (C.diff) or hospital acquired Escherichia coli (E.coli).
- The hospital received 19 complaints during the reporting period.

Services accredited by a national body:

- The hospital held no national accreditations.

Services provided at the hospital:

- Cosmetic Surgery
- Diagnostic imaging
- Endoscopy
- Medical care (includes older people's care)
- Oncology
- Outpatients
- Surgery

Services provided at the hospital under service level agreement:

- Catering
- Decontamination
- MRI Scanner
- RMO provision

A Nuffield Hospital central hub provided sterile services supplies. This ensured re-usable equipment was cleaned, sterilised and packed at a central hub before return to the hospital.

Jacqueline Ritchie has been the Accountable Officer for Controlled Drugs (CDs) since December 2015.

During our inspection, we inspected two core services at the hospital; these were surgery and outpatient and diagnostic services. We reviewed a wide range of documents and data we requested from the provider. This included policies, minutes of meetings, staff records and results of surveys and audits. We requested information from the local clinical commissioning group. To enable patients to provide us with their views we placed comment boxes at the hospital before our inspection.

So that staff could talk to inspectors and share their experiences of working at the hospital, we held two focus group meetings. We interviewed the management team and chair of the medical advisory committee. We spoke

Summary of this inspection

with 39 staff, including nurses, the resident medical officer, radiographers and administrative and support staff. We also spoke with 16 patients and 6 relatives who were using the hospital. We observed care in the outpatient and imaging departments, in operating theatres and on the wards, and we reviewed 22 patient records. We visited all the clinical areas at the hospital.

There were no special reviews or investigations of the hospital ongoing by the CQC at any time during the 12 months before this inspection. The hospital had been inspected three times in the past and the most recent inspection took place in September 2013. This inspection found that the hospital met the standards of quality and safety that were inspected.

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

We rated safe as inadequate because:

- The use of the five steps for safer surgery including the World Health Organisation (WHO) surgical safety checklist was not embedded in the theatre department. The WHO surgical safety checklist is a tool for the relevant clinical teams to improve patient safety. We observed six procedures, reviewed 21 sets of records of patients, and found the WHO checklist was incomplete in 15 sets of records reviewed and in three out of six procedures observed.
- Staffing levels on the inpatient ward were not appropriate to provide the level of care required for inpatients and for immediate post-operative patients. On reviewing, the staffing toolkit over 28-day shifts there were deficits of 'care hours' on 16 days. The process for taking patients to theatre meant that ward-nursing staff were spending significant time off the ward and therefore not caring for patients on the ward.
- Staffing levels within the theatre recovery area did not follow the recommendations of the 'Association for Perioperative Practice' with regard to numbers of staff on duty during the immediate post-operative period.
- Actions based on recommendations from incidents were not always implemented in an effective way.
- The inpatient environment was carpeted and patient bedrooms did not have access to a clinical hand washbasin to perform hand hygiene. Some clinical areas within outpatients had carpets. The hospital had a refurbishment plan to replace carpets with hard flooring and fit clinical sinks which was due to be completed in 2020. From staff meeting minutes in June 2016, we saw that, due to financial restraints, refurbishment plans had been placed on-hold. However, since the inspection the provider has informed us that refurbishment work was now underway again in the service.
- For consultants with practising privileges and resident medical officers, there was a lack of an effective process for recording mandatory training compliance.
- Staff decontaminated endoscopes on site; during the inspection the environment used for decontamination of endoscope equipment did not meet best practice guidance (Management and decontamination of flexible endoscopes Health technical memorandum (HTM) 01-06). There were plans to move this offsite.

Inadequate



Summary of this inspection

- From 12 sets of patient records reviewed, we saw that none of the patients who attended the outpatient department for a minor procedure had their observations recorded either before or after their procedure. This included patients undergoing cystoscopies.
- The minor procedures room in the outpatient department was used for a range of procedures including cystoscopies. The procedure room did not have specialist ventilation in line with The Health Technical Memorandum 03-01: Specialised ventilation for healthcare. The senior management team of the hospital had sought external assurance sought external assurance from a consultant microbiologist regarding the use of the room. The evidence provided was an article where cystoscopies were listed as a minor procedure for which natural ventilation was acceptable. Therefore, the hospital continued to use the minor procedure room for cystoscopies, although they have since advised that they no longer use the room for that purpose.

However:

- The hospital environment was visibly clean.
- We saw an effective process for recording practising privileges, compliance, indemnity and appraisals.
- Patients we spoke with were positive about their experience of care.
- We observed that staff delivering care to patients were caring and compassionate.
- The hospital had an out of hours rota for anaesthetists to provide 24- hour cover for patients post-operatively and there was a service level agreement for emergency transfer arrangements with the local NHS trust.
- Medications were stored securely in appropriately locked rooms and fridges. Staff checked and recorded fridge temperatures daily.
- The rate of infections during primary knee arthroplasty procedures was below the rate of other independent health hospitals data held by CQC.

Are services effective?

We rated effective as requires improvement because:

- At the time of the inspection, guidance provided to patients on pre-operative fasting did not align with the Royal College of Anaesthetists guidance. Records we reviewed during the inspection showed that patients fasted for longer than the recommended guidance. Eight out of eight patient case notes we reviewed fasted for longer than two hours for fluids. On

Requires improvement



Summary of this inspection

average patients fasted for 9 hours 52 mins. Some staff told us that this was because several of the anaesthetists instructed them that patients have their last clear fluids at 2.30 a.m. prior to admission.

- Health care assistants (HCA) had to complete a competency assessment booklet to undertake theatre escort duties including assisting in the anaesthetic room. Registered nurses working on the inpatient ward did not have to complete competency programmes to allow them to assist in the anaesthetic room.
- The Radiology department had recently changed Radiation Protection Advisors. An action plan was in place and they were in the process of reviewing standard radiology protocols. The deadline for completion was December 2016.

However:

- The hospital had an out of hours rota for anaesthetists to provide 24- hour cover for patients post-operatively and there was a service level agreement for emergency transfer arrangements with the local NHS trust.
- The rate of unplanned transfers of care from this hospital to a nearby NHS trust, unplanned readmissions and unplanned returns to theatre was similar to other independent health hospitals data held by CQC.

Are services caring?

We rated caring as good because:

- Patients understood the care and treatment choices available to them and said staff provided appropriate information and support regarding their care.
- Feedback from patients and visitors was consistently positive. Patients said they felt well supported, well cared for and staff had respected their privacy and dignity. Friends and family test results from January 2016 to June 2016 showed 100% of patients would recommend the hospital.
- We observed caring interactions between staff, patients and relatives. Staff were compassionate and patients and relatives said they felt re-assured about the care and treatment they received.

Good



Are services responsive?

We rated responsive as good because:

Good



Summary of this inspection

- People who used the service could raise concerns and complaints. These were investigated and responded to in a timely manner. To improve the service, the hospital took account of complaints and comments.
- In the reporting period July 2015 to June 2016 the hospital achieved the overall referral to treatment indicators of 92% of incomplete admitted patients beginning treatment within 18 weeks of referral, which complied with NHS England operational standards for referral to treatment targets (RTT).
- Patients were able to access appointment and scans in a timely manner. Waiting times for appointments were minimal and were managed appropriately.

However:

- Patient flow in the outpatient department was not monitored. The hospital did not audit waiting times within the department. Five out of six patients we spoke with had waited past their allocated clinic time but staff had not spoken to them about this.

Are services well-led?

We rated well-led as inadequate because:

- The senior management team used the standardised corporate template for their hospital risk register. None of the risks had dates for review or had an indication when the item was placed on the risk register. Individual departments did not maintain their own risk registers. We identified some risks that were not on the hospital's risk register, for example no specialist ventilation in the minor procedure room.
- We saw effective local level leadership on the inpatient ward.
- Although staff consistently told us that they felt supported by their immediate management, some staff felt the senior management team would not listen to them if they raised concerns. They felt action would not be taken in response to concerns raised. We did not see any information displayed informing staff how to raise concerns. However, the hospital had undertaken a staff survey in February 2016; this had identified low morale, concerns over pay and additional benefits. The senior management team were aware of the low morale and had responded to this survey by running staff forums; staff we spoke with said these were held on a monthly basis and were well attended.
- Although formal governance processes were in place, we were concerned that actions based on recommendations from incidents were not always implemented in an effective way.

Inadequate



Summary of this inspection

- Based on an analysis of the pre-inspection information request, there appeared to be inaccuracies in data held locally within the hospital compared to data held at the head office. This may have affected any benchmarking data used to review quality at the hospital compared with other BMI services.
- The majority of staff we spoke with told us that there were difficulties between staff working in the operating theatre and in patient ward areas. Ward staff had to escort patients to theatre and be present in the anaesthetic room until the patient was asleep. Staff we spoke with in both services said this had caused problems with effective communication and effective liaison between the services.
- At a hospital level there was no clear ownership of the workforce and race equality standards (WRES). The organisation had a corporate workforce and race equality standards report. However, the report was for the organisation and not individual to the hospital.
- There was some evidence of continuous quality improvement. There was minimal evidence of audits in the outpatient department apart from environmental and hand hygiene audits. Staff we spoke with in the inpatient area were unclear about which audits took place and any consequent changes in practice. We saw no evidence of action plans to ensure that recommendations had been put in place. The positive assurance the senior management team derived from clinical audits that we reviewed did not corroborate with what we found at inspection. For example, the results of the effectiveness of the five steps to safer surgery and the WHO surgical safety checklist and patient pre-operative fasting audits indicated 100% compliance, but we did not find this on inspection.
- BMI have a corporate vision and an operational plan with strategic objectives, which is individualised at hospital level. Each head of department fed into the operational plan to highlight how they were going to deliver the strategic objectives for their department. Therefore there was no single strategy for outpatients and diagnostic services at this hospital. Staff were unable to articulate the vision, strategy and priorities for their service.

However:

- BMI hospitals had a corporate operational plan outlining the key strategic objectives. From this the hospital had an operational plan outlining how they would deliver the strategic objectives.

Summary of this inspection

- Staff spoke positively and felt well supported by their immediate managers.
- Medical staff we spoke with were very complimentary about the culture of the hospital.
- We saw good local level leadership on the inpatient ward and the administration and outpatient departments.






Detailed findings from this inspection

Overview of ratings

Our ratings for this location are:

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

Surgery

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

Are surgery services safe?

Inadequate 

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

We rated safe as inadequate.

Incidents

- During the reporting period, July 2015 to June 2016 there had been one never event within the hospital relating to a wrong optical lens implant. Never events are serious patient safety that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious harm or death but neither need have happened for an incident to be a never event. A root cause analysis (RCA) investigation had been undertaken. Recommendations from the RCA following the never event had been implemented and changes in practice had been made since the incident. This includes improvements in the storage arrangements for optical lenses and the checking procedures prior to implantation.
- During the same reporting period there were no serious incidents. Serious incidents are incidents that require further investigation and reporting. The hospital had a policy for the reporting of incidents, near misses and

adverse events. At the time of the inspection, the hospital had an effective process for ensuring that mandatory training records for employed staff were reviewed and recorded.

- Although staff knew of this process, we were not assured that all incidents were reported or that this process was effective for identifying themes, trends and lessons learned. The senior management team said that, in the near future, the current paper system was changing to an electronic system.
- The majority of staff we spoke with said that learning from incidents was shared internally through team meetings.
- Incidents were discussed at hospital committees, such as the integrated clinical governance committee and the medical advisory committee (MAC).
- Information submitted by the hospital prior to the inspection reported a total of 123 clinical incidents in the same reporting period, 91% of which (112 incidents) occurred in surgery or inpatients. None of the incidents were graded as death, or severe harm, 12 were graded as moderate harm, 43 graded as low harm and 97 graded as no harm/ near miss. In addition, in the information originally submitted there was one non-clinical incident reported.
- Subsequently revised data provided by the hospital reported 142 clinical incidents but no breakdown was supplied by service type, degree of harm and quarter and so it was not possible to provide a breakdown. The provider also subsequently revised the non-clinical incident figure to 11, but a quarterly breakdown of the revised number of non-clinical incidents was not provided.

Surgery

- From minutes we reviewed, we saw that themes of incidents reported were varied and included both clinical and non-clinical issues.
- The senior management team said that to prevent a re-occurrence, all incidents graded moderate or above were investigated using a root cause analysis (RCA) process and action plans were developed. We reviewed two RCA reports. In one report, an unexpected death in October 2015 had occurred after a patient transfer to NHS care. The lessons learned identified issues relating to staffing levels and staff recognising that a patient's condition had deteriorated.
- An action plan had been produced. However, during the inspection, it was clear that some of the actions outlined in the action plan were not being consistently implemented. For example, the action plan recommendation for the 'identification of person in the role of theatre/ward escort where activity identifies the need'. The action plan listed this recommendation as 'in place and ongoing'. However there were occasions where this action had not been implemented effectively. For example, there were concerns regards shortages of staff to safely support this function during the inspection. Staff reported to us that cover for staff breaks during 13-hour shifts was still a problem which meant that staff were unable to take their allocated breaks.
- We reviewed another RCA that did not address a number of issues, which may have contributed to the incident. The action plan did not have a period within which to have improvements re-assessed and nor did it mention the duty of candour requirements. Duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support to that person).
- Staff could access on the company's intranet the BMI healthcare policy relating to the duty of candour requirements.
- Staff we spoke with understood the concept of the duty of candour requirements and described it as being open and honest with patients and their family. We reviewed three incidents and two did not mention duty of candour. In addition, duty of candour did not feature on the incident template. It was not clear how duty of

candour information was collated and acted upon. However, we saw letters from individual consultants, which contained an apology when processes had not gone as well as planned.

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

- To monitor performance, the hospital completed a range of BMI corporate dashboards and these were discussed at the relevant hospital governance meetings. Example dashboards included quality, safety, health and environment, complaints and information security incidents.
- Venous thromboembolism assessments were carried out in the hospital. A venous thromboembolism (VTE) is a blood clot, which forms in a vein, often in a leg, which can lead to harm to patients. In the reporting period October 2015 to June 2016, data showed 98% compliance.
- In the same reporting period there were no incidents of hospital acquired VTE or pulmonary embolism (PE).
- In the reporting period July 2015 to June 2016 there had been no pressure ulcers, no falls with harm and no catheter and urinary tract infections. The hospital used the safety thermometer tool for NHS patients to monitor performance against the harms identified above.

Cleanliness, infection control and hygiene

- In the reporting period July 2015 to June 2016 the hospital reported zero cases of hospital acquired Methicillin resistant Staphylococcus aureus (MRSA) and hospital acquired Clostridium difficile (C.Diff).
- Wards and departments were visibly clean and ward cleanliness scores were displayed in public areas. There were dedicated cleaning staff, and staff had been appropriately trained and were aware of nationally agreed colour coded equipment and standards.
- Environmental cleaning schedules were available and displayed in public areas. We reviewed patient led assessment of the care environment (PLACE) results for the hospital for the period February 2016 to June 2016 and noted this was 96%, which was slightly below the 98% England average for cleanliness.
- Equipment cleaning assurance labels provided assurance that re-usable patient equipment was clean and ready for use. We reviewed six pieces of clinical equipment and found these to be clean and labelled.

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- We saw that staff had access to the BMI corporate nationally recognised infection control policy, hand hygiene policy and uniform policy. These met agreed standards of the World Health Organisation (WHO) Guidelines on Hand Hygiene in Health Care 2010.
- Processes and procedures were in place for the management, storage and disposal of general and clinical waste, disposal of sharps, such as needles, and environmental cleanliness. We observed staff adhering to these in practice.
- We observed staff washing their hands, using hand gel between patients and staff complying with 'arms bare below the elbows' policies. Protective clothing was available and seen to be used appropriately.
- In the reporting period May to September 2016 hand hygiene audit data showed 100% compliance. During the inspection, we observed hand hygiene compliance data displayed on the wards and department we visited.
- Taps in bedroom areas did not comply with recognised standards of infection prevention and control and did not comply with the Department of Health Building Note 00-10 part C; sanitary assemblies.(HBN00-10). This was recognised as a problem on the hospital risk register. However, there were sufficient numbers of hand wash basins available for staff use outside of patient rooms. We discussed this with the senior management team and requested a copy of the refurbishment action plan. This indicated that refurbishment would not be complete until 2020. The minutes of the staff meeting in June 2016 stated that the refurbishment plan was on-hold. However, since the inspection the provider has informed us that refurbishment work was now underway again in the service.
- There were carpeted areas in the majority of the rooms in the ward area. This was recognised as a problem on the hospital risk register. Replacement flooring was included in a five-year refurbishment plan. However, at the time of the inspection the management team could not inform us of any immediate action and told us that there was no formal funding for this. The refurbishment action plan indicated that refurbishment would not be complete until 2020 and again, from the minutes of the staff meeting in June 2016, indicated that the refurbishment plan was on-hold. However, since the inspection the provider has informed us that refurbishment work was now underway again in the service.
- Staff decontaminated endoscopes on site, but the environment used for decontamination of endoscope equipment did not meet best practice guidance (Management and decontamination of flexible endoscopes health technical memorandum (HTM) 01-06). There was no designated separate dirty and clean space to decontaminate endoscopes, and there were no dedicated separate sink facilities for washing and rinsing scopes. Clean scopes were not stored in a clean area and there was the potential for clean scopes and dirty equipment returning to the decontamination area to cross over. This was not on the risk register.
- During the inspection staff had taken out of service one of the washer disinfectors used for endoscopy decontamination; this was because water samples taken from this machine were above normal limits. Patient procedures had been cancelled due to this issue.
- The senior management team spoke with us about the plans to move endoscope decontamination in early January 2017 off site to a central area. We asked the provider to confirm these plans and they advised these were due to be implemented in February 2017. We were concerned that there was ongoing delay in the new decontamination plans.
- The hospital had completed infection prevention audits in this area in August and September 2016. The unit scored 84% in August rising to 94.5% in September 2016. Action plans were available.
- As required by BMI policy, the lead for infection prevention and control carried out surgical site infection surveillance and reported this monthly to the director of clinical services and to the relevant IPC committees. In the reporting period July 2015 to June 2016 data supplied to us by the hospital showed there were 11 surgical site infections.
- The rate of infections during primary hip arthroplasty, other orthopaedic trauma and spinal procedures was worse than expected when compared to the data held for other independent hospitals. Following the inspection the hospital provided their monthly surveillance reports which showed no primary hip arthroplasty surgical site infections (SSIs) although one hip arthroscopy SSI was reported for the period.
- The rate of infections during primary knee arthroplasty procedures was lower than expected when compared to the data held for other independent hospitals.

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- No infections were reported for breast surgery, gynaecology, and upper gastro intestinal tract, colorectal, urological, cranial, or vascular procedures.
- The scheduling of theatre lists allowed for patients who had infections to be last on the theatre list.
- To comply with best practice guidance the hospital carried out testing on water samples for legionella bacteria.
- Deep cleaning of theatre took place as per BMI policy.
- A new lead nurse for infection control and prevention had been recruited and was continuing to work across the hospital to implement the BMI hospital infection prevention and control strategy.
- Three levels of infection prevention and control training were offered on the BMI Learn system. We saw that the rate of compliance for infection prevention and control (IPC) awareness was 96.8%, IPC in healthcare 60.8% and IPC with high impact intervention/care bundles and aseptic non-touch technique (ANTT) 59%, against an organisational target of 90%. There was no documented plan to address the low levels of training. However, the hospital had recently employed a qualified infection prevention and control specialist and training was included in the annual plan of work.

Environment and equipment

- There were two theatres in the hospital. Both of these had laminar flow (specialist ventilation) which is best practice for orthopaedic surgery.
- The theatre and recovery area was cluttered. During the inspection, we observed consumables being stored in a fire escape route. We reported this to the senior management team. Storage rooms were dusty and had cardboard waste in them. We raised this in general discussion at the time of inspection.
- The difficult airway intubation trolley was stored within theatres. Staff knew where to access this and had worked with the anaesthetist to ensure that the layout of the trolley was identical to that of the local NHS trust so that staff were familiar with this.
- One of the anaesthetic rooms was small; if a patient trolley was in the room, we observed staff having difficulty moving around the patient to deliver care. Staff working in this area had to move and climb over equipment in order to reach the items they required. Movement around the trolley space in this room meant that the doors to the theatre area opened and compromised the airflow and had the potential to increase the risk of infection. This was not identified or highlighted as a risk by the service.
- We observed two bed tables in the recovery area which were damaged and difficult to clean.
- We saw that an area of flooring in the scrub room was damaged which made cleaning more difficult. We saw that there were miscellaneous items such as bags and newspapers in the theatre and anaesthetic rooms. These should not have been stored in these areas.
- We reviewed six pieces of electrical patient equipment. These had been routinely checked for safety with visible stickers demonstrating when the equipment was next due for service.
- Patients in day and inpatient areas had single en-suite bedrooms, which were located in a main area. To attract staff attention, all rooms had nurse call bells.
- In the inpatient and theatre areas, we saw that resuscitation equipment was checked daily and staff had recorded checks completed. Single use items were seen to be sealed and in date, and emergency equipment had been serviced.
- Staff we spoke with were aware of the process for reporting faulty equipment. We observed a member of staff reporting a broken suction pipe whilst we were on the ward and this had been fixed soon after the time of reporting.
- Staff we spoke with said there were adequate stocks of equipment and we saw evidence of stock rotation both in the ward and theatre areas.
- A central hub provided sterile services and supplies. Surgical instruments were available for use and staff reported there were no issues with supply. The area prioritised instruments most frequently used for a quick return. There was an agreement with the local NHS trust and a local taxi firm, which allowed them to collect specific equipment if required. However, staff we spoke with said that occasionally pieces of equipment had been damaged in the decontamination process but were readily replaced.
- Outside the operating theatres there was a white board detailing which equipment required collection and decontaminating and which equipment had been delivered.
- The Association of Anaesthetists of Great Britain and Ireland (2012) recommend a pre-use check of the anaesthetic equipment. We reviewed safety checks of

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anaesthetic machines; records reviewed did provide assurance that daily safety checks had been undertaken. Anaesthetic records we reviewed showed consistency in the recording of safety checks including pre-check use. Staff we spoke with stated they were assured about the safety of the equipment that they used.

- To comply with best practice guidance the theatre ventilation system underwent annual checks.
- Hoists were available on the inpatient area for those patients who required assistance.

Medicines

- Pharmacy staff provided a five day a week service. The resident medical officer was also able to access pharmacy and supply medications out of hours.
- Medicines were stored in a locked room, with access restricted to authorised staff.
- Medicines requiring refrigeration were stored in fridges, on the majority of occasions these were locked, the temperatures were checked daily, and staff were aware of the action to take if the temperature recorded was not within the appropriate range.
- Emergency medicines were readily available in a tamper evident box and they were found to be in date.
- Controlled drugs are medicines, which are stored in a designated cupboard, and their use recorded in a special register. We reviewed the controlled drugs register on the inpatient ward and saw that in the previous fourteen checks these were accounted for and signed appropriately. In the theatre suite, we observed seven out of 24 occasions when a second witness signature was not present in the controlled drug book.
- Pharmacy staff visited the ward daily from Monday to Friday to check current stock levels, review pre-assessment medications and discharge medications.
- We looked at the prescription and medicine administration records for ten patients on the ward. We saw arrangements were in place for recording the administration of medicines. These records were fully completed and were clear and legible.
- The lead pharmacist informed us that an antimicrobial stewardship audit took place twice a year. Antimicrobial stewardship is a co-ordinated programme that promotes the appropriate use of antimicrobials, (including antibiotics) with a view to improve patient outcomes, reduce microbial resistance and decreases

the spread of infections caused by resistant organisms. This included snapshot viewing of those patients on the ward who were prescribed antibiotics and reviewed correct prescribing and documentation. We saw a clear protocol for changing non-oral antibiotics to oral. As a result of the audit, there had been changes in routine pre-operative antibiotic prescribing. The lead pharmacist was also monitoring the use of restricted antibiotics and was assured that they were prescribed appropriately.

- We reviewed a missed dose audit completed by the lead pharmacist in May 2016. There were no missed medication doses noted in the period of the audit over three months.
- There was clear guidance for out of hours prescribing for patients drugs to take home. The RMO prescribed and two nurses signed for their allocation. We were told that this was a rare occurrence as routine take home drugs were given in office hours prior to discharge.
- There had been recent incidents where patients own medication had been left in lockers; a change in practice was made to complete a discharge checklist, prompting medication checks. Pharmacy staff had also implemented controlled drug refresher training for registered staff because of a number of controlled drug errors.
- Within the anaesthetic room, we observed three intravenous bags of medication with administration sets attached. These were set up in a room that was not occupied and it was not clear as to whether the medication was set up to use, had been used or required disposal. We reported this to the theatre manager at the time of the inspection and these were removed.

Records

- Paper records were available for each patient that attended the hospital; the hospital used a computerised patient administration system to book appointments and hold non-clinical information, however records and patient assessments were still paper based.
- Staff we spoke with told us that there had been ongoing issues with the administration department and capacity. This had affected the availability of the medical records. Staff we spoke with said that, when a patient was admitted, they did not always have access to background health information. This had caused minor problems in some cases. Staff also said that there were

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times that the correct information was not in the records such as referral letters and patient pathways. However, we spoke with consultants who told us that these problems had begun to be improved. As this had not been reported as a risk it was not possible to confirm this.

- Patient records were stored in a lockable cupboard at the nurses' station in the ward, or were stored in secure areas.
- We reviewed 18 sets of medical and nursing care records on the ward. In compliance with BMI policy and professional standards, we found staff used black ink, legible handwriting, and documentation occurred at the time of the review or administration of medication. We saw clear post-operative instructions for the inpatient ward staff. All had consent recorded, and all had a surgical site checklist completed. However, two of these did not have the staff members name printed. This was a requirement for traceability purposes.
- Integrated care records for patients were in use. These covered the entire patient pathway from pre-operative assessment to discharge; they outlined comprehensive care plans for identified care needs. Patient records were multidisciplinary and we saw where therapy services had made entries.
- To meet the requirements of practising privileges, a consultant should make a daily entry in their patient's records, at the time of their visit. However, we reviewed six sets of medical records and only one contained daily entries from the patient's consultant in the integrated care record.
- We saw in the records we reviewed, that risks to patients, for example, falls, malnutrition and pressure damage, were assessed, monitored and managed on a day-to-day basis using nationally recognised risk assessment tools. Individualised patient care plans we reviewed were clear in the records.
- Completion of venous thromboembolism (VTE) assessment was 98% and higher than the corporate compliance rate of 95%.
- The director of clinical services was the Caldicott Guardian for the hospital. A Caldicott Guardian is a senior person responsible for protecting the confidentiality of a patient and service-user information and enabling appropriate information sharing with other agencies.
- In the reporting period July 2015 to June 2016, there were no safeguarding concerns reported to the CQC.
- The wards and services had systems in place for the identification and management of adults and children. There was access to information about vulnerable people. However, three members of staff out of the six we spoke with were unclear about female genital mutilation and the requirement for reporting. They were not clear whether this had been included in training.
- There was a corporate safeguarding and protecting vulnerable people policy and procedure, which included guidance on safeguarding adults and both the Executive Director and Director of Clinical Services were trained to level three in safeguarding children and adults.
- Staff we spoke with could describe their roles in relation to the need to report and take action as required when safeguarding issues were identified. However, young people aged 16 – 18 years were considered adults by many staff and were unclear about safeguarding children issues for that age group. Issues, which could potentially affect young people and would have been addressed in level 3 training were not shared over the hospital, such as, issues for looked after children, child sexual exploitation and female genital mutilation.
- Staff received mandatory training in the safeguarding of vulnerable adults as part of their induction, followed by refresher training. We reviewed safeguarding training compliance rates for level one for vulnerable adults and they showed 88.1% compliance with a hospital target of 90% whilst safeguarding vulnerable adult's compliance for level two showed 81.1%.
- We reviewed mandatory training for level one safeguarding children and this showed a 96.4% compliance rate. Compliance rates for level two safeguarding children showed 81.1% against a target rate of 90%.
- There were no clear processes to identify whether consultants and resident medical officers (RMOs) had received any training in the local NHS trusts in which they worked, or how this was captured in BMI figures. It was also unclear as to where consultants who had retired from the NHS received safeguarding training.
- Two senior managers had received level three safeguarding children training. Two members of staff we spoke with were unsure who the safeguarding lead in the hospital was.

Safeguarding

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- The hospital had treated 155 young people over the last year from between the end of June to July 2016 although there had been a recent decision by the hospital not to treat young people under 16; they did treat the 16-18 age groups who were still subject to the protection afforded as described in the Children Act (2004). The Intercollegiate Document (2014) is clear that safeguarding of children extends to private healthcare. All staff working in health care settings, including those working predominantly to treat adults who may have dependent children and be affected by their health or behaviours, should receive training to ensure they attain the competencies appropriate to their role. Since the inspection the provider has informed us that they have updated their policy and is working towards achieving staff training at level 3 for those who provide care to patients under the age of 18 years.
- The hospital had completed the annual safeguarding audit and the director of clinical services was the link into local safeguarding board structures.
- There were no examples of safeguarding referrals to review.

Mandatory training

- Mandatory training for employed staff was delivered as both face-to-face training sessions or through e-learning programmes.
- The corporate target for mandatory training completion was 90% compliance; training data we reviewed showed an overall training compliance rate for the hospital of 87.5%. The hospital was unable to separate mandatory training data into individual clinical areas. Individual levels of compliance for training ranged from 59% to 100%. Lowest scores included acute illness management, which rated as 50% for health care assistants (HCA's) and 63.2% for registered nurses. Highest rates of training were for safeguarding children and adults level one and fire safety, both rated as 100% compliance for all staff.
- New staff received a corporate induction, which included some aspects of their mandatory training such as fire, health and safety issues.
- At the time of the inspection the hospital did not have an effective process for ensuring that mandatory training records for consultants and RMOs was reviewed and recorded in the hospital. We reviewed five sets of consultants with practising privileges training records and two sets of RMO records. Of the five consultant

records reviewed, one set showed training records, however many of the training sessions were out of date; in the other four sets, no training records were available. We reported these issues to the senior management team and during the unannounced part of our inspection we were shown a letter that had been sent to the NHS employers of the consultants to ask them to provide the training data. We were told that collecting and storing this data was not part of BMI policy and therefore the hospital could not have been assured training was up to date.

- The hospital did not directly employ registered medical officers (RMO) and was not responsible for the training of the two staff. However, it was a requirement of the hospital that all RMOs showed evidence of completed mandatory training on employment and attended yearly refresher training. However, during the announced inspection, it was not possible to identify up to date training data for one RMO within the hospital records and therefore the hospital could not have been assured that one of the RMO's training was up to date. We reported these issues to the senior management team and during the unannounced part of our inspection, we were shown up to date training data for both RMOs.
- At the time of the inspection, the hospital had an effective process for ensuring that mandatory training records for employed staff were reviewed and recorded. We reviewed five sets of nursing personnel records. There was a clear process to collect training data. All records we reviewed showed that staff were up to date with all appropriate training.

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

- The hospital undertook the five steps for safer surgery safety checklist, which incorporated the World Health Organisation (WHO) safer surgery checklist. The hospital had a procedure to check compliance with the safety checklist; staff reviewed ten random sets of patient notes for each theatre, each month. Results of audits showed 100% compliance. Records we reviewed from June 2016 showed staff had been encouraged to ensure records were completed accurately and discussion was held about the process of completion.
- Evidence from the inspection demonstrated a lack of effective compliance with the requirements of the safer surgery checklists. During the inspection, we reviewed

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nine sets of medical notes. Of the notes reviewed, three were completed accurately and two records did not contain WHO safety checklists. A further four records did not have the practitioners name printed which could have led to traceability problems.

- During the announced inspection, we observed two procedures. One case did not have checks one or two signed, stage three was completed and stage four was signed before the procedure had been completed. One case did not have a signed checklist. We discussed this with the senior management team following the announced inspection and they provided an action plan detailing actions taken to improve compliance including audit and reminding staff of requirements. During the unannounced inspection, we observed four further surgical procedures. On one occasion the checklist was completed but not verbalised, on three occasions, the checks were verbalised and the checklist completed correctly.
- All patients attended a nurse-led pre-operative clinic and the assessment included observations such as blood pressure, review of medication and discussion and understanding of admission and forthcoming procedure. This assessment complied with the National Institute for Health and Care Excellence (NICE), guidelines on pre-operative care. The patient completed a comprehensive health questionnaire prior to leaving the clinic. This included social information in order to assess care arrangements following discharge.
- Patient allergies were clearly documented in patients' notes.
- To identify deteriorating patients, the hospital used the modified national early warning score (NEWS) tool. Nursing staff we spoke with were able to articulate the use of this tool in the recognition of a deteriorating patient. Following an incident of mortality post transfer, the action plan recommended that staff required further training on its use. The action plan stated that this training was to take place in February 2016. We saw that one member of staff had attended and that the sessions had not been repeated up to the time of our inspection. However the provider subsequently informed us that NEWS training formed part of immediate life support training, which all nurses and ODP's had attended.
- Current documentation indicated when escalation was required highlighting significant deviations from the norms in respiratory rate, blood pressure, heart rate and oxygen saturation. NEWS documentation we reviewed in the records on our inspection was appropriately completed.
- Whilst children between 16-18 were being risk assessed we saw there were no separate pathways The registered manager said that any child not deemed able to be nursed on an adult pathway would have their care transferred to an alternative hospital, however we did not see this pathway documented.
- Staff we spoke with were knowledgeable about sepsis pathways. These were found on the corporate website and we observed information in staff areas.
- There was a clear hospital policy in place for the emergency management of cardiopulmonary resuscitation. Staff we spoke with, and minutes of clinical governance meetings we reviewed, showed that regular simulated cardiac arrest scenarios were carried out so staff were able to respond quickly and be rehearsed should a real life cardiac arrest occur.
- A resident medical officer (RMO) was on duty 24 hours a day, on a two-week rota alternating with another RMO. The RMO responded to any concerns staff had regarding a patient's clinical condition.
- Consultants with practising privileges were required to be contactable at all times when they had an inpatient in the hospital. They were required to be available to attend within an appropriate timescale according to the level of surgical emergency and no longer than thirty minutes.
- There was an anaesthetist on site at all times when patients were in the recovery room post-operatively. We saw evidence of an on call anaesthetist rota.
- Blood products were available in the hospital for use in an emergency. A supply of blood for all blood groups could be ordered from a local NHS trust and arrived on site within a minimum time scale. Patients undergoing major surgery were cross matched for patient specific blood type in a pre-admissions clinic, so blood was available on site at all times during their stay.
- Systems and processes were in place with a local NHS trust if further blood was required. Simulation of the major haemorrhage protocol activation took place in the hospital, so staff were familiar with their responsibilities in the unlikely event of needing to use this protocol. A major haemorrhage is excessive blood loss which can be life threatening. There had been a recent drill.

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- There was a formal arrangement in place for patients to be transferred to the local NHS trust hospital if the patient required critical care to level two or level three. These would be patients who required additional monitoring or support in the immediate post-operative period.

Nursing and support staffing

- At the time of the inspection, the inpatient department had 13.3 WTE registered nursing posts and 4.1 WTE unqualified nursing posts. We reviewed vacancy rates and this showed an 11% vacancy rate, which equated to 1.7 WTE posts. No vacancies were noted for healthcare assistants.
- At the time of the inspection, the theatre department had 9.3 WTE registered nursing posts and 11.9 WTE unqualified nursing posts and operating department assistants. We reviewed vacancy rates for theatre nurses and this showed a 23% (2.3 WTE) vacancy rate. No vacancies were noted in ODPs and HCA roles. At the time of our inspection, one member of staff was on long-term sick leave and one in full time education.
- The hospital used the BMI dependency tool kit, which assessed nursing staff requirements for a ward and department, for a shift. This tool counted health care assistants and registered nurses within the number of care hours required/rostered. Staff used the dependency tool to plan the amount of care hours required and skill mix required five days in advance.
- On reviewing the BMI staffing toolkit over a four-week period there was a deficit in the care hours available on 16 out of 28 day shifts. This deficit ranged from 2.2 to 13.1 hours.
- Ward staffing skill mix ratios were based on 80% registered nurses to 20% health care assistant ratio. Medical advisory (MAC) minutes July 2016 we reviewed showed that this skill mix ratio was 84% registered nurses to 16% health care assistants.
- The senior management team said that the ward operated on a ratio of three registered nurses to twenty patients. We reviewed data that showed over a four-week rota from July to October 2016 (81 shifts) two registered nurses were on duty on 47 occasions. We reviewed patient occupancy rates and saw that over the same four-week period (81 shifts) patient occupation rates were 20 or above on 14 occasions. On eight of these occasions, there were two registered nurses on duty. We were informed, that because of staggered admissions and discharges the figures could fluctuate, however we were not assured that the staffing levels for the inpatient department were appropriate.
- We saw that significant time was spent by the ward nursing staff taking and collecting patients to theatre. All staff we spoke with told us that they had to provide 'third anaesthetic cover' until the patient was fully anaesthetised and that they could be away from the ward up to 45 minutes. This was contrary to information provided by the senior management staff who told us that staff returned to the ward immediately.
- We reviewed data, which showed that the staff spent an average of 17 minutes away from the ward every time they took a patient to theatre. The amount of patients requiring escort to theatre in a 24-hour period could fluctuate and data we reviewed showed that between five to 18 patients each day required escort. This meant that when only two registered nurses were on duty, there were periods when only one registered nurse was available for the remaining ward inpatients. This issue had been highlighted in a RCA in October 2015. The lessons learned identified issues of staffing levels and the amount of time staff spent away from the ward on escort duties. An action plan had been produced, which included the employment of a member of staff to undertake theatre escorts; this was only just being actioned in September 2016.
- The same RCA highlighted staff not receiving a break whilst on a 13-hour shift. Actions had been identified to allow them to receive breaks. However, staff we spoke with said that they did not always manage to take their breaks. Data we reviewed showed that over a three-month period on 38 occasions staff did not receive a break and received payment instead. The information provided to us also showed that some staff had requested to work through their break to leave slightly earlier on their shift.
- Staff we spoke with had concerns about staffing levels on the ward and said that when the ward was very busy they were concerned about the potential impact on the patients. Non-clinical staff told us that at times they were concerned about the welfare of the registered nurses and the impact on their welfare such as not getting breaks.
- The senior management team spoke with us about additional assurance they gained on staffing levels from

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the weekly activity management meeting. This meeting reviewed the forthcoming week's activity and staffing requirements. However, from discussions with staff not all senior managers attended this meeting.

- The hospital had its own nursing bank, however, on occasion agency staff were still required, and staff told us that when agency staff were required they could not be booked before 24 hours prior to the shift that was required. However, the hospital provided us with evidence that some agency staff were requested up to a few days prior to the required shift. There was a process to induct new agency and bank staff to the hospital.
- In the reporting period July 2015 to June 2016, the rate of the use of bank and agency registered nurses and healthcare assistants working in the inpatient department, was higher than the average rate of other independent acute hospitals.
- In the same reporting period the rate of the use of bank and agency working in the theatre department was variable and the rate of healthcare assistants was lower than the average rate of other independent acute hospitals. In the reporting period July 2015 to June 2016, staff turnover for inpatient ward nurses and other staff was above the average when compared with other independent acute providers that we hold data. There was no staff turnover data for health care assistants (HCAs). Staff we spoke with said that staffing levels in theatres had changed recently due to staff sickness and study leave. The department had recently started to use increased numbers of agency staff.
- We reviewed theatre duty rotas, duty allocations and theatre lists. From the data we reviewed, the hospital did not follow the recommendations of the 'Association for Perioperative Practice' (AfPP) with regard to numbers of staff on duty during the immediate post-operative period. AfPP recommends one practitioner per patient for the immediate post-operative period. We reviewed 27 shifts from the theatre duty rotas from July to September 2016. We saw that one member of staff was allocated to work in the theatre recovery area on 19 occasions with two members of staff allocated to work in the recovery area on eight occasions. On reviewing theatre lists for these days, we saw an average of 13 patients a day attending theatre with between 2-14 patients a day having a general anaesthetic.
- Formal handovers took place three times a day; occurring during the shift when staff changed. We observed a formal handover and saw that patients'

clinical conditions were discussed and levels of support or risks were identified. We saw a new handover tool being used, which had been devised by ward staff and a student nurse.

Medical staffing

- Patient care was consultant led. There was the expectation that the patient's consultant reviewed their patients on a daily basis. This might be more frequently at the request of the resident medical officer (RMO) or senior nursing staff.
- There was always a resident medical officer (RMO) on duty that provided 24-hour medical cover for patients. RMOs worked on a two-week rotation and were recruited and overseen by an external organisation. We were told that if further RMO support was required, that the external agency had staff on standby. Resident medical officers did not assist in theatre.
- It was a requirement that consultants were able to be contacted 24 hours a day if they had patients in the hospital and were able to return to the hospital within 30 minutes. The hospital carried out a formal risk assessment if a consultant did live outside this travel time. If the consultant was unable to attend because of theatre duties in the local NHS trust then they would arrange alternative cover.
- We saw staff in the ward area and theatres had access to up to date contact numbers for those consultants with practising privileges.
- If a patient who had been discharged following surgery deteriorated, the patient would normally return to the hospital for review and further treatment where appropriate. The hospital had an out-of-hours rota for clinical staff, and consultants provided 24-hour cover for their patients post-operatively.
- There was 24 hours a day, seven days a week anaesthetic on call cover and an emergency service level agreement (SLA) transfer arrangement with the local NHS trust.
- There were 91 doctors and dentists granted practicing privileges at the hospital. The majority of these worked at local NHS trusts. They included consultants with specialties such as ophthalmology and orthopaedics. The term "practising privileges" refers to medical practitioners not directly employed by the hospital but

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who have permission to practise there. Data we reviewed showed all have had their registration validated in the last 12 months; however, mandatory training data was unclear.

- We saw from personnel records that that the hospital had completed appropriate checks for doctors with the disclosure and barring service (DBS).
- We observed from records that the registered manager and the medical advisory committee (MAC) chair liaised with the General Medical Council (GMC) and the local NHS trusts to check for concerns and restrictions on individual consultants.
- Formal handovers between resident medical officers (RMO) took place on changeover days. We were unable to observe this. Informal handovers took place during the shift as required between RMOs and consultants.

Emergency awareness and training

- The hospital had a corporate BMI Healthcare business continuity policy, which set out the minimum standards for preparedness and response required by all BMI facilities.
- We saw a major incident plan; this outlined the process for managing and co-ordinating the hospital's emergency response in the event of such an incident. All staff we spoke with were familiar with these plans.
- The external fire risk assessment was completed every three years and was in date. However, the BMIs annual internal review was out of date at the time of our inspection. A number of areas had been highlighted on the fire risk assessment. The accompanying action plan did not address all documented risks identified. This was not highlighted on the risk register but the management team were aware of this and we were told that this would be updated. The fire escape required attention, due to inappropriate glass being present. We were told that this would form part of the risk assessment actions. We did not see that actions had taken and a window remained a risk.
- There were fire evacuation tests and evacuation plans in place.
- We were told that there was an immediate link to the local fire station if a fire broke out on the hospital site.
- Monthly tests took place on the backup generator.
- The hospital had a business continuity plan which was available on the intranet.

Are surgery services effective?

Requires improvement 

We rated effective as requires improvement.

Evidence-based care and treatment

- We saw that patients' treatment plans were not always based on national guidance from the National Institute for Health and Care Excellence (NICE), the Association of Anaesthetics, and from the Royal College of Surgeons. For example, at the time of the inspection, guidance provided to patients on pre-operative fasting did not align with the Royal College of Anaesthetists guidance. Records we reviewed during the inspection showed that patients fasted for longer than the recommended guidance. Eight out of eight patient case notes we reviewed fasted for longer than two hours for fluids. On average patients fasted for 9 hours 52 mins. We discussed this with the senior management team who advised us that, to improve compliance, they had changed the letter being sent to the patient.
- We saw that emergency theatres were available 24 hours a day as required by the National Confidential Enquiry into Patient Outcome and Death (NCEPOD) guidelines.
- BMI policies and procedures were stored on the hospital intranet and staff we spoke with said (and were able to show us) that they knew how to access these. We observed up to date paper copies of policies, procedures and standard operating procedures (SOPs) in the operating theatre and inpatient ward areas.
- The hospital collected data and reported to the national joint and breast implant register. The breast implant register was kept for ten years and allowed for traceability should future concerns arise. It complied with the requirements of the general medical council (GMC) following the Keogh report 2012.
- So the rehabilitation progress could be evaluated, patients undergoing knee surgery were assessed using the Oxford Scale, which measures muscle strength and range of movement pre and post-operatively.
- We saw evidence of a range of standardised, documented pathways and agreed care plans across surgery. Examples of these included cataracts and endoscopy.

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- The hospital undertook a local audit programme. These included inpatient ward nursing audits in venous thromboembolism (VTE) and falls audits. Results were collated monthly and discussed at the monthly clinical governance meeting.
- The hospital provided data to the competition and markets authority (CMA). This had been provided since January 2016 and was also, from September 2016; uploaded to the private healthcare information network (PHIN). This included the specific procedures each consultant performed plus their outcomes, including variances, to enable patients to make an informed choice about their surgery.

Pain relief

- Dependent upon the surgery, the hospital used a number of different medicines for relieving pain post-operatively. We saw the pre-admission health questionnaire detailed adverse reactions to analgesia. In accordance with NICE guidelines, information about pain management was given to patients prior to surgery and following their operation. This enabled the patient to communicate effectively with staff and obtain the correct pain relieving medication following their surgery.
- In February 2016 the hospital carried out a pain management audit. This showed that patients were receiving pain relief according to their level of need. However, the audit also showed both inpatients and outpatients had not had the pain assessment tool explained to them. Staff we spoke with were not aware of an action plan around this.
- Staff used a pain-scoring tool to assess patients' pain levels; staff recorded the assessment on paper records. We observed staff reviewing pain in the recovery area post-surgery.
- We saw that in clinical governance meeting records that, to assist patients in describing their pain levels, pain assessment laminated tools of a facial descriptive nature were to be placed in patients' bedrooms. At the time of our inspection, this had not yet been commenced.
- All prescription charts we reviewed showed regular and as required pain relief prescribed. This meant there should be no delay in the administration of pain relief, as there was no delay in prescribing medication. Some surgical patients received intravenous patient controlled pain relief post-operatively.

- We spoke with six patients who told us that they received timely pain relief post-operatively. We observed the care of one patient who was given effective pain relief as soon as a spinal anaesthetic was wearing off. Patients we spoke with said staff checked that pain relief administered had been effective.
- If a patient's pain level deteriorated, there were systems in place to prescribe and dispense out of hours pain relief.

Nutrition and hydration

- Pre-admission information for patients gave them clear instructions on fasting times for food and drink prior to surgery. Current guidance recommends fasting from food for six hours and fluid for two hours. Patient letters we reviewed advised them to fast from fluids for six hours. This was not in accordance with best practice and enhanced recovery programmes.
- Records we reviewed showed staff checked patients had adhered to fasting times before surgery went ahead. We reviewed the hospital fasting audit June to September 2016; this showed that on a random sample of 10 patients a month the hospital met the two hours fasting time from fluids on 100% of occasions. However, case notes we reviewed during the inspection, showed that patients fasted for longer than the recommended guidance. Eight out of eight patients we reviewed fasted for longer than two hours for fluids; on average patients fasted for nine hours 52 minutes. Some staff told us that this was because several of the anaesthetists instructed that patients have their last clear fluids at 2.30 a.m. prior to admission.
- We observed patients were offered drinks and food. Staff, by using the malnutrition universal screening tool (MUST) documentation, identified patients at risk of malnutrition, weight loss or those requiring extra assistance at mealtimes. Patient notes, which we reviewed, showed appropriate levels of completion.
- Initial assessment of nutritional status was made at the pre-assessment appointment. This was repeated on admission, post-operatively and daily until discharge.
- If patients scored two on the MUST scoring tool, had a 10% weight loss in six months, or there were concerns that they were not eating well after five days, they were referred to the dietitian.

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- After surgery, there were accurate and complete records to show fluid intake and output was monitored. Where there were concerns, we observed protocols were in place, for example, if the patient had been vomiting.
- Staff we spoke with provided examples of arranging specialised diets. The hospital had access to suitable and nutritious hot food, out of hours, when a patient had been to theatre or was not able to go to theatre.
- We saw that the hospital had received an award in September 2016 from the local authority, ‘scores on the doors’, for good catering arrangements and standards of hygiene.
- Inpatient food provision scored 96% for patient satisfaction and was above the national average of 92% for patient satisfaction on the patient led assessment of the environment (PLACE).
- We observed that meal services were individual in choice and of a good standard; meals were served at appropriate times.
- Patients had access to fresh water where appropriate and all of the patients we spoke with commented positively about the food. The hospital provided three meals a day for in-patients plus snacks.
- For visitors and patients there was hot drinks provision in the reception area.
- The hospital participated in national and local audits. All clinical services were included in the corporate audit tracker. Audit was a standing agenda item on the heads of departments’ monthly meetings.
- We reviewed patient reported outcomes measures (PROMs) during the reporting period April 2015 to March 2016. Data for many indicators did not permit calculation the recognised indicators. However, data we reviewed showed the hospital performed better than the England average for primary knee, hip replacements and groin hernia surgery (NHS patients).
- The hospital measured their performance against a range of clinical indicators through the BMI performance dashboard for private patients and with standard performance for NHS patients.
- The endoscopy unit was not accredited with the Joint Advisory Group for gastrointestinal endoscopy group (JAG). Staff we spoke with were aware of the JAG programme and were aware of work being commenced to acquire accreditation. However, no action plans or deadlines for completion were available.

Competent staff

Patient outcomes

- In information provided by the hospital prior to the inspection, in the reporting period July 2015 to June 2016, the hospital reported nine cases of unplanned transfer of an inpatient to NHS care. Subsequently the provider revised the number to nine unplanned transfers of care. The assessed rate of unplanned transfers (for each 100 inpatient attendances) was similar to the group of independent acute hospitals, which submitted performance data to CQC.
- Patients transferred from the hospital to NHS care were discussed at the clinical governance meetings and all had been documented as appropriate transfers.
- For the reporting period July 2015 to June 2016, there were four cases of unplanned readmission within 28 days of discharge. This was similar to other independent acute hospitals, which submitted performance data to CQC (for each 100 inpatient attendances).
- In the same reporting period there were two cases of unplanned returns to the operating theatre.
- New staff had an induction relevant to their role. A new BMI induction programme had been implemented.
- Staff we spoke with said that agency and bank staff received an orientation and induction to the ward area. This included the use of resuscitation equipment and medicines management.
- Consultants worked within their scope of professional practice and only carried out the same procedures as in their substantive post. This was a criterion of the hospital’s practising privileges process and two consultants we spoke with confirmed this.
- There was an effective process in place for granting practicing privileges, which included an interview with the Executive Director. The term “practising privileges” refers to medical practitioners not directly employed by the hospital but who have permission to practise there. For consultants who were granted ‘practising privileges’ to work at the hospital, in line with legal requirements, the registered manager kept a record of their employing NHS trust together with the responsible officer’s (RO) name.
- In the reporting period July 2015 to June 2016, there were four consultants who had had their practising

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privileges removed and three had theirs suspended. This was mainly due to the consultants not providing the relevant paperwork to continue, or due to retirement.

- The Resident Medical Officers (RMO) were employed by an external agency which undertook a recruitment process before they commenced employment. This involved checking suitability to work at the hospital and checks on their qualification. The chair of the Medical Advisory Committee (MAC) mentored them.
- Hospital induction for RMOs included the BMI induction programme and a local RMO to RMO programme.
- We reviewed a competency assessment booklet for theatre escort duties. Competency assessment programmes were in line with BMI learning development programmes. We saw an example of a health care assistant (HCA) who had completed competencies for them to admit and take patients to theatre. Staff we spoke with said that one registered nurse countersigned the HCA actions, prior to theatre but sometimes if the ward was busy, this was not done until after the surgical procedure. The registered nurses did not have to complete competency programmes to allow them to be the 'third person' in the anaesthetic room.
- A registered nurse signed off competencies, such as health care assistant's administration of eye drops, which allowed health care assistants to administer eye drops without supervision.
- Staff we spoke with said they had been supported with national vocational qualifications and care certificate programmes.
- The inpatient ward manager had developed the senior staff nurse role. Two staff members we spoke with said this role helped with communication and had raised staff morale.
- The hospital had an internal appraisal target to achieve 100% for the period October 2015 to September 2016. Appraisal records we reviewed showed that in the same reporting period within the inpatient department and theatre department, 75% of staff had an up to date appraisal. Six staff we spoke with said they had received an appraisal in the last year and thought these were valuable. Three staff we spoke with about their appraisals gave us a varied perception as to their value.
- There was an online BMI appraisal programme and template for completion. We reviewed five appraisal documents for nurses and found them fully completed.
- The NHS employer or an independent organisation carried out medical staff appraisals. Information we saw showed 100% of consultants had received a practice appraisal, 100% had supplied evidence of their medical indemnity insurance, and 100% had evidence of a Disclosure and Barring Service (DBS) check in the last three years. The hospital policy was to repeat DBS checks for consultants every five years. There was a process in place to monitor this.
- There was a system to ensure qualified doctors' and nurses' registration status had been renewed on an annual basis. Data provided to us by the hospital showed a 100% completion rate of verification of registration for all staff groups working in inpatient departments and theatres. We checked five nurses' registration and found them to be in date.
- If a consultant's clinical practice raised concerns, there was a process in place to ensure appropriate communication was received and passed on to the NHS trust. We saw ongoing training plans which were reviewed in the clinical governance meetings. This included a NEWS process update, which had been part of the action plan following a root cause analysis where there had been concerns about identification of a deteriorating patient. However, only one member of staff had attended this session.
- There were systems in place to withdraw practising privileges in line with policy in circumstances where standards of practice or professional behaviours of consultants were in breach of contract. Fitness to practice issues for consultants were assessed and acted upon by the hospital director and the Medical Advisory Committee. Actions were documented and shared with regulatory bodies and other agencies if required. One of the operating department practitioners was undertaking specialist training to work closely with the surgeon to facilitate the procedure and process of surgery. They were undertaking classroom and on the job training before being deemed competent.
- The hospital was identified by a local university to be an appropriate learning environment for nursing students. At the time of our inspection, there were no students on placement; one was expected the following week. There were systems in place to mentor these students, however two staff we spoke with said this was difficult sometimes due to the registered staffs' availability at busy times. We saw that one registered nurse had recently attended mentoring training.

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- A local university had assessed the operating theatres to be suitable learning environments to place operating department assistants. Placements were to begin in the near future.
- Staff we spoke with were aware of the registered nurse revalidation requirements.
- We heard from staff working in the inpatient and outpatient areas that they did not always feel they received specialist training, education and portfolio development. Staff we spoke with expressed there was variance between departments who could be supported in further study. Staff felt this was part of the different cultures between areas. We discussed this with the senior management team who said that further training was available for all departments.
- There was an online and telephone BMI Manage service in place to support the full range of human resource (HR) enquiries including HR support for managers.

Multidisciplinary working

- A multi-disciplinary approach was evident in the pre-assessment pathway. This included information, which informed the discharge process. We saw that this included carer's arrangements and the liaison with external agencies if required.
- The majority of staff we spoke with told us that there were difficulties between staff working in the operating theatre and in patient ward areas. This was mostly around the escort issues of taking patients to theatre and having to be present in the anaesthetic room. Staff we spoke with in both departments said this had caused problems with effective communication and effective liaison between the departments.
- There were clear service level agreements between the hospital and the local NHS trusts as regards transfer of patients, equipment and other services such as blood transfusion.
- We saw from physiotherapy meeting minutes that, when the ward had been very busy, clinic staff were happy to help the ward assigned physiotherapists.
- When patients were discharged, a letter was sent to the patient's GP to inform them of the treatment and care provided. They also received letters informing them of the cosmetic surgery to be performed on their patient prior to the procedure being undertaken. However, two staff said that they did not always have pertinent information from the general practitioner (GP).

- Pathology services were provided for the inpatient unit from the local NHS hospital.

Seven-day services

- The hospital had two operating theatres open six days a week. Operating times were from 08.30 to 17.00 or 18.00 hours on weekdays and 08.30 to 18.00 on Saturdays. There were arrangements for theatres to be open at 07.30 hours for urgent cases.
- Consultants were responsible for the care of their patients from the pre-admission consultation until the conclusion of their episode of care. Consultants were required to be within thirty minutes travel to the hospital. There were clear policies that alternative consultant cover be available if the lead consultant was not going to be available. Out of hours, a senior nurse on-call team was available.
- There was a Resident Medical Officer (RMO) in the hospital 24 hours a day with immediate telephone access to on call consultants.
- To support clinical decision-making, access to diagnostic and radiology services was available 24 hours, seven days a week. There was emergency cover on a Sunday.
- There was an on call rota for key staff groups, including theatre staff, anaesthetists and senior managers.
- Medication was prescribed and dispensed to patients prior to their discharge. There were processes in place to obtain medication out of hours. The RMO was available to check and dispense medication on an out of hour's basis, if required. A pharmacist was on site four days a week, pharmacy technician cover was available 5 days a week and service level agreements were in place with community pharmacies to dispense private prescriptions out of hours.
- Maintenance cover was available over twenty-four hours.

Access to information

- Staff recorded information about patients in paper format and on a computer based patient administration system. For NHS commissioned patients there were processes in place for staff to access NHS patient information.
- Staff we spoke with said that sometimes notes were not received in a timely way for pre-operative assessment. For example, we were told by one registered nurse that she was unable to check that the anti-coagulation

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treatment of a patient had been stopped ten days prior to surgery (as required by their pathway) because their records had not been available to view until two days prior to the pre-assessment clinic.

- Two staff we spoke with said that consultants did not always share the patient's previous medical history and therefore the nursing staff were reliant on the patient's own information, which may not have been accurate. For example, a patient was asked if they had a history of falls. The patient had multiple sclerosis and was vulnerable to falls. Medical records were stored for a period in the hospital records department in case a patient was re-admitted.
- There had been significant problems within the administration team in the previous year prior to inspection, this included staffing. This had resulted in a backlog of work such as filing. We saw that administrative staff had worked weekends to address the backlog. The senior management team said that the entire backlog was now cleared.
- Staff we spoke with said that there had been problems about some consultants taking patients notes home. However, this had been resolved and there was a process to trace records.
- There was a process for staff to have access to General Practitioner (GP) referral letters when patients attended pre-admissions clinic or on admission. We were told that there had had been occasions when this had not been possible, but this was not documented in any incidents.
- Handover reports were comprehensive and contained relevant information in a new format devised by the ward manager.
- Discharge summaries were prepared for the GP. Records we reviewed showed these contained relevant information including analgesia medication on discharge.
- If discharged patients had any concerns post-operatively, they could call the ward contact number supplied to them following discharge. However, we observed that there had been confusion in the case management of a patient who had developed a post-operative infection. The patient had accessed their general practitioner (GP) in the first instance. We were unclear if the patient had been provided with written information on discharge.

- Relevant information for patients on that ward area was displayed on the walls of corridors such as fire arrangements and hand washing advice.
- Staff showed us where the BMI policies and procedures were stored on the intranet. We also saw up to date hard copies of these stored in nursing office areas in the ward and theatre areas.
- All substantive staff had a live e-mail hospital address and told us that they received regular BMI information.
- The resident medical officer (RMO) had access to hospital protocols and guidelines such as medication and anti-coagulation pathways.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Consent was included in the hospital's mandatory training programme. Overall 94.8% of staff had completed consent training. The hospital was unable to break the training data into individual services.
- The hospital policy for the use of the Mental Capacity Act and Deprivation of Liberty Safeguards was incorporated into the hospital's safeguarding adults' policy.
- We reviewed clinical records and observed that patients consented to surgery in line with trust policy and department of health guidance.
- We saw that there was a new corporate consent policy, which had been discussed by the clinical governance committee and had been distributed to staff.
- Staff were aware of the hospital policy on consent and knew where to find it on the hospital intranet. We saw that there was an updated policy, which staff were informed that they should read and record that they had done so. Consent was sought from patients prior to the delivery of treatment. We looked at nine consent forms during our inspection; consent was appropriately obtained in all of the forms we reviewed. We observed that consent was included in mandatory training with 94.8% of all clinical staff trained.
- In theatres, we observed staff checking consent forms were signed before proceeding with surgery. We were told that consent forms were audited as part of regular record keeping audits.
- Nursing and medical staff obtained consent through both verbal and non-verbal routes. The staff we spoke with were aware of how to gain both written and verbal consent from patients and their representatives.

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- Where patients lacked capacity to make their own decisions, staff told us they sought consent from an appropriate person (advocate, carer or relative), that could legally make those decisions on behalf of the patient. They knew how to seek advice if they were not clear on an individual case.
- Staff we spoke with were knowledgeable about the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS) although they had not had recent experience of these being used.
- The policies for the resuscitation of patients and 'Do Not Attempt Cardiopulmonary Resuscitation' (DNACPR) decisions were available. No DNACPR forms were in place at the time of our inspection.
- Those patients who attended for cosmetic surgery had a clear pathway. This included counselling and identified psychologically vulnerable patients. It ensured that they were referred for appropriate care if required and a cooling off period prior to surgery in order to allow the patient to change their mind.
- The consultant gained permission from the patient and liaised with the patient's general practitioner about any concerns.
- The hospital did not audit compliance with the Royal College of Surgeons recommendation of a two-week cooling off period prior to cosmetic surgery being performed; but from the records we reviewed, all patients had received longer than the two-week period.

and well-being was 80%, being below the 83% England average. The hospital scored above the national average for dementia care with 81% against the national average score of 80%.

- The NHS Friends and Family test (FFT) is a satisfaction survey that measures satisfaction with the healthcare the patient has received. It was noted that the response rates were mainly lower (between 16% and 31%) than the England average of 40% from July 2015 to June 2016. 100% of patients reported that they would recommend the hospital to family and friends.
- The BMI group carried out their own patient satisfaction monitoring. During the period July to June 2016, 99% of patients surveyed would recommend the hospital to friends and family.
- Patients on the wards we visited appeared comfortable. All of the ten patients we spoke with were satisfied with the standard of care they received.
- We observed all staff knocking on doors and waiting for a response before entering and referring to patients by their name of choice, which staff clarified during the admission process.
- We observed that patients were covered for their dignity while in the anaesthetic room, operating theatre, recovery areas and during transfer between the ward and theatre areas.
- We observed staff, whilst delivering care, closing curtains/doors.

Are surgery services caring?

Good 

We rated caring as Good.

Compassionate care

- We spoke with ten patients and six relatives. During the inspection, we observed positive and friendly interactions between patients and staff. The majority of patients we spoke with were happy with the care they received and had felt safe and valued.
- During the inspection, we received seven comments cards specific to the ward environment, and all were positive about the inpatient care they received.
- Patient-led assessments of the care environment (PLACE) scoring for the hospital showed privacy, dignity,

Understanding and involvement of patients and those close to them

- All the ten patients we spoke with said that they had been fully involved in their care decisions at all stages of their care pathway. This included discussion of the risk and benefits of treatment.
- Patients we spoke with said they had been made aware that they would have a named nurse on admission. Patients also said they understood who to approach if they had issues regarding their care, and they felt able to ask questions.
- Patients we spoke with were aware of their discharge arrangements and actions required prior to discharge. They had appreciated that discharge arrangements had been considered at the pre-admission contact, especially about who would care for them at home and advice about when they could drive again post-operatively.

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- We saw that that the ward manager was visible on the inpatient wards and that patients and relatives were able to speak with them.

Emotional support

- We observed staff giving re-assurance to patients. For example, on the journey from the ward to the operating theatre, we witnessed the nurse providing emotional support to the patient.
- For patients who were anxious we saw staff providing re-assurance. This included a newly admitted patient who had never been in hospital before.
- All of the ten patients we spoke with told us the staff were calm, re-assuring and supportive and this helped them to relax prior to undergoing surgery.
- Staff we spoke with said that medications to help patients with anxiety were prescribed before surgery if necessary.

Are surgery services responsive?

Good 

We rated responsive as good.

Service planning and delivery to meet the needs of local people

- The hospital engaged with the local NHS Clinical Commissioning group to plan and deliver contracted services based on local commissioning requirements.
- The hospital stopped providing surgical services for children and young people under the age of 16 on 31 August 2016.
- The hospital provided elective surgery and supporting services six days a week. The booking system was responsive to patients' needs as, where possible, patients could select times and dates to suit their family and work commitments.
- The hospital had seen a rise in elective activity in the reporting period July 2015 to June 2016. Orthopaedic surgery accounted for the largest number of surgical procedures performed in the same reporting period.
- The operating theatre lists for elective surgery were planned with the operating theatre manager to ensure patients' safety and needs were met in conjunction with the available utilisation of operating theatres. Staff we

spoke with said that patients were identified for treatment at the hospital by the consultants who assessed their well-being for elective surgery in accordance with best practice guidance.

- Surgeons were provided with allocated theatre times in order for pre-planning of patients and theatre activity.
- When extra capacity for day case surgery was required, the sitting room area was utilised to have ophthalmic day cases. Staff we spoke with were aware that this area might be utilised for ambulatory care full-time in the near future. This area was carpeted but did have handwashing facilities.
- The admission process and care provided was the same for self-funded patients and NHS patients. Staff consistently informed us that the funding source made no difference to how a patient was treated.
- The hospital was part of the BMI group and therefore was aligned to the company's overall planning and future direction.
- We were informed that staff provided patients with advice and guidance post discharge following surgery. Following the inspection the provider confirmed that all patients received a business card with the contact details of the inpatient ward prior to discharge.

Access and flow

- There were 2,858 episodes of inpatient activity from July 2015 to June 2016. There were a total of 1,045 overnight inpatients and 1,045-day case inpatients during this time. Of these admissions, 33% were NHS funded and 67% were other funded. Orthopaedic and ophthalmology procedures accounted for the largest number of surgical procedures performed in the same reporting period.
- NHS England published operational standards for the expected level of referral to treatment targets (RTT) for patients and incomplete pathways were set at 92%. The hospital had a NHS contract, which reflected national waiting list expectations of 18 weeks. Staff monitored the contract through weekly reviews and breaches were reported to the clinical commissioning group (CCG).
- In the reporting period July 2015 to June 2016 the hospital achieved the overall referral to treatment indicators of 92% of incomplete admitted patients beginning treatment within 18 weeks of referral.

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- Elective theatre lists were available six days a week and emergency theatre lists were available seven days a week including overnight. We saw on call rotas for anaesthetists and key theatre staff.
 - Hospital data showed that in the reporting period July 2015 to June 2016 two patients had had their procedures cancelled due to non-clinical reasons. These patients were offered another appointment within 28 days.
 - For unplanned returns to theatre in an emergency, the hospital operated a 24 hour on call service with a 30-minute response time.
 - Administration staff arranged theatre scheduling with discussion with medical and nursing staff. The majority of the consultants had scheduled theatre dates throughout the year and directly listed private patients after seeing them in clinic. Urgent cases were added after consultation with the theatre department to ensure staffing was in place. We were told that the theatre manager would have no hesitation in cancelling lists if they felt that the staffing situation was unsafe.
 - Staff we spoke with said that in the majority of cases, private patients for cosmetic surgery had their procedure within four weeks of the decision to operate, allowing for any cooling-off period and after pre-operative assessments.
 - We saw that discharge arrangements were made at an early stage of the patient's treatment pathway including care needs.
 - The senior management team had introduced communication meetings each morning (Monday to Friday) to address any immediate concerns for the coming day including staffing and patient flow. Staff we spoke with said that meetings were aligned to the key lines of enquiry and were addressed in the framework of the 3Cs: cause, concern and counter-measure. We attended one of the communication meetings and saw that the majority of staff required attended it; it was professionally led and held clear and concise discussions.
- Disabled toilets were available. The admitting nurse reviewed the patient's needs on admission, or during pre-assessment, which included the identification of those patients with hearing difficulties.
- A range of leaflets were available for patients. This included a new leaflet, which was developed to offer pre and post-operative advice. Translation services were available for people whose first language was not English. Staff we spoke with said that this service rarely had to be used, but were aware that there was a BMI interpreting policy and showed us where this was on the intranet. Staff were clear that family members should not be used for interpretation.
 - Patients with particular needs, for example, learning disabilities, mental health and those living with dementia, were identified at the pre-assessment stage. Staff we spoke with said that the consultant who managed the individual case did not generally accept those patients who had a high level of complex needs and referred them to the care of the local NHS trust.
 - The patient led assessment tool identified that the hospital was the same as (81%) the national average of (80%) for dementia care. We did not see specific pathways for dementia care.
 - We observed that patients had drinks and call buzzers located within easy reach. Patients we spoke with said that staff did not take long to answer call bells. During the inspection, we observed that staff answered call bells in a timely manner.
 - In pre-operative assessment clinics, nursing staff completed assessments of patients' personal and social circumstances prior to surgery to anticipate their requirements after discharge. Staff we spoke with said that they checked to ensure that initial arrangements were still appropriate at the time of discharge. Staff provided us with an example where there had been social care involvement when the patients care needs were assessed to be at a higher level than previously anticipated.
 - Theatre staff identified patients, such as diabetic patients, and usually scheduled these for surgery at the beginning of the theatre lists in case they developed complications during their procedure.

Meeting people's individual needs

- There were no mixed sex accommodation breaches.
- The inpatient bedrooms were accessible for people with limited mobility and people who used a wheelchair.

Learning from complaints and concerns

- The hospital had a process that addressed both formal and informal complaints that were raised. This included a three-stage escalation process. After a stage one

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response from the hospital, the complainant was signposted to stage two, if not satisfied with the response. This involved a member of BMI Healthcare regional team having oversight of the complaint. If the complaint remained unresolved, then there were processes to escalate the matter further. These were to refer to the Independent Sector Complaints Adjudication Service (ISCAS) for privately funded patients or the Parliamentary and Health Service Ombudsman.

- From July 2015 to June 2016 there were 19 complaints received within the hospital. The top three complaint themes were associated with errors in invoices sent to patients. No complaints were referred to the Ombudsman of the Independent Healthcare Sector Complaints Adjudication Service in the same reporting period. The assessed rate of complaints (per 100 inpatient and day case attendances) was similar to the average of other independent acute hospitals.
- There was an expectation complaints would be resolved within 20 days; if this was not possible a letter was sent to the complainant. An acknowledgment letter was sent within two working days of a complaint being received. The hospital had a target of 100% to achieve this deadline; within the hospital, one case had been outside of this timescale.
- All complaints were logged onto the hospital electronic database to allow for oversight by the clinical governance team. We reviewed the last three months of clinical governance meetings and saw that complaints and actions arising from these were a standing agenda item.
- There were policies and procedures in place relating to complaint handling. The executive director took overall responsibility for the management of complaints and supported the heads of department in the investigation and reporting of responses. Where more than one head of department was involved, the clinical governance team considered this.
- Staff could describe their roles in relation to complaints management and the need to accurately document, provide evidence, take action, investigate or meet with patients or relatives as required. Senior staff we spoke to were aware of the number of complaints and the themes received for their area.
- Staff talked to us about changes in practice that had occurred post a complaint. For example, bedrooms were locked in between cleaning from the previous

patient to a new admission due to a complaint about concerns that a room had not been cleaned in between patients. This prevented anyone entering the bedroom before a new admission.

- Complaints were a standing agenda item on the monthly quality and clinical governance meetings and cascaded through a number of forums including the heads of department meetings and ward meetings.
- Patients we spoke with said that they had no reason to complain, but would feel they could do so if needed. We saw that in patient bedrooms there were accessible leaflets ('please tell us') about making a complaint. Patient satisfaction surveys were given on patient discharge. We saw that there was a section, which encouraged the patient to contact the hospital if there were any low level comments.
- Complaints were included in the medical advisory committee (MAC) clinical governance report. These ensured consultants were aware of general issues and could use this evidence for learning.
- Response letters to complaints included an apology when things had not gone as planned. This is what we would expect to see and is in accordance with the expectations of the service under duty of candour requirements.

Are surgery services well-led?

Inadequate 

We rated well-led as inadequate.

Leadership / culture of service related to this core service

- Staff, with the exception of medical staff, consistently voiced concerns about difficult working relationships with the senior management team, between theatres and the inpatient ward, within the administration and physiotherapy team and within the operational teams. We were told that the hospital had investigated some of these issues and had taken action following work with the Advisory, Conciliation and Arbitration Service (ACAS) to address some of the concerns within the administration and physiotherapy department. Since the inspection we have been informed that in some areas, particularly the inpatient ward and the operating

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theatre, individual meetings between the Director of Clinical Services and the ward and Theatre Managers and joint meetings to discuss different ways of working, had taken place.

- We saw no cohesive leadership between the senior management team. From our discussions with nursing staff, they said that senior leadership were verbally supportive, but that the support did not always translate into actions such as providing assistance when the ward was particularly busy. However, when we spoke with the senior management they said that both the Executive Director and Director of Clinical Services had worked clinical shifts covering night shifts and late shifts when the wards had been busy or had staffing challenges because of staff sickness/vacancies. We saw evidence on the duty rota to corroborate this. Staff also spoke about degrees of variance in their confidence in senior leadership and the responses they had received when raising concerns.
- Staff responses to perceptions about leadership visibility and involvement with day-to-day activity of the hospital were inconsistent. The majority felt supported by their immediate manager, but were less confident about support from higher management.
- Some staff told us that they felt demoralised by BMI changes to their employment terms and conditions. They told us they were upset that there had been no consultation about the process. However, we saw evidence from the hospital that consultation had taken place.
- Staff we spoke with said that they did not always raise concerns, as they did not feel they would be listened to and they were worried about recriminations. Management had recognised there were issues and had involved external agencies to support relationship challenges within hospital teams.
- BMI Healthcare Limited had a corporate workforce and race equality standards report. The report was for the organisation which was in the process of working with a number of independent healthcare providers and the NHS WRES Team to look at appropriate implementation of the requirements across the independent sector as a whole.
- At a hospital level there was no clear ownership of the workforce and race equality standards (WRES). Senior management told us that they had not carried out audits, assessments or consultation with staff working within the hospital therefore the data on the WRES indicator could not be collected at the time of our inspection. We spoke with one BME member of staff who did not report any discriminatory experiences within the hospital.
- In February 2016, the hospital had undertaken a staff survey. Staff told us this had identified low morale, and concerns about changes to pay, conditions and additional benefits. The hospital management team informed us that they had responded to these issues and had started monthly staff forums, which had been well attended. At the time of our inspection, there was no localised action plan shared with us and we were unclear as to the outcome of the forums.
- Staff working in the inpatient area had not received their allocated breaks on thirty-eight occasions in the three months prior to inspection despite this being a recommendation in a root cause analysis report.
- Staff spoke about their colleagues in a respectful manner.
- The senior management team had an effective process for challenging issues of performance within the consultant body and sharing any concerns with the consultants' substantive employer. Effective checks were made to ensure disclosure and barring checks were undertaken pre-employment and maintained during employment.
- Medical staff we spoke with were very complimentary about the culture of the hospital. They said it was warm and welcoming; the senior management had an open door policy and it was a friendly environment.
- There was a daily communication meeting each morning to highlight any immediate concerns in any department including staffing and incidents. Staff told us that this was a positive development.
- Staff sickness in the operating theatre was better than expected when compared to the data held for other independent hospitals. This included registered nurses, operating department assistants (ODA's) and Health Care Assistants (HCA's) and ranged from 0-5% for all staff groups.
- Staff sickness in the inpatient area was generally better than expected when compared to the data held for other independent hospitals. This ranged from 0% to two months when this had risen to 10% for registered nurses. For health care assistants (HCAs) the sickness range was 0-5%.
- All staff we spoke with were clear about the duty of candour requirements and some had received training.

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We were told that it was implicit on induction and mandatory training. We saw evidence in patient letters following complaints. However, there was no evidence of this requirement addressed in one of two root cause analysis investigations we reviewed. There had been no whistleblowing concerns reported in the previous 12 months; however, during the inspection we received two cases of whistleblowing.

- There was a five-year plan to refurbish bedrooms. This included decoration and replacing carpets with hard flooring and sinks that complied with infection control and prevention standards. However, we saw that the plan would take until 2020 to complete and there were no corporate funds identified to complete refurbishment.

Vision and strategy for this this core service

- BMI hospitals had a corporate operational plan outlining the key strategic objectives. From this the hospital had an operational plan outlining how they would deliver the strategic objectives.
- The senior management team and heads of department were aware of the strategy and business unit plan. However, operational staff could not always tell us of the vision of the hospital services.

Governance, risk management and quality measurement

- The hospital had a formal governance structure. We reviewed three sets of governance meetings, medical advisory committee (MAC) management meetings and senior management meeting minutes. It was clear from these that there was a standing agenda and information had been shared, but from the records we reviewed it was unclear about the discussions held and actions identified. The ward and the theatre team meetings were clear with actions recorded.
- The hospital held regular medical advisory committee (MAC) meetings. The chair of the group said that they met the corporate medical director and other MAC chairs to discuss issues on an annual basis. Representatives from all specialities were able to attend the MAC meeting.
- Prior to the inspection, the hospital submitted information about the service. Subsequently we received revised data including clinical incidents, and unplanned transfers. When we discussed this with the senior management team, they said that the original

data had been completed by the head office of BMI and the registered manager had identified the inaccuracies. The differences raised concerns about the accuracy of data held by head office and could potentially lead to inaccuracies when comparing and benchmarking other BMI hospitals.

- There were governance processes in place to assess and minimise risk however, from root cause analysis investigations and incidents we reviewed lessons learned and recommendations for action were not always completed in a timely manner. For example addressing the staffing concerns on the ward in relation to theatre escort duties.
- A corporate risk register had been modified to provide a hospital specific register. The senior management team told us that no items had been escalated to regional or national level for the hospital register for the previous year.
- Data from risks we reviewed showed one as high risk, six as medium risk, eleven as low risk and nineteen as very low risk. None of the risks had dates for review or had an indication when the item was placed on the risk register.
- The senior management team spoke with us about their main risks for the hospital as being threats to business, staffing, patient safety and the infrastructure; not all of these were issues identified on the current risk register.
- The hospital used a paper system to report incidents; the manager then uploaded the information into a computer system. The senior management team said that they were currently in the process of moving across on to a different computer system for reporting incidents. The need for this had been identified to improve the efficiency of the process. The hospital was aware about the issues of the computer system used to record incidents and complaints; however, this was not identified as a risk on the corporate risk register.
- There was an effective process for issuing practising privileges; the MAC chair was able to provide an example of a refusal from the hospital to issue. Seven consultants had their practicing privileges removed from July to June 2016. This was due to the required paperwork not being submitted and retirement.
- The positive assurance the senior management team derived from clinical audits we reviewed did not corroborate with what we found at inspection. For

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example, the effectiveness of the WHO safer surgery checklist and patient pre-operative fasting audits indicated 100% compliance but we did not find this on inspection.

Public and staff engagement






- The senior management team spoke with us about staff engagement. This was encouraged and relationships and co-operation encouraged in order for staff feel valued and respected. However, operational staff we spoke with consistently said that they did not feel their concerns about staffing were listened to; they did not see any sustained action.
- Patient survey rates were low although responses were positive about the care received.
- The hospital customer satisfaction survey given to patients on discharge showed a completion rate between 16% and 27% in the period from July 2015 to June 2016. The rating given by patients regarding quality of care was between 97% and 100%. This was benchmarked monthly to other BMI sites and varied between being seventh and fiftieth with the highest score being one.
- The hospital satisfaction rates were published on the public hospital website.
- Department managers said that they felt that staff members could discuss issues with them and that they all had an open door policy.
- The senior management team had initiated a monthly staff forum over the last year led by the executive director. The aim of this was to encourage communication and teamwork.
- There was a staff award process, which identified staff that had made a significant contribution to the hospital; 'above and beyond' awards were displayed in the dining room.

- There was no evidence of staff engagement as regards the workforce race and equality standards.
- We saw that there were regular ward meetings, which were recorded. We reviewed the last three sets of minutes, which showed that relevant issues from the ward were discussed and followed up.

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

- At the ward and department level there had been some changes, which we were told, had resulted in improved practice. These included a new handover tool, which included all aspects of patients' care needs.
- There had been the introduction of communication meetings each morning to address any immediate concerns for the coming day including staffing and patient flow. Staff we spoke with said that concerns were aligned to the key lines of enquiry and were addressed in the framework of the 3Cs: cause, concern and counter-measure.
- There had been the change in roles of three staff nurses who had been identified as senior staff nurses. We were told that this had improved communication and improved the morale of those professionals.
- A member of the theatre staff was receiving further training to be a Surgical Care Practitioner.
- The day area was planned to be an extra area for ambulatory care short stay patients, which would increase patient flow.
- Some staff told us that they had good ideas but it was difficult to implement changes to practice because of time, staffing and financial constraints.

Outpatients and diagnostic imaging

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

Are outpatients and diagnostic imaging services safe?

Requires improvement 

BMI the Duchy Hospital provided outpatient consultations and a range of diagnostic imaging services. The outpatient clinics covered approximately 16 different specialities, including orthopaedics, cardiology, dermatology, ophthalmology, urology and cardiology. The hospital only provided services for patients over the age of 16. The hospital discontinued all services for children under the age of 16 on the 31 August 2016.

The outpatient department had 10 consulting rooms, a minor procedures room and a phlebotomy room. The hospital provided outpatient physiotherapy services and had three treatment rooms and a gymnasium.

Diagnostic imaging provided a range of services including X-ray, fluoroscopy, ultrasound and mammography. A mobile MRI scanner visited the hospital weekly on a Saturday and alternate Mondays. This was not inspected as part of our inspection. The service did not have an on-site pathology service; a local NHS provider provided this.

From July 2015 to June 2016, the hospital saw 19,034 outpatients in clinics. The hospital treated self-funded, insured patients and NHS patients through choose and book. Out of the 19,034 attendees, 27% were NHS patients and 73% were other funded appointments.

During our inspection, we observed the outpatient, physiotherapy and diagnostic imaging departments and spoke with 23 members of staff, including managers, nurses, medical staff, healthcare assistants, radiographers,

physiotherapists, administrators and receptionists. We also spoke with six patients. We looked at 12 sets of records and four request cards in diagnostic imaging. Before the inspection, we reviewed performance information from and about, the hospital.

We rated safe as requires improvement.

Incidents

- From July 2015 to June 2016 there were no never events reported in the service. Never events are serious patient safety that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious harm or death but neither need have happened for an incident to be a never event.
- In the same reporting period the hospital reported no serious incidents. Serious incidents are incidents that require reporting and further investigation.
- In the same reporting period there were 11 clinical incidents reported within outpatients and diagnostic imaging services. This was similar to the rate of other independent acute hospitals.
- In the same reporting period there were eight non-clinical incidents reported within outpatients and diagnostic imaging services. This was similar to the rate of other independent acute hospitals.
- We reviewed incident data provided by the hospital. From July 2015 to June 2016, 157 incidents were reported. Of these, five related to the outpatient department and they were all classified as no harm. No incidents were reported in diagnostic imaging.
- From July 2016 to the time of our inspection, the hospital had not reported any incidents to the CQC in

Outpatients and diagnostic imaging

accordance with the Ionising Radiation (Medical Exposure) Regulations 2000 (IR(M)ER). Staff in the diagnostic imaging department understood their responsibilities for reporting IR(M)ER incidents.

- The hospital had a policy for the reporting of incidents, near misses and adverse events. Staff reported incidents using a paper incident reporting form; this was then reviewed by the hospital's management team and inputted onto the hospital's electronic reporting system.
- Staff were able to describe the process of incident reporting. Staff in both outpatients and diagnostic imaging said the number of incidents in the department had been very low. When an incident was reported staff said they did not always receive individual feedback.
- We found some inconsistency in the reporting of incidents that resulted in no harm or near misses. We heard examples of incidents within the radiology department that staff would not report. For example, staff said if the wrong side had been requested on an imaging request form they would not report this despite it being a near miss for the patient. Staff also described an incident when a scan had to be repeated due to a power failure in the department. This incident was shared with the hospital's medical physics team but not reported internally as an incident.
- The outpatient department had changed the system for checking prescription pads in and out following an incident in April where seven prescriptions went missing. The outpatient manager said this was shared with staff through individual discussion. Staff we spoke with were aware of the new process for checking prescription pads.
- Any lessons learned from incidents were shared with staff at the daily communication cell with representatives from each hospital department and at department meetings.
- The hospital had a corporate BMI healthcare policy, BMI Being Open and duty of candour policy. The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support to that person.
- Staff were broadly aware of the duty of candour principles and spoke about being open and honest with patients and their relatives. All staff we spoke with said they would be happy to speak to patients and their families if an incident had occurred.

Cleanliness, infection control and hygiene

- From July 2015 to June 2016, there were no incidents of Methicillin-Resistant Staphylococcus Aureus (MRSA), no incidents of Clostridium Difficile (C. difficile) and no incidents of Methicillin Sensitive Staphylococcus Aureus (MSSA) within the hospital.
- From July 2015 to June 2016, there were no incidents of E-Coli.
- The departments we visited were visibly clean and we saw evidence of green cleaning assurance stickers to indicate when a piece of equipment had been cleaned. We reviewed seven pieces of equipment and saw evidence of green cleaning assurance stickers.
- Antibacterial gel dispensers were available in the main outpatient department and in clinical areas. There was signage encouraging visitors and staff to use the antibacterial gel.
- Staff complied with 'arms bare below the elbows' policy, correct handwashing technique and use of hand gels. The hospital completed monthly hand hygiene audits. Results from June 2016 showed all staff complied with arms bare below the elbow and all were compliant with hand hygiene.
- We saw personal protective equipment (PPE) was readily available in clinical areas such as gloves and aprons. In the diagnostic imaging department, PPE equipment (including lead aprons) were clean and in good condition.
- Across all departments we visited appropriate containers for disposal of clinical waste and sharps were available and in use.
- We found some clinical areas within outpatients and diagnostic imaging had carpets. Staff said that in the event of a spillage an internal cleaning team would clean the carpets.
- Carpets in clinical areas was recognised as a problem on the hospital risk register. Replacement flooring was included in a five-year refurbishment plan. However, at the time of the inspection the management team could not inform us of any immediate action and told us that there was no formal funding for this. The refurbishment action plan indicated that refurbishment would not be complete until 2020 and again, from the minutes of the staff meeting in June 2016, indicated that the refurbishment plan was on-hold. However, since the inspection the provider has informed us that refurbishment work was now underway in the service.

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- Scopes that were used in the minor procedure room were decontaminated in theatre and transferred up from theatre in containers. Staff said they used disinfectant wipes to clean the scopes after use and before they were transferred back down to theatre.
- We reviewed the environment used for decontamination of endoscope equipment including cystoscopes. The environment did not meet best practice guidance for decontamination of endoscopes. There was not a designated separate dirty and clean space to decontaminate endoscopes and there was no clean to dirty flow in the room. Clean scopes were not stored in a clean area. Clean scopes and dirty equipment returning to the decontamination area had the potential to crossover. This does not meet best practice guidance (management and decontamination of flexible endoscopes (HTM 01-06)). There were plans to move this offsite to improve compliance.
- We checked seven pieces of equipment in the outpatient department including; observation machines, urodynamic testing machines and ultrasound machines. All equipment had visible evidence of electrical testing indicating safety checks and when it was next due for servicing.
- Equipment in both the radiology and outpatient department was subject to a preventative maintenance programme of regular servicing.
- The outpatient department had a minor procedure room. From the 30 August 2016 to the 04 October 2016 the room had been used for a variety of procedures including; wound checks, excision of cysts and lesions including basal cell carcinomas (a type of skin cancer), removal of sutures, endoscopic biopsies and cystoscopies. The room did not have specialist ventilation. Guidance from the Department of Health, The Health Technical Memorandum (HTM) 03-01: Specialised ventilation for healthcare premises states, endoscopy, day-case and minimum invasive suites, such as the minor procedure room, require a degree of specialist ventilation.

Environment and equipment

- The outpatient department was located on the first floor and had ten consulting rooms, a phlebotomy room and a minor procedure room. The physiotherapy department was located on the second floor and had three treatment rooms and a gym with a range of rehabilitation equipment. Both departments were accessible using a lift.
- The radiology department was located on the ground floor and consisted of an x-ray room and a dedicated room for mammography and ultrasound examinations. The service also had a mobile x-ray unit and a mobile image intensifier that was used in theatre. A mobile MRI service was provided by an external company and visited the hospital on a Saturday.
- Resuscitation equipment was available in the outpatient and physiotherapy departments. We checked the adult resuscitation trolleys in both areas and found daily and weekly checks had been completed in line with best practice. All the trolleys were sealed with tamper-proof tags.
- There was no resuscitation equipment in the radiology department; staff said in an emergency they would use the resuscitation trolley from the ward, which was a short distance from the department. The resuscitation co-ordinator from the local NHS trust attended the hospital and ran cardiac arrest clinical scenarios with staff to ensure emergency equipment could be obtained in a timely manner.
- Whilst this guidance applied to new installations and major refurbishments, the hospital had not identified this as a risk or considered how they would apply these best practice guidelines or the Health and Social Care Act 2008 Code of Practice (DH, 2015) in order to comply with the regulations. Despite having a refurbishment plan for the service the risks to IPC in the minor procedure room had not been assessed and had not been considered at the planning stage for refurbishment work to ensure adequate ventilation of this room was provided. There was no action plan in place to mitigate any infection risk to patients. We raised our concerns with the hospital manager.
- Following the inspection, a risk assessment was completed by the hospital's infection prevention lead. The risk assessment identified a number of actions to mitigate the risk including daily cleaning of the room in accordance with theatre standards. The management team also sought assurance from an external microbiologist regarding the use of the room. The evidence provided did not reference compliance with HTM03-01 for all procedures that are classed as 'invasive'. An invasive procedure is a diagnostic or therapeutic technique that requires entry of a body cavity, breaking of the skin, or interruption of normal body functions.

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- On our unannounced inspection, we saw cystoscopies were still being undertaken in the minor procedure room. However, following the inspection, the management team informed us that they no longer perform cystoscopies in the clinical procedure room.
 - The handwashing sink in the minor procedure room was non-complaint due to having an overflow. The hospital had identified this and was in the process of purchasing a replacement sink. In the interim staff were using the scrub sink located in the minor procedure room.
 - Patient led assessments of the care environment (PLACE) assessed how the environment supported patients' privacy and dignity, and food, cleanliness and general building maintenance. From February to June 2016 the hospital scored the same or higher than the England average for dementia and ward food and lower than the England average for cleanliness, condition, appearance and maintenance, disability, food, organisational food and privacy, dignity and well-being. The PLACE audits were for the whole hospital and were not specific to outpatient and diagnostic imaging services.
 - In the radiology department PPE equipment including lead coats were checked and found to be in good condition. Staff wore personal radiation dosimeters (a device that measures exposure to ionizing radiation). These were monitored in accordance with legislation.
 - Appropriate environmental measures and signage was in place to identify areas where radiological exposure was taking place in line with IR(M)ER regulations. This ensured staff and visitors did not accidentally enter a controlled zone.
 - The table in the main x-ray room was not adjustable. Therefore, some patients may not be able to get onto the table for their x-ray. Staff said if a patient was unable to get onto the table they had to use a step. The department had completed a risk assessment for this.
 - Staff had raised concerns about the lamp used in the minor procedure room, which was used during some dermatology procedures. Staff said the lamp was difficult to move and became very hot. We reviewed the lamp and found the safety checks were overdue and should have been completed in April 2016. We informed the outpatient manager who arranged to have the lamp reviewed.
 - We reviewed the fridges used to store specimens. We saw evidence of daily temperatures being recorded.
 - Staff said they had sufficient equipment to meet the needs of patients, however a number of staff felt a lot of the equipment was old and due for replacement. The hospital had a process in place for the replacement of equipment however, staff said it was difficult to get new pieces of equipment and that funding was not readily available.
- ## Medicines
- We checked the storage of medications in the departments we visited. We found medications were stored securely in appropriately locked rooms and fridges. No controlled drugs were stored in the department.
 - Medications that required refrigeration were stored appropriately in fridges. The drugs fridges were locked and there was a method in place to record daily fridge temperatures. We saw minimum and maximum fridge temperatures were recorded daily and were within the correct range.
 - We checked six sets of records of patients who had undergone a flexible cystoscopy. Patients received a sterile gel containing local anaesthetic. In three sets of records the dose, date and time, who it was administered by and the prescribers signature was not completed.
 - Consultants attending the outpatient department had access to prescription pads upon request. These were stored securely in a locked cupboard and the department had introduced a system on signing the prescription pads in and out.
 - Contrast media was safely stored in the diagnostic imaging department. Contrast media is a substance introduced into a part of the body in order to improve the visibility of internal structures during radiography.
- ## Records
- We reviewed 12 sets of medical records across the outpatient and physiotherapy department. All were legible and contained information such as patient history and allergies.
 - Paper records were used in the outpatient department and physiotherapy department. The radiology department used a mixture of electronic and paper records.
 - The hospital had a medical records department that was responsible for filing, storing and maintaining patient records. We visited the medical records

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department, and found the room that stored patient records was open and could be accessed. There was a risk that confidential patient information could be accessed. The door did have a key pad lock and there was a sign on the door reminding staff to keep the door locked.

- We saw that records were appropriately stored within the outpatient and radiology department.
- In the physiotherapy department, patient records were stored in cabinets in a locked room behind the reception desk. When we visited the department, on the unannounced inspection, the door was open and the reception desk un-attended. Therefore, confidential patient information could be accessed.
- The hospital had a system to ensure records were readily available for patient clinic appointments. Over the past three months, the hospital reported 0.5% of patients were seen in outpatients without all relevant medical records being available. However, staff said there had been several occasions when patient records were not available in outpatient clinic or in the pre-assessment clinic.
- Patients' medical records were stored on site for two years, and after two years staff scanned the patients' medical records and they were archived.
- The hospital had a medical record tracking and tracing system. This ensured that the whereabouts of records were known.
- The hospital ran an outreach clinic for orthopaedic patients. Patients' medical records were taken off site so the consultant had access to the patient's records. We spoke to staff who said the hospital had a process in place whereby consultants could take medical records off site. The consultant signed for the records and returned them to the medical records department the same day. This was tracked within the department. We saw evidence of a risk assessment for taking records off site. We reviewed incident data from July 2015 to June 2016 and found no incidents relating to medical records being taken off site had been reported.
- The hospital completed monthly patient health record audits. Medical notes were randomly selected. From January to July 2016 results from the audit ranged from 77% to 88%. Audit results and areas for improvement were discussed at clinical governance meetings.

Following the inspection the hospitals provided a copy of their action plan. We saw the plan was not sufficiently detailed and did not include time scales or who was responsible for implementing the action plan.

Safeguarding

- BMI Healthcare safeguarding adults' policy provided a framework for all staff when identifying, responding to and reporting any aspects of safeguarding.
- Staff were aware of their roles and responsibilities in relation to safeguarding and could describe how they would raise a safeguarding concern and what types of concerns they would report.
- In the reporting period from July 2015 to June 2016, no safeguarding concerns were reported to the CQC.
- The service had suspended paediatric services for children under 16 years old as of the 31 August 2016 but continued to provide services for children aged 16 to 18 years old.
- Staff completed safeguarding training as part of BMI mandatory training programme. Training data was not split into each core service. Training data from September 2016 showed 100% of staff had completed safeguarding vulnerable adult `s level one training and safeguarding children level one training. There were 90.7% of staff who had completed safeguarding vulnerable adults level two training and 92% of staff had completed safeguarding children level 2 training.
- The Executive Director and Director of Clinical Services had completed safeguarding vulnerable adults and safeguarding children, level three training
- The radiology department displayed a flow chart advising staff on what to do if they had concerns about a person's welfare.
- Gynaecology clinics were held in the outpatient department; however, clinical staff did not have an awareness of female genital mutilation (FGM). Four members of clinical staff said that FGM was not included in safeguarding training. Information provided by the hospital showed that FGM was included in safeguarding level two training.
- FGM has been illegal in the UK since October 2015. Registered health professionals have had statutory duties around identifying and reporting cases of FGM. We were not assured staff would know what to do if they identified a woman had FGM, as staff had not received any training.

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Mandatory training

- Mandatory training topics included fire safety in a hospital environment, information governance, conflict resolution, safety, health and the environment, manual handling, infection prevention and control awareness and adult basic life support.
- The hospital was unable to separate mandatory training data into individual clinical areas. The corporate target for mandatory training completion was 90% compliance; training data showed on average the hospital was 87.5% compliant with mandatory training.
- Staff we spoke with confirmed they were up to date with their mandatory training. Staff said training was accessible and the majority of training was completed through e-learning. Practical training sessions such as moving and handling were face to face and could be difficult to access due to staffing levels. Some staff said it was challenging to complete mandatory training during working hours due to the clinical demand.
- Each department manager confirmed that they received information about mandatory training compliance weekly through an email. Staff would also receive emails and be notified when their mandatory training was due for renewal.
- Consultants with practising privileges received mandatory training from the NHS that employed them. The term “practising privileges” refers to medical practitioners not directly employed by the hospital but who have permission to practise there.
- The hospital did not have an effective process for ensuring mandatory training records for consultants and RMOs were reviewed. We reviewed five sets of records of consultants with practising privileges. Of the five records, one set showed training records, however many of the training sessions were out of date, and in the other four sets there was no evidence of training records.
- It was a requirement of the hospital that all resident medical officers (RMOs) complete mandatory training on employment and attend yearly refresher training. We reviewed two sets of RMO training records during the announced inspection. We could not identify up to date training data for one RMO. We reported this to the senior management team. On our unannounced inspection, we saw evidence of up to date training data for both

RMOs and a letter had been sent to the NHS employers of the consultants to ask them to provide the training data. We were told that collecting and storing this data was not part of BMI policy.

Assessing and responding to patient risk

- The hospital had RMO cover which was provided 24 hour, seven days a week.
- It was a requirement of the hospitals practising privileges policy that consultants needed to reside or work within 30 minutes of the hospital to be able to respond in a timely manner. In addition, the hospital had a 24 hour, seven day a week anaesthetic on call cover.
- The hospital had a service level agreement with a local NHS trust to transfer patients in the event of an emergency or if a deteriorating patient was not suitable to be cared for by the hospital.
- All consulting rooms had emergency buttons that could be pressed in an emergency.
- Within diagnostic imaging, there was an appointed radiation protection supervisor (RPS) who was responsible for ensuring compliance with the arrangements made by the radiation employer under IRR99.
- Appropriate environmental measures and signage was in place to identify areas where radiological exposure was taking place in line with IR(M)ER regulations. This ensured that staff and visitors did not accidentally enter a controlled zone.
- The hospital had a service level agreement with an external radiation protection advisory body as required under IRR99. This body also provided medical physics expert advice as per Ionising Radiation (Medical Exposure) Regulations 2000 IR(ME)R. The hospital had recently changed radiation protection advisors.
- The radiation protection advisor (RPA) undertook annual inspections of the radiology services at the location. We reviewed the RPA audit completed in September 2016 and saw the hospital required further documentation to achieve compliance. The service had produced an action plan and was making progress to ensure the appropriate actions were taken.
- We saw checks were in place to ensure the service identified women who may be pregnant. We saw a sign displayed in the waiting area requesting women discuss with the radiographer if they thought they might be pregnant.

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- The five steps to safer surgery, including the World Health Organisation (WHO) surgical safety checklist, is a tool for the relevant clinical teams to improve the safety of surgery by reducing deaths and complications. The outpatient department used a modified version of this checklist for patients who were undergoing minor procedures. We reviewed 12 sets of records in outpatients and found the WHO checklist was incomplete in nine sets of records.
- From the 12 sets of records we saw that none of the patients who attended the department for minor procedures had their observations recorded either before or after the procedure. This included patients undergoing cystoscopies.
- We saw evidence of completed risk assessments for when staff were working alone in the physiotherapy department. Actions to mitigate the risk included staff taking a portable phone into the treatment room with them.

Nursing staffing

- Data submitted by the hospital showed that on the 1 July 2016 the outpatient department employed 5.5 whole time equivalent staff (WTE). This consisted of three WTE registered nurses and 2.5 (WTE) health care assistants.
- From July 2015 to June 2016, no agency or bank registered nurses worked in the outpatient department. However, the rate of bank and agency health care assistants working in the outpatient department varied throughout the reporting period from 12% up to 67%.
- Staff said there were usually two registered nurses on duty in the outpatient department but staffing levels would vary depending on the number of consultant clinics.
- From July 2015 to June 2016, the rate of sickness for nursing staff working in the outpatient department was above the average of other independent acute providers, with the exception of December 2015 and June 2016.
- Data submitted by the hospital showed that as of the June 2016 the radiology department employed 2.64 WTE clinical staff/radiographers.
- There were no vacancies in radiology at the time of the inspection. The radiology manager was also acting operations manager. The radiology department had administrative staff to support them.

- The radiology department did not use bank or agency staff. Staff felt they had adequate numbers of staff to meet the demands of the services.
- Dressing clinics were run in the outpatient department. We did not see any evidence of competencies completed by staff working in the clinics however, aseptic none touch training (ANTT) was included in the hospital's mandatory training programme. The department had good links with the tissue viability team at the local trust and could contact them for any advice and transfer patients if required.
- Staff working in the minor procedure room had not completed any additional training to support them in their role. The outpatient manager explained that all the procedures were consultant led and staff supported the consultant by passing packs and dressings.

Medical staffing

- The term "practising privileges" refers to medical practitioners not directly employed by the hospital but who have permission to practise there. Data showed all medical staff had their registration validated in the last 12 months.
- There were 91 doctors and dentists operating under practising privileges at the hospital. From July 2015 to June 2016 of the staff that had practising privileges 23 recorded no episodes of care, three recorded between one and nine episodes of care, 23 recorded between ten and 99 episodes of care and 42 recorded 100 or more episodes of care.
- The hospital outsourced the provision of its resident medical officers (RMO) from a national agency. An RMO was onsite 24 hours a day, seven days a week. From 2015 to 2016 the hospital had two regular RMOs who worked on a two weekly rota basis.
- The hospital completed relevant checks against the Disclosure and Barring Service (DBS). The registered manager and Medical Advisory Committee (MAC) chair liaised appropriately with the General Medical Council and local NHS trusts to check for any concerns and restrictions on practice for individual consultants.
- Staff said there were sufficient medical staff to cover outpatient clinics and that medical staff were supportive and advice could be sought when needed.

Emergency awareness and training

Outpatients and diagnostic imaging

- The hospital had a corporate BMI Healthcare business continuity policy, which set out the minimum standards for preparedness and response required by all BMI facilities.
- The hospital ran a major haemorrhage scenario twice a year. A major haemorrhage is excessive blood loss which can be life threatening. A blood practitioner from the local NHS trust would attend and supervise a scenario so staff were familiar with their responsibilities in the event of a major haemorrhage. The trust provided staff with feedback.
- The resuscitation co-ordinator from the local NHS trust attended the hospital and ran cardiac arrest clinical scenarios with staff.

Are outpatients and diagnostic imaging services effective?

Not sufficient evidence to rate 

The effective domain was inspected, but not rated in line with our inspection approach.

Evidence-based care and treatment

- Within outpatients and diagnostic imaging, policies and procedures had been developed and referenced to the National Institute for Health and Care Excellence (NICE) and national guidance. These were accessible to all staff on the hospital's intranet. The outpatient department also had a file containing relevant policies and procedures that staff could access.
- The diagnostic and imaging department did not participate in the Imaging Services Accreditation Scheme (ISAS). This was because the on-site radiology service was small.
- The radiology department operated a 'stop, check' process before carrying out procedures. This involved checking patient identification, whether staff were viewing the correct records, and questioning whether the procedure was appropriate.
- Within radiology, the service considered national guidance from the Department of Health in regard to setting diagnostic reference levels (DRLs) in practice. This provided radiographers with information about the radiation dose levels expected for examinations. The department had a limited number of local DRLs and the remainder were covered by national DRLs.

- We observed that DRLs were not displayed in the x-ray department and not all staff were able to articulate the DRLs. Therefore, staff did not have the means to recognise when a patient's exposure triggered the threshold for external reporting.
- The Radiology department had recently changed Radiation Protection Advisors. An action plan was in place and they were in the process of reviewing standard radiology protocols. The deadline for completion was December 2016.

Pain relief

- Staff said they would offer support to patients who reported being in pain. Staff said that they would assess the level of pain and contact the registered medical officer for further advice and support.
- The outpatient department had a weekly pain clinic. Staff said this provided treatment and support to patient with acute and chronic pain conditions.
- Staff in the physiotherapy department routinely asked patients about their pain levels and used this as a subjective marker to assess the impact of treatments.
- Some of the minor procedures that took place in the outpatient department were performed under local anaesthetic. A consultant was present for the procedure and administered the pain relief.

Patient outcomes

- Staff in the physiotherapy outpatient department used an outcome measure to assess patient outcomes following treatment for musculoskeletal conditions. Staff said this information was collated but not audited.
- The outpatient department did not audit or collect data on the number of clinics cancelled or the patients who did not attend appointments. Staff reported that the hospital cancelled clinics on a daily basis but no formal data was collected on the number of clinics cancelled.
- The hospital did not audit waiting list times for patients to receive an appointment. Staff said patients rarely had to wait for an appointment. None of the patients raised concerns about being able to access clinics in a timely manner.
- Management staff said they did not audit or collect data on how long patients waited in the department after their allocated time. Staff said clinics in the outpatient department did run late and we heard an example of a

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patient who had been waiting in the department for 40 minutes. Five out of six patients we spoke with had waited past their allocated clinic time and not been kept up to date by staff.

- The hospital was supportive of the Private Healthcare Information Network (PHIN) and submitted data to PHIN.
- The hospital had a BMI Healthcare corporate annual clinical audit programme. Examples of audits on the audit calendar included; patient health records, WHO checklist, VTE, medicines management, controlled drugs, resuscitation and hand hygiene. We found a lack of audits in the outpatient department. Management staff said they only participated in hand hygiene audits.
- The outpatient department did not undertake a chaperone audit to ensure patient records matched the chaperone log.

Competent staff

- The hospital had a process in place for granting practising privileges to medical staff who worked there. For practising privileges to be granted medical staff needed to demonstrate that they were licensed and on the specialist general medical council (GMC) register, held a substantive consultant post within the NHS or the defence medical services within the last 5 years and be able to demonstrate relevant clinical experience relating to practice.
- Before a RMO commenced work at the hospital, the Director of Clinical Services was responsible for reviewing their curriculum vitae (CV), General Medical Council (GMC) details and any additional training certificates.
- From July 2015 to June 2016, four doctors had their practising privileges removed and three were suspended. The hospital said this was due to failure to comply with paperwork requirements and due to retirement.
- Any clinical practice concerns arising in relation to a consultant were discussed with the medical advisory committee (MAC) chair. Actions were agreed and the hospital had a process in place to ensure appropriate communication was received and passed on to the NHS trust if a consultant's clinical practice raised concerns.
- Data provided by the hospital showed that 100% of outpatient nurses and health care assistants had received an appraisal in the current appraisal year (October 2015 to September 2016).

- We spoke with new staff within the services we visited. They described shadowing staff at another BMI hospital, having time to complete their mandatory training and learning on the job.
- Staff said they had received support from their colleagues with revalidation. A Senior Radiographer was the qualified radiation protection supervisor (RPS) within the service. We saw evidence of their most recent update training and evidence of a competence update for their role as RPS in June 2016.
- Radiographers who had completed specific competencies operated imaging equipment used in theatres. None of the surgeons acted as operators of this equipment.
- Staff working in the radiology department said that they had the opportunity to attend study days and external courses on dose optimisation and chest reporting.
- Staff working in the minor procedure room had not completed any additional training to support them in their role. The outpatient manager explained that all the procedures were consultant led and staff supported the consultant by passing packs and dressings.
- Dressing clinics were run in the outpatient departments. Patients would attend the clinic post-operatively for the removal of sutures and clips and for wound checking. Staff had not completed any additional training. The outpatient manager assured us that staff had the required skills and competencies to carry out the role. The department had good links with the tissue viability team at the local trust and could contact them for any advice and transfer patients if required.
- Some staff described being supported in undertaking further learning to develop their skills and knowledge. We heard examples of a healthcare assistant being supported in completing their nurse training. However, some staff reported a lack of development opportunities and being unable to attend training courses due to staff shortages and a lack of funding.
- Staff in the outpatient department reported they had not completed any chaperone training.
- We saw evidence of training course and study days displayed on the noticeboard for staff in the physiotherapy department.
- Staff working in phlebotomy had completed blood transfusion and venous blood sample competencies.

Multidisciplinary working

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- We observed close working relations between clinical and non-clinical staff within the outpatient department. Staff told us that everyone worked together well as a team.
- The hospital had appropriate service level agreements (SLAs) in place. There was an SLA in place between the hospital and the local NHS provider who provided pathology and histology services.
- The service had good working links with the local NHS trust. Staff could refer patients to the tissue viability team if they had concerns about a patients wound.
- The physiotherapy team did not routinely see patients who attended pre-assessment clinic. Staff were looking at ways of bringing the two services together.
- There were arrangements in place to transfer patients' care to the local trust in emergencies.
- Within diagnostic imaging, staff worked closely with the local NHS provider to make use of previous images. Any previous images could be shared using a secure portal and viewed.
- The radiology department used a commercial reporting information system. The system supported a range of functional requirements such as radiology operational workflow and storage of patient data contributing to the electronic patient record across all modalities.
- Within radiology, there was a system in place to request diagnostic images. Any previous images could be shared using a secure portal and viewed using a picture archiving and communications system.
- The hospital outsourced pathology services to a local NHS trust. The hospital had a robust system in place to ensure all test results were logged and cross-referenced. The RMO reviewed all test results daily on an electronic reporting system. Staff in pathology faxed copies of the results to the medical secretaries so that the results could be filed in patients' medical records.
- Staff said clinic information was shared with patients' GPs in letter format. However, this was not monitored and the service could not provide assurance that this was routinely happening.

Seven-day services

- The hospital had a RMO who was onsite 24 hours a day, seven days a week.
- The diagnostic imaging department was open Monday to Friday and had an on call radiology team of radiographers who provided cover 24 hours a day, seven days a week.
- The outpatient department was open from 8am to 8pm, Monday to Friday. Some consultants offered clinics on a Saturday morning.
- The outpatient physiotherapy department was open from Monday to Friday. Evening appointments up until 7.30pm were available on a Thursday.
- An MRI scanner visited the site once a week on a Saturday.

Access to information

- All staff had access to the hospital intranet to gain information relating to policies, procedures, national guidance and e-learning.
- The hospital reported that in the past three months, 0.5% of patients had been seen in the outpatient department without all relevant medical records. However, staff said there had been several occasions when patient records were not available.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Consent was included in the hospitals mandatory training programme. Overall 94.8% of staff had completed consent training. The hospital were unable to break the training data into individual services.
- The hospital policy for the use of the Mental Capacity Act and Deprivation of Liberty Safeguards was incorporated into the hospitals safeguarding adult's policy.
- Staff appeared to have a broad understanding of issues in relation to capacity. They explained that any concerns would be escalated to the matron or consultant for further advice or assistance.
- We reviewed ten sets of records for patients undergoing minor procedures and saw that patients undergoing procedures were appropriately consented and there was evidence that risks had been discussed with the patient.
- Staff in the physiotherapy department used specific consent forms for patients undergoing acupuncture and for all patients seen in the women's health clinic.

Are outpatients and diagnostic imaging services caring?

Outpatients and diagnostic imaging

Good 

We rated caring as good.

Compassionate care

- We spoke with six patients in the outpatient and diagnostic imaging waiting area. All patients spoke positively about their experience and told us staff had respected their privacy and dignity.
- We observed staff communicating with patients and their families in a respectful and considerate manner. Reception staff in the main entrance were welcoming and we saw respectful interactions between staff and patients.
- During our inspection we collected feedback from people who used the service. We received 31 comment cards, and found 30 of the responses were positive, and one was neutral.
- From January 2016 to June 2016, the hospital's response rates for the friends and family test ranged from 16% to 31%. This was lower than the England average. During this reporting period, 100% of people would recommend the hospital. There were no specific friends and family data available for outpatient and diagnostic imaging services.
- The consulting rooms in the outpatient department displayed 'free/engaged' signs on the door. This provided privacy and dignity to patients during their consultation. These signs were not displayed in the physiotherapy department. However, we observed staff knocking on the door before entering when patients were in treatment rooms.
- The outpatient department kept a chaperone log to record when a chaperone was offered and whether a patient accepted or declined. Private changing facilities were available for patients in the diagnostic imaging department.
- Within the outpatient departments and diagnostic imaging, corporate comment cards were available for patients to leave feedback. The card asked if patients were likely to recommend the service. There was no specific patient satisfaction survey undertaken in the outpatient or diagnostic imaging departments.

Understanding and involvement of patients and those close to them

- Patients we spoke with said they felt fully informed about their care and treatment. All the patients we spoke with had a good understanding of their condition and proposed treatment plan.

Emotional support

- We observed caring interactions between staff, patients and relatives. Staff re-assured patients and relatives about the care and treatment they received.
- The majority of people we spoke with said they felt they received emotional support from staff, or this would be available if needed.

Are outpatients and diagnostic imaging services responsive?

Good 

We rated responsive as good.

Service planning and delivery to meet the needs of local people

- The hospital engaged with the local NHS Clinical Commissioning group to plan and deliver contracted services based on local commissioning requirements.
- The hospital provided outpatient and diagnostic imaging services for people over the age of 16. The hospital had discontinued all services for children under the age of 16 on 31 August 2016.
- From July 2015 to June 2016, there were 263 (1.4%) attendances were from children aged three to 15 years old and 3580 (18.8%) attendances were from adults aged over 75.
- The hospital provided a range of outpatient clinics. Around 16 specialities were offered, of which the largest was orthopaedics (30%), followed by neurosurgery (13%), ear, nose and throat (10%), general surgery (7%), cardiology (7%), dermatology (6%) and ophthalmology (6%).
- The outpatient department was located on the first floor and the physiotherapy department was on the second floor. Patients could access these using a lift or stairs.
- We saw magazines and newspapers were readily available in waiting areas. The outpatients department had a TV and a radio playing.
- Hot drinks were available free of charge in the outpatient and diagnostic waiting areas.

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- All departments had water machines that patients and visitors could access.
- Free car parking was available for patients, with a number of designated disabled spaces available closer to the building.
- All departments were signposted. However, signs were small and not dementia friendly or accessible for visually impaired people.
- We saw corporate BMI-Healthcare information displayed in waiting areas but there was no evidence of information in accessible formats or charitable organisation leaflets.
- Patients had a choice for booking the dates and times of appointments. Patients we spoke with confirmed appointments were offered that suited their needs and they could access appointments in a timely manner.
- Notices on the wall told patients to enquire at the reception desk if their appointment was delayed by more than 10 minutes. However, there was no information on display to inform patients of waiting times. This meant patients were not kept informed of any disruption to their care and treatment. The hospital did not audit patient waiting times in the department.
- In the outpatient department, five patients said they had waited past their allocated clinic time. The times they had waited range from 10 minutes to 40 minutes. The patients said they had not been kept updated. Staff said patients often waited past their allocated times and as the clinics were consultant led it was difficult for them to know how long a patient had been waiting in the department.

Access and flow

- From July 2015 to June 2016, the hospital saw 19,034 outpatients in clinics of which, 7,764 were first appointments and 11,270 were follow-up appointments.
- The hospital accepted referrals from local NHS trusts. The referrals related to a number of specialities. Out of the 19,034 attendees, 27% were NHS funded and 73% were other funded appointments.
- From July 2015 to June 2016, the hospital met the referral to treatment time (RTT) waiting times for incomplete pathways target of 92% for NHS funded patients.
- The hospital outsourced pathology services to a local NHS trust. Staff sent the majority of patients' samples to an off-site laboratory for testing. Couriers collected samples twice a day. Staff could request extra courier runs when required for urgent tests.
- The hospital reported that diagnostic reporting times for routine examinations were three days. Any urgent reports or GP referrals were done on the same day.
- The hospital did not collect data on waiting times. However, staff in all departments told us the wait times for appointments were short. The radiology and outpatient managers both told us patients could get an appointment within a week. Staff said any patients needing an urgent appointment could be booked at the end of clinics.
- The outpatient department did not have a DNA policy. The hospital recorded the number of NHS patient who DNA their appointment however, they did not collect data or audit the number of privately funded patients who DNA their appointment. If a patient DNA their appointment, they were contacted and an alternative appointment was made.

Meeting people's individual needs

- The hospital had a policy in place for the use of chaperones. This provided guidance on chaperones, their availability to patients and that the patient had the option to reschedule an appointment or procedure if a chaperone was not available. We saw chaperones were available in the departments we visited.
- The main reception desk and the reception desk in the outpatient department had a hearing loop; however, there was not a hearing loop available in the diagnostic imaging department.
- There was a system in place for accessing interpreting services and interpreters were usually arranged prior to arrival by booking system. Staff said they rarely saw patients who required an interpreter.
- Information leaflets were all provided in English. Staff were not aware of how to access written information in other languages.
- In the 2016 patient led assessment of the care environment audit (PLACE), the hospital scored 81% for dementia (slightly above the England average) and 79% for disability (lower than the England average).
- We did not see any evidence of any specific pathways for dementia patients.
- Appropriate seating was available in both the outpatient and diagnostic imaging waiting areas. Each of the waiting areas had a raised-height chair for patients who had difficulty standing from low heights.

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- The table in the main x-ray room was not adjustable. If a patient was unable to get onto the table, they had to use a step.
- Disabled toilets were available in the outpatient department and were wheelchair accessible.
- Within the outpatient department, the reception desk was in an open environment that did not offer privacy to patients when talking to reception staff. Staff said they would use a free consultation room if they needed to have confidential discussions with patients.
- The physiotherapy department had three individual consulting rooms. One of the rooms was used for women's health appointments. This room provided privacy and respected the dignity of patients during their consultation.
- There was a lack of changing facilities for patients in the physiotherapy department. Patients used the same changing area as staff and the lockers did not lock securely.
- Within the radiology department, we saw patient information leaflets explaining what to expect from an MRI and ultrasound scan. Patients said they had received appropriate information about their care and treatment.
- We saw a sign in the radiology department that advised self-funded patients that they would receive separate invoices for the services they received.
- Patients were informed of any changes to clinic times or days; however, staff said this could be challenging if a clinic was cancelled at short notice.
- Hot drinks were available free of charge in the outpatient and diagnostic waiting areas and all departments had water machines that patients and visitors could access.

Learning from complaints and concerns

- The hospital followed corporate BMI healthcare guidelines for managing complaints. Staff told us they would attempt to resolve complaints at the earliest opportunity. Patient complaints followed a three-stage process. Stage one involved acknowledging the complaint and explaining the process; complainants should get an investigation and a response by the hospital within 20 days. If the complaint was not resolved, it would be escalated to stage two. This stage involved a corporate investigation. Stage three involved

- an independent review by the Independent Sector Complaints Adjudication Service (ISCAS), for self-funded or privately funded patients, or the Parliamentary and Health Service Ombudsman for NHS patients.
- From July 2015 to June 2016, the hospital received 19 complaints. This number of complaints was similar to other independent acute hospitals. The hospital reported that in the past six months the outpatients department had received five complaints. There had been no complaints within radiology. None of the complaints were referred to the Ombudsman or ISCAS.
- We saw that the hospital had 'please tell us' information leaflets which provided patients with guidance on how to raise concerns.
- Learnings and themes from complaints were shared at the hospital communication cell to ensure learning was shared and actions shared. Complaint numbers and themes from complaints were discussed at monthly clinical governance committee meetings, departmental meetings and as appropriate at the hospital medical advisory committee. In response to a patient complaint, staff in the radiology department had displayed a sign in the waiting area to inform patients of potential additional costs associated with imaging.
- We reviewed three complaint letters and responses to the complaints and found that an apology was offered when care and treatment fell below the expected standard.
- Patients we spoke to were positive about the service provided and said they had no cause for complaint. Patients felt they would be taken seriously if they did need to complain and would feel confident to contact the hospital directly if they wanted to make a complaint.

Are outpatients and diagnostic imaging services well-led?

Requires improvement 

We rated well-led as requires improvement.

Leadership and culture of service

- Staff reported that their immediate managers were supportive and approachable. Departmental managers had clinical roles and were easily accessible. Staff reported good support and guidance from their managers.

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- Some departmental managers said they could access support from other managers within BMI for support and advice. For example, within radiology, staff said they had regional meetings with other radiology managers across BMI.
- Staff within radiology felt well supported by senior radiographers and radiologists.
- Not all staff felt supported by the senior management team. We heard that the senior management team were not visible within the hospital.
- Some staff felt the senior management team would not listen to them if they raised concerns. They felt action would not be taken in response to concerns raised. We did not see any information displayed informing staff how to raise concerns. However, the hospital had undertaken a staff survey in February 2016; this had identified low morale, concerns over pay and additional benefits. The senior management team were aware of the low morale and had responded to this survey by running staff forums; staff we spoke with said these were held on a monthly basis and were well attended.
- From July 2015 to June 2016, the rate of sickness for nursing staff working in the outpatient department was above the average of other independent acute providers, with the exception of December 2015 and June 2016.
- Within the 12 months prior to the inspection, the Advisory, Conciliation and Arbitration Service (ACAS) had worked with the physiotherapy department and the administrative team to help improve working relationships in these departments. Staff said that following staffing changes working relations had improved.

Vision and strategy for this this core service

- A BMI group-wide corporate vision “to be serious about health, passionate about care” was in place. This focused on four core beliefs of safety, clinical effectiveness, patient experience and quality assurance.
- The corporate vision was individualised at each local hospital, including BMI Duchy. However outpatients and radiology did not know about the vision or strategy locally, and staff were unable to articulate the vision or strategy for individual departments.
- There were plans for the outpatient department to undergo a refurbishment; however, staff we spoke with were unsure when this was due for completion.

Governance, risk management and quality measurement

- During the inspection we identified some risks within the departments visited which were not on the hospital’s risk register. For example, the lack of positive air pressure in the outpatients minor procedure room.
- The hospital had a refurbishment plan to replace carpets with hard flooring. However, from discussion with the senior management team there was no agreed funding available for the refurbishment and from staff meeting minutes in June 2016, we found, due to financial constraints, refurbishment plans had been placed on-hold.
- The hospital had a BMI Healthcare corporate annual clinical audit programme. Examples of audits on the audit calendar included; patient health records, WHO checklist, VTE, medicines management, controlled drugs, resuscitation and hand hygiene. There was minimal evidence of audits in the outpatient department apart from environmental and hand hygiene audits. Management staff said they only participated in hand hygiene audits. We saw no evidence of action plans or follow-up from audits to ensure any recommendations had been put in place.
- We found some inconsistency in the reporting of incidents that resulted in no harm or near misses. We heard examples of incidents within the radiology department that staff would not report. For example, staff said if the wrong side had been requested on an imaging request form they would not report this despite it being a near miss for the patient.
- Radiology had an on-site radiation protection supervisor who was responsible for ensuring local compliance. Arrangements were in place to seek advice from the radiation protection advisor in accordance with local rules. The radiation protection advisors supported quality assurance, governance, radiology local rules and local risk assessments.
- Due to a newly appointed RPA and RPS the hospital were unable to provide us with a copy of the recent radiation protection committee (RPC) meeting minutes, as they were yet to meet. The service had a planned RPC meeting on 11 November 2016.

Public and staff engagement

- Within the outpatient departments and diagnostic imaging, corporate comment cards were available for

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patients to leave feedback. The results of these were shared and published monthly. Results were shared at monthly operations meeting and recorded within the clinical governance report.

- The hospital did not carry out specific outpatient surveys.
- Any member of staff who was named in a compliment letter received a thank you letter from the hospital.

- We did not find any evidence of public engagement within the departments visited. This meant people's views and experiences were not included in any plans to improve services.

Innovation, improvement and sustainability

- There were plans for the outpatient department to undergo a refurbishment but staff were unsure when this was due for completion.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider **MUST** take to improve

- The hospital must ensure that all reasonable steps are taken to prevent cross infection including completing their refurbishment plan in a timely manner; ensuring procedures carried out in the clinical procedure room are assessed against and meet national guidance for ventilation and that the plan to stop endoscope decontamination occurring on site is completed.
- The hospital must ensure that the five steps to safer surgery including the WHO health Organisation checklist, in both the theatre and outpatient departments is embedded.
- The hospital must ensure that there are sufficient numbers of suitably qualified, competent, skilled and experienced staff at all times within the inpatient and theatre department.
- The hospital must ensure that they assess, monitor and mitigate risks to improve the quality and safety of the services they provide, especially in relation to learning from incidents and investigations.

- The hospital must ensure that patients are fasted in accordance with national best practice guidelines.

Action the provider **SHOULD** take to improve

- The hospital should ensure consultants record their daily assessments in the patient care pathway.
- The hospital should improve the effectiveness of leadership, staff morale and confidence in leadership throughout the hospital to enable effective team working throughout all departments.
- The hospital should ensure that information recorded and used for benchmarking is robust and accurate.
- The hospital should ensure that all risks relevant to the hospital are recorded on a risk register.
- The hospital should ensure that the workforce and race equality standards (WRES) are implemented appropriately.
- The hospital should improve audit facilities in the outpatient department in relation to patient cancellations, clinic cancellations and amount of time patients spend in departments.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Treatment of disease, disorder or injury	<p>Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment</p> <p>How the regulation was not being met:</p> <ul style="list-style-type: none">• The environment used to decontaminate endoscope equipment did not meet best practice guidance (Management and decontamination of flexible endoscopes Health technical memorandum (HTM) 01-06). Regulation 12 (1)(2)(h)• There was no specialist ventilation in the minor procedure room. The room was used for a variety of invasive procedures. Guidance from the Department of Health, The Health Technical Memorandum 03-01: Specialised ventilation for healthcare premises states endoscopy, day-case and minimum invasive suites, such as the minor procedure room, require specialist ventilation. Regulation 12 (1)(2)(d)• In the theatre and outpatients department, the use of the five steps for safer surgery including the World Health Organisation (WHO) surgical safety checklist was not embedded. Regulation 12(2)(b)
Treatment of disease, disorder or injury	<p>Regulation 18 HSCA (RA) Regulations 2014 Staffing</p> <p>How the regulation was not being met:</p> <ul style="list-style-type: none">• In the inpatient ward and theatre recovery area sufficient numbers of suitably qualified, skilled and experienced nursing staff to meet patients' needs were not always available. Regulation 18(1)(2)(a)
Regulated activity	Regulation

This section is primarily information for the provider

Requirement notices

Treatment of disease, disorder or injury

Regulation 17 HSCA (RA) Regulations 2014 Good governance

How the regulation was not being met:

- The governance system in place was not operated effectively to ensure compliance with regulations. Regulation 17 (1)
- The corporate risk register lacked local risk identification. The service had not identified risks in respect of safety in surgery, or with the environment in the minor procedure room within outpatients. The provider had not effectively assessed, monitored or mitigated these risks relating to the health, safety and welfare of service users and others who may be at risk which arise from the carrying on of the regulated activity. Regulation 17 (2)(b)
- The provider did not act on poor staff survey results, or low staff morale, staff were concerned to speak out and there was no clear plan of how cultural concerns would be addressed to improve the service. Regulation 17(2) (e)

Regulated activity

Regulation

Treatment of disease, disorder or injury

Regulation 14 HSCA (RA) Regulations 2014 Meeting nutritional and hydration needs

How the regulation was not being met:

- Pre-operative fasting guidance was not consistently delivered in line with national guidance and the best practice outcomes for patients. Regulation 14(4)(a)