BMI Chelsfield Park Hospital

Quality Report

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

Ratings

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

Summary of findings

Letter from the Chief Inspector of Hospitals

Chelsfield Park hospital is one of 59 hospitals and clinics provided by BMI Healthcare Limited. BMI Healthcare is the UK's largest private hospital group and was formed in 1970. In 1993 after various changes, the group was renamed BMI Healthcare, and its new corporate group became General Healthcare Group (GHG). In 2006 GHG was acquired by a consortium led jointly by Netcare Limited, a South African healthcare company.

We inspected the hospital as part of our independent hospital inspection programme. The inspection was conducted using the CQC's comprehensive inspection methodology. This was a routine planned inspection.

The hospital provides a range of medical, surgical and diagnostic services. The onsite facilities include two operating theatres (both with laminar airflow), 36 registered beds spread across two floors, a minor procedure theatre, seven consulting rooms and a minor procedure room.

The hospital offers physiotherapy treatment as both an inpatient and outpatient service in its own dedicated physiotherapy suite. The imaging department provides plain x-ray, ultrasound, and mobile MRI onsite four days a week, and full field digital mammography.

The dedicated assisted conception unit was not included in this inspection.

Services offered include general surgery, bariatrics, and cosmetic surgery. Diagnostic imaging and endoscopy provide diagnostic services. In addition there is limited general medicine provision, oncology and physiotherapy. Patients are self-paying or use private medical insurance. Some services are available to NHS patients through the NHS choose and book system or spot contracts.

The announced inspection took place between 12 and 13 July 2016, followed by a routine unannounced visit on 21 July 2016.

This was a comprehensive planned inspection of all core services provided at the hospital: surgery, outpatient and diagnostic imaging, both of which include services for children and young people. General medical services are provided to patients using the same nursing staff, patient rooms and facilities as other patients. For this reason we have not reported this separately but have included endoscopy and children and young peoples services within surgery.

Are services safe at this hospital

- Improvements were required to ensure a safe service was consistently provided. This included improving the completion of the World Health Organisation (WHO) 'five steps to safer surgery' checklist, and patient treatment and care records.
- Infection prevention and control practice in theatres and on the wards was mostly good. The use of personal protective equipment was not always used by consultants during procedures which may have posed as a risk of exposure.
- Staff were provided with relevant safety training, including safeguarding vulnerable people. They were knowledgeable about the hospital's safeguarding policy and clear about their responsibilities to report concerns. Staff were supported by a designated safeguarding lead. However, the number of staff trained to safeguarding level 3 did not meet the recommended guidance.
- Medicine optimisation was managed safely.
- Staff were fully aware of the incident reporting process, and there was a formal system for reviewing and learning such matters. The duty of candour was understood by staff with regards to incidents, which met the threshold of informing relevant individuals.
- Nursing staffing levels were organised to ensure the delivery of safe care. The service ensured a Resident Medical Officer (RMO) was on duty at all times.

Summary of findings

- Consultants with practising privileges took ultimate responsibility for treatment and care.
- There were arrangements for communicating patient related information between shift changes, and at times when the admitting consultant needed to be made aware of their respective patient's condition.
- A national early warning score was used to identify patients whose condition might deteriorate, and transfer arrangements had been established for patients who required higher levels of treatment or care.

Are services effective at this hospital

- Staff provided care and treatment, which took account of nationally recognised evidence based guidance and professional standards. Audit of practices followed a defined programme and included medicine management, and urinary catheters. Action plans were completed and acted upon where audits achieved less than 100% compliance.
- Policies related to service provision at the location were shared with staff and then discussed at the Medical Advisory Committee.
- Pain management and nutritional support was integral to the provision of effective patient care.
- There were effective arrangements for reviewing and agreeing consultant practising privileges, and for removing these when required information was not forthcoming. The revalidation of the consultants and registered nursing staffs fitness to practise ensured services could be delivered effectively.
- There were nine unplanned returns to theatre during the reporting period April 2015 to March 2016. Unplanned readmissions within 28 days of discharge for the same period was 18. There were five unplanned transfers of inpatients to another hospital, which was better than other similar independent hospitals.
- NHS Patients participated in the patient reported outcome measures (PROMS) data collection if they had undergone surgery for hip or knee replacement and inguinal hernia repair. Insufficient data was available for the period April 2014 to March 2015 (reported February 2016) to calculate the average adjusted health gain score for either primary knee or hip replacement.
- Staff had been provided with training in the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS) as part of mandatory training. They understood their responsibilities, and were clear about the processes to follow if they thought a patient lacked capacity to make decisions about their care. The Gillick test and the Fraser guidelines, which related to a child's capacity to give independent consent to medical procedures, were understood by relevant clinical staff.
- Patients were provided with information as part of the consent process; however, most patient notes reviewed showed consent was obtained on the day of treatment.

Are services caring at this hospital

- The hospital participated in the 'friends and family test' (FFT). Between October 2015 and March 2016 the hospital reported 100% of patients would recommend the hospital to their friends and families. The amount of patients who responded to the test was moderate (between 30% and 58%).
- The Patient Led Assessments of the Care Environment (PLACE) audit between February 2015 and June 2015 score for privacy, dignity and wellbeing was 92%, compared to an England average of 87% for independent acute hospitals.
- Staff recognised patients individuality and ensured they provided sufficient information and emotional support to enable a rapid recovery. Staff were respectful in their administrations, and treated patients and family members with kindness, courtesy and compassion.

Are services responsive at this hospital

- The executive team worked with clinical commissioning groups to determine the range of surgical and other services provided to NHS patients within the surrounding population. Private provision of services reflected the agreed range of activities, based on the suitability of facilities, available support and risk criteria.
- An inclusion/acceptance criterion was applied by staff after assessing the patient's needs. All patients are risk assessed for potential to require extended recovery care. The admitting consultant would make decisions regarding the suitability of admitting patients with specific needs associated with dementia or learning disabilities.

Summary of findings

- The Resident Medical Officer reviewed patients throughout the day and was available out of hours. Consultants reviewed their own patients and were required to attend to their patients within a thirty minute journey time, should the need arise. Transfer arrangements were set up in the event of a patient's condition deteriorating.
- The hospital dealt with complaints and concerns responsively, and learning from such matters was used to improve the quality of care.

Are services well led at this hospital

- Staff were aware of the expectations of executive team and understood what the vision and values were. They were supported by an effective and responsive leadership at the executive level, as well as their respective departments.
- Staff enjoyed working at the hospital, and described an open culture and of feeling valued and supported. The recent changes in management at the hospital were positively acknowledged.
- The Medical Advisory Committee worked with the executive team to ensure the monitoring of quality of services was reviewed, and challenged where needed. They were responsible for reviewed practising privilege, including fit and proper person information, before agreeing acceptance to use the service.
- Governance arrangements ensured incidents, complaints, audit results and policy development were reviewed and learning was shared appropriately. However, the risk register, which was a temporary document, was not sufficiently robust and lacked evidence of review dates for many of the identified risks.
- Staff were encouraged to continuously learn and improvement was fostered through training and development opportunities.
- The availability of capital helped the service to improve and develop services. Recent purchases included a bariatric operating table, new theatre stack systems and endoscopes.
- As an approved service for Bariatric surgery, equipment was available to support the service, and a designated team of specialty trained staff worked with the consultant to ensure patients received the required standards of treatment and care.
- An enhanced recovery program provided a comprehensive rehabilitation program for orthopaedic patients, including specialised physiotherapy to achieve earlier mobilisation and discharge.
- The pharmacy manager had implemented a pharmaceutical care plan, and an antibiotic care plan had also been introduced to improve practices.
- The service was working toward obtaining accreditation for the endoscopy services with an external body.

Our key findings were as follows:

- The service was led by a dedicated local executive team, supported by loyal staff, who were professional in their duties and responsibilities.
- The areas in which patients received treatment and care were noted to be clean and well organised. Infection prevention and control measures were followed by the majority of staff.
- Staffing levels, skills and experience contributed to high standards of care and good patient experiences.
- Patients' needs including effective pain management and nutrition were optimised.
- The standards of leadership and governance arrangements contributed to the effectiveness and responsiveness of the services.
- There were sufficient and appropriately skilled staff available to support the safe delivery of patient care.
- The nutritional and hydration needs of patients were assessed and catered for.

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

Importantly, the provider should:

- Improve compliance with the World Health Organisation (WHO) 'five steps to safer surgery' procedures.

Summary of findings

- Improve consultant compliance with the use of personal protective equipment during invasive procedures, in line with NICE guidelines and BMI policy.
- Improve the completion of patient records to enable the availability of a fully detailed record.
- Consider how professional guidelines can be applied to support the safeguarding training further.
- Improve the use of the risk register with the incorporation of review dates for all identified risks.
- Consider having leaflets available in other languages as well as in English.

Professor Sir Mike Richards
Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Surgery	Good	We rated surgical services as requires improvement for safe and good for effective, caring, responsive and well-led. Implementation of the World Health Organisation (WHO) 5 steps to safer surgery checklist was not consistently completed. Infection prevention and control practices were not always consistently adhered to. Patient records were not always completed with required information. Whilst there were appropriate staffing levels and the skills of staff enabled them to support the delivery of care, the level of safeguarding training did not meet best practice guidelines. Surgical services provided good care and treatment to patients, and had a compassionate and patient centered approach. Patients received information about their treatment and were involved in decisions about their care, and treatment plans. We observed staff maintain patients' respect and dignity at all times. Medical and nursing staff carried out effective risk assessments from pre-assessment through to discharge. Staff followed evidence based care and treatment, and monitored and reviewed patient outcomes. The staff worked effectively across different disciplines and had good links with staff at other BMI hospitals and local NHS services. There was effective and responsive leadership at the executive level, and staff commented favourably on the hospital manager and other senior leaders Governance arrangements ensured incidents, complaints, audit results and policy development were reviewed and learning was shared appropriately.
Outpatients and diagnostic imaging	Good	Overall, we rated the outpatients department, diagnostic imaging and oncology services as good. However, we rated safety as requires improvement, and there was insufficient evidence to rate the effectiveness of services.

Summary of findings

The outpatients, physiotherapy, and diagnostic imaging departments provided a broad range of services for both privately funded and NHS funded patients. The patients we spoke with were complimentary about the care, treatment, and service they had received in both departments.
Patients we spoke with told us they were treated with dignity and respect. All patient feedback on the inspection was positive. They described the service as 'very good' and 'professional', and described the process of making an appointment as easy.
The oncology department provided treatment for cancer patients by means of chemotherapy, monoclonal antibodies therapy, and supportive therapies. The service was provided by Chemotherapy specialist trained nurses.
Staff were competent and worked to national guidelines, ensuring patients received the best care and treatment.
The culture within both departments was patient focused, open, and honest. The staff we spoke to felt valued and worked well together. Staff followed policies and procedures to manage risks and made sure they protected patients from the risk of harm.
There were short waiting times for appointments. Private patients were seen within one week, and NHS patients were usually seen within four weeks of referral. We found patients could get appointments with their chosen consultant and most clinics started on time.
The departments, including oncology, were visibly clean, well equipped and we observed staff using personal protective equipment (PPE) appropriately.
However;
Some staff involved in the direct care of children and young people had not received the required level of safeguarding training. Non clinical staff had not been trained to identify patients who may become unwell whilst awaiting their appointment.
Nursing staff receiving patient calls to the out of hour's oncology service did not always include an assessment of the patient's temperature. This is an important indicator for sepsis diagnosis.
Oncology patient notes did not always contain a summary of the multidisciplinary team (MDT) held at the consultants NHS trust. As a result, staff did not have up to date information on the patient.

Summary of findings

	It was not always clear if equipment used for outpatient care had been cleaned.

Summary of findings

Contents

Good

Services we looked at

Surgery including endoscopy and services for children and young people; Outpatients & diagnostic imaging, and Oncology.

Summary of this inspection

Background to BMI Chelsfield Park Hospital

The hospital was opened in 1987, and benefited from a 3.5 million pound refurbishment programme during 2014/15.

The hospital provides a range of services including; general surgery, bariatric surgery (for weight loss), cosmetic surgery, diagnostic imaging, endoscopy, general medicine, oncology and physiotherapy. Patients are self-paying or use private medical insurance. Some services are available to NHS patients through the NHS choose and book system, and spot contracts. BMI Chelsfield Park has 36 registered beds with all rooms offering en-suite facilities, television and telephone. The hospital has two operating theatres (both with laminar airflow), a minor procedure theatre, seven consulting rooms and a minor procedure room.

The following services are outsourced:

- Agency clinical staff
- Catering services
- Instrument decontamination
- Pathology service
- Resident Medical Officer (RMO)
- Blood transfusion
- Laundry services
- Histo-Pathology
- Histology
- Radiation and Laser protection
- Magnetic Resonance Imaging (MRI)

Neither the dedicated assisted conception unit nor any of the outsourced service providers were included in this inspection.

We inspected the hospital as part of our planned inspection programme. This was a comprehensive inspection and we looked at two core services provided by the hospital: surgery to include endoscopy and services for children and young people. Outpatient and diagnostic imaging to include oncology and physiotherapy.

The registered manager is the hospital manager and has been in post at Chelsfield Park Hospital for one year at the time of the inspection; however, they have worked for BMI Healthcare for 26 years.

Our inspection team

Our inspection team was led by Stella Franklin, a CQC hospital inspection manager.

The team of seven included three CQC inspectors, a consultant surgeon, a head of nursing for children and neonates and a senior theatre nurse.

Why we carried out this inspection

We carried out this inspection as part of our annual programme.

How we carried out this inspection

To get to the heart of patients' experiences of care, we always ask the following five questions of every service and provider:

Is it safe?

Is it effective?

Summary of this inspection

Is it caring?

Is it responsive to people's needs?

Is it well-led?

Before visiting, we reviewed a range of information we held about the hospital, and additional information requested from the hospital. We carried out an announced inspection visit between 12 and 13 July 2016, and a routine unannounced inspection on 21 July 2016. We spoke with 19 members of staff, including managers, consultants, medical staff, registered nurses, health care assistants, operating department assistants, allied health professionals and administrative staff. We spoke with patients and relatives, and observed care and treatment. We also reviewed patients' records

Information about BMI Chelsfield Park Hospital

The hospital provides a range of services to patients at any age, though most commonly patients are aged 16 years and over. Between April 2015 and March 2016, 5% of the hospital's overall activity was care and treatment delivered to children between the ages of three and 15 years old. Of this activity, 1% was delivered to young people aged 16 or 17 years old. The total activity in the same reporting period for children under the age of three years old was also 1%. Adult patients aged 18 -74 years represented 81%, and those over 75 years represented 12% of overall hospital activity respectively during the same time frame.

There were 5,009 inpatient and day case episodes of care recorded at the hospital during the period April 2015 and March 2016; of those 18% were NHS funded, and 82% funded by other means. NHS funded patients accounted for 45%, and 24% of patients funded by other means stayed overnight.

During the same period there were 29,005 outpatient total attendances; 11% were NHS funded and 89% were funded by other means.

Hospital activity during the year April 2015 to March 2016 included:

- 3,600 day-case patients;
- 4,595 visits to theatre;
- 9,901 outpatients (first attendees) (NHS 1,089, other 8,812);
- 19,104 outpatients (follow up appointments) (1,963 NHS, 17,141 other)

Within the two main theatres between April 2015 and March 2016; the five most common procedures performed were:

- 342 Laparoscopy and therapeutic procedure including laser, diathermy.
- 280 Phako-emulsification of lens with implant.
- 161 Hysteroscopy including biopsy, dilation, curettage and polypectomy.
- 143 Multiple arthroscopic operations on knees, including meniscectomy.
- 123 Laparoscopic repair of inguinal hernia.

The most common medical procedures were:

- 247 Diagnostic colonoscopy, including forceps biopsy
- 186 Diagnostic oesophago-gastro-duodenoscopy (OGD), including forceps biopsy, biopsy urease test and dye spray
- 159 image guided injection(s) into joint(s)
- 155 Diagnostic endoscopic examination of bladder (including any biopsy)

The controlled drugs accountable officer was the hospital manager.

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?

Requires improvement

- Improvements were required to ensure a safe service was consistently provided. This included improving the completion of the World Health Organisation (WHO) 'five steps to safer surgery' checklist, and patient treatment and care records.
- Infection prevention and control practice in theatres and on the wards was mostly good. The use of personal protective equipment was not always used by consultants during procedures which may have posed as a risk of exposure.
- Staff were provided with relevant safety training, including safeguarding vulnerable people. They were knowledgeable about the hospital's safeguarding policy and clear about their responsibilities to report concerns. Staff were supported by a designated safeguarding lead. However, the number of staff trained to safeguarding level 3 did not meet the recommended guidance.
- Medicine optimisation was managed safely.
- Staff were fully aware of the incident reporting process, and there was a formal system for reviewing and learning such matters. The duty of candour was understood by staff with regards to incidents, which met the threshold of informing relevant individuals.
- Nursing staffing levels were organised to ensure the delivery of safe care. The service ensured a Resident Medical Officer (RMO) was on duty at all times.
- Consultants with practising privileges took ultimate responsibility for treatment and care.
- There were arrangements for communicating patient related information between shift changes, and at times when the admitting consultant needed to be made aware of their respective patient's condition. A national early warning score was used to identify patients whose condition might deteriorate, and transfer arrangements had been established for patients who required higher levels of treatment or care.

Are services effective?

Good

- Staff provided care and treatment, which took account of nationally recognised evidence based guidance and professional standards. Audit of practices followed a defined programme and included medicine management, and urinary catheters. Action plans were completed and acted upon where audits achieved less than 100% compliance.

Summary of this inspection

- Policies related to service provision at the location were shared with the Medical Advisory Committee and signed off, before disseminating across the staff groups.
- Pain management and nutritional support was integral to the provision of effective patient.
- There were effective arrangements for reviewing and agreeing consultant practising privileges, and for removing these when required information was not forthcoming. The revalidation of the consultants and registered nursing staffs fitness to practise ensured services could be delivered effectively.
- There were nine unplanned returns to theatre during the reporting period April 2015 to March 2016. Unplanned readmissions within 28 days of discharge for the same period was 18. There were five unplanned transfers of inpatients to another hospital, which was better than other similar independent hospitals.
- NHS Patients participated in the patient reported outcome measures (PROMS) data collection if they had undergone surgery for hip or knee replacement and inguinal hernia repair. Insufficient data was available for the period April 2014 to March 2015 (reported February 2016) to calculate the average adjusted health gain score for either primary knee or hip replacement.
- Staff had been provided with training in the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS) as part of mandatory training. They understood their responsibilities, and were clear about the processes to follow if they thought a patient lacked capacity to make decisions about their care. The Gillick test and the Fraser guidelines, which related to a child's capacity to give independent consent to medical procedures, were understood by relevant clinical staff.
- Patients were provided with information as part of the consent process; however, most patient notes reviewed showed consent was obtained on the day of treatment.

Are services caring?

Good

- The hospital participated in the 'friends and family test' (FFT). Between October 2015 and March 2016 the hospital reported 100% of patients would recommend the hospital to their friends and families. The amount of patients who responded to the test was moderate (between 30% and 58%).
- The Patient Led Assessments of the Care Environment (PLACE) between February 2015 and June 2015 privacy, dignity and wellbeing scored 92% compared to an England average of 87% for independent acute hospitals.

Summary of this inspection

- Staff recognised patients individuality and ensured they provided sufficient information and emotional support to enable a rapid recovery. Staff were respectful in their administrations, and treated patients and family members with kindness, courtesy and compassion.

Are services responsive?

Good

- The executive team worked with clinical commissioning groups to determine the range of surgical and other services provided to NHS patients within the surrounding population. Private provision of services reflected the agreed range of activities, based on the suitability of facilities, available support and risk criteria.
- An inclusion/acceptance criterion was applied by staff after assessing the patient's needs. High risk patients and those requiring complex surgery were not accepted. The admitting consultant would make decisions regarding the suitability of admitting patients with specific needs associated with dementia or learning disabilities.
- The Resident Medical Officer reviewed patients throughout the day and was available out of hours. Consultants reviewed their own patients and were required to attend to their patients within a thirty minute time frame, should the need arise. Transfer arrangements were set up in the event of a patient's condition deteriorating.
- The hospital dealt with complaints and concerns responsively, and learning from such matters was used to improve the quality of care.

Are services well-led?

Good

- Staff were aware of the expectations of executive team and understood what the vision and values were. They were supported by an effective and responsive leadership at the executive level, as well as their respective departments.
- Staff enjoyed working at the hospital, and described an open culture and of feeling valued and supported. The recent changes in management at the hospital were positively acknowledged.
- The Medical Advisory Committee worked with the executive team to ensure the monitoring of quality of services was reviewed, and challenged where needed. They were responsible for reviewed practising privilege, including fit and proper person information, before agreeing acceptance to use the service.

Summary of this inspection

- Governance arrangements ensured incidents, complaints, audit results and policy development were reviewed and learning was shared appropriately. However, the risk register was not sufficiently robust and lacked evidence of review dates for many of the identified risks.
- Staff were encouraged to continuously learn and improvement was fostered through training and development opportunities.
- The availability of capital helped the service to improve and develop services. Recent purchases included a bariatric operating table, new theatre stacker and endoscopes.
- As an approved service for Bariatric surgery, equipment was available to support the service, and a designated team of specialty trained staff worked with the consultant to ensure patients received the required standards of treatment and care.
- An enhanced recovery program provided a comprehensive rehabilitation program for orthopaedic patients, including specialised physiotherapy to achieve earlier mobilisation and discharge.
- The pharmacy manager had implemented a pharmaceutical care plan, and an antibiotic care plan had also been introduced to improve practices.
- The service was working toward obtaining accreditation for the endoscopy services with an external body.

Detailed findings from this inspection

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Surgery	Requires improvement	Good	Good	Good	Good	Good
Outpatients and diagnostic imaging	Requires improvement	N/A	Good	Good	Good	Good
Overall	Requires improvement	Good	Good	Good	Good	Good

Notes

Good

Surgery

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

Information about the service

BMI Chelsfield Park provides elective surgery to patients who pay for themselves, are insured or are NHS funded patients. Between April 2015 and March 2016, there were 4,595 visits to theatre.

Surgical operations included general surgery, ophthalmology, ear, nose and throat (ENT), orthopaedic including spinal surgery, urology, vascular surgery, neurosurgery, bariatric service and chronic pain procedures.

The hospital has two operating theatres, both of which have laminar airflow ventilation systems (a system of circulating filtered air to reduce the risk of airborne contamination). The hospital has 36 beds spread over two floors. There are no critical care facilities. In an emergency, the hospital transfers these patients to nearby NHS hospitals.

The on-site bariatric facility was recognised as a centre of excellence in 2013 and 2015. The service has also recently been re-accredited with the International Federation Surgically Obese award (IFSO). The department has two dedicated extended recovery beds for all level one post-op patients. Gastric bypass surgery is not performed at this hospital as it does not have the required level two (high dependency) facilities. Gastric bypass surgery is performed at another BMI hospital, and any outpatient appointments are conducted at the Chelsfield Park Hospital.

Between April 2015 and March 2016 there were 3,600 day case and 1,409 inpatient treatments. The NHS funded approximately 18% of those treatments.

There were 247 diagnostic colonoscopies, 186 diagnostic oesophago-gastro-duodenoscopies, 159 image-guided injections into joints and 155 diagnostic endoscopic examinations of the bladder amongst others during the reporting period. The hospital does not perform endoscopic examinations on children and young persons under sixteen years.

The most commonly performed surgical operations were:

- Laparoscopy and therapeutic procedure including laser and diathermy.
- Phako-emulsification of lens with implant –unilateral;
- Hysteroscopy including biopsy, dilation, curettage and polypectomy;
- Multiple arthroscopic op on knee including meniscectomy;
- Laparoscopic repair of inguinal hernia – unilateral
- Arthroscopic meniscectomy
- Laparoscopic cholecystectomy
- Total prosthesis replacement knee joint, with/without cement

Surgeons carried out the majority of procedures on weekdays, with theatre one also open on weekends and theatre two also open on Saturday (weekend opening according to planned activity).

The hospital carries out surgical treatments for children and young people over the age of three years. In the period April 2015 to March 2016 there were 209 day case treatments for children and young people. Children are admitted to the ward as day case patients and have their own private room.

The inspection included a review of all the areas where patients receive care and treatment. We visited the pre-assessment clinic, the surgical ward, anaesthetic rooms, theatres and recovery area. We spoke with six patients and reviewed seven patient records. During the

Good

Surgery

inspection we spoke with 11 members of staff, including managers, medical staff, and registered nurses, health care assistants, operating department assistants, allied health professionals, and administrative staff. Before, during and after our inspection we reviewed the hospital's performance and quality information.

Summary of findings

We rated surgical services as requires improvement for safe and good for effective, caring, responsive and well-led.

- The World Health Organisation (WHO) 'five steps to safer surgery' checklist was not always fully implemented.
- During our inspection we looked at a selection of patient notes and found there were a number of sections not completed, for example; incomplete patient details, pre-op checklist incomplete, incomplete anaesthetic record, no pre-op verification list completed.
- The number of staff trained to safeguarding level 3 did not meet the recommended guidance.
- Consultants did not always follow best practice guidelines with regard to infection prevention and control.
- Most areas of the service we visited were visibly clean, with the exception of the sterile room within the theatre complex, and there were systems to support the safe delivery of care and treatment.

We also found;

- Surgical services provided good care and treatment to patients. Nursing and medical staff were caring, compassionate and patient centred in their approach. Patients felt they received enough information about their treatment and were involved in decisions about their care. We observed staff maintain patients' respect and dignity at all times. Patients reported being happy with their care and described the staff as lovely.
- Medical and nursing staff carried out effective risk assessments from pre-assessment through to discharge. They planned treatment, recovery and discharge in line with patients' specific needs.
- Staff followed evidence based care and treatment, and monitored and reviewed patient outcomes. The Staff worked effectively across different disciplines and had good links with staff at other BMI hospitals and local NHS services.

Good

Surgery

- There was effective and responsive leadership at the executive level, and staff commented favourably on the hospital manager and other senior leaders
- Governance arrangements ensured that incidents, complaints, audit results and policy development were reviewed and learning was shared appropriately.

Are surgery services safe?

Requires improvement

We rated safety as requires improvement. This was because:

- The World Health Organisation (WHO) 'five steps to safer surgery' checklist was not always fully implemented, namely 'time out' and 'sign out'
- The number of staff trained to safeguarding level 3 did not meet the recommended guidance.
- Patient treatment and care records were not always properly completed.
- We observed the available personal protective equipment (gloves) was not used in the anaesthetic room during the insertion of a cannula.

However;

- There were no hospital acquired infections between April 2015 and March 2016.
- Staff understood their responsibilities to raise concerns and report incidents, and there was evidence learning occurred as a result.
- Most clinical areas were visibly clean and all were appropriately equipped to provide safe care and treatment.
- Infection prevention and control practice in theatres and on the wards was good. Infection prevention and control link staff in all departments provided advice and guidance for staff.
- Staff were knowledgeable about the hospital's safeguarding policy and clear about their responsibilities to report concerns.
- Nursing staffing levels were sufficient to provide safe care. Hospital managers responded quickly to address any staff shortages.
- A resident medical officer was on duty at all times, and consultants took responsibility for overseeing the treatment of patients admitted under their care.
- Staff were provided with safety training.
- Staff routinely assessed and monitored risks to patients. They used the national early warning score to identify patients whose condition might deteriorate. There were appropriate transfer arrangements to transfer patients to a local NHS hospital if required.

Good

Surgery

Incidents

- A robust process was used to consider serious incidents and never events. A never event is defined as: 'a serious, largely preventable patient safety incident that should not occur if the available preventative measures have been implemented by healthcare providers. Although each Never Event type has the potential to cause serious potential harm or death, harm is not required to have occurred for an incident to be categorized as a Never Event'.
- We reviewed the root cause analysis (RCA) investigation report provided to us for a wrong site regional anaesthetic block. This event occurred in November 2015 and was deemed to be a never event under the NHS England never events list 2015/16.
- The RCA was sufficiently detailed, covering contributory factors, chronology, root cause, recommendations and lessons learnt. We saw details regarding the support provided for the patient and staff, and the duty of candour to be open and honest had been adhered to, although there is no record of a written apology being given to the patient. A detailed action plan accompanied the RCA and lessons learnt had subsequently been communicated to staff formally in meetings, which were minuted.
- The Serious Injury incident, which occurred in January 2016, concerned an elderly patient who received a new lens from a batch which had been the subject of a field safety notice on 31 December 2015, and as such should not have been used. The RCA was again sufficiently detailed, with a comprehensive action plan. The duty of candour was adhered to.
- Staff had access to information related to duty of candour. This was in the form of the corporate 'Being Open and Duty of Candour Policy'. The policy indicated training on duty of candour was incorporated into risk management training, and staff also had access to e-learning through the National Reporting and Learning Service, (NRLS).
- During the reporting period there were 392 clinical incidents; 90% of those occurred in surgery or inpatients and 10% in other services. 316 of those were recorded as causing no patient harm, 78 as low and 19 as moderate and one as severe. When analysed over the reporting period as per 100 bed days the rate of clinical incidents was over 14% higher than the data we held for other independent hospitals (12 records).
- The Quarterly Clinical Report, 1 January to 31 March 2016 was reviewed and we noted Mortality and Morbidity figures were reported on. There had been no in-patient mortalities or deaths within 30 days of surgery.

Duty of Candour

- From November 2014, NHS providers were required to comply with the duty of candour, Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. 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 we interviewed were fully aware of the duty of candour regulation (to be honest and open) thereby ensuring patients received a timely apology and support.
- Both RCA's for the notified incidents provided evidence of the duty of candour being properly implemented by staff.

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

- The NHS Safety Thermometer is a tool for measuring, monitoring, and analysing patient harms and 'harm free' care on one day each month. The hospital audited and monitored avoidable harms caused to patients. On the first floor ward we observed a safety thermometer displaying venous thromboembolism (VTE) assessments, number of patient pressure sores (0), Meticillin Resistant Staphylococcus Aureus (MRSA) and Clostridium difficile (C. diff) swab results, both zero.
- Staff routinely assessed patients for VTE and the screening rate was 100% for the whole of the reporting period from April 2015 to March 2016.

Cleanliness, infection control and hygiene

- During the period April 2015 to March 2016 there was no incidence of meticillin Resistant Staphylococcus Aureus (MRSA), meticillin Sensitive Staphylococcus Aureus (MSSA), Clostridium difficile (C. diff) or Escherichia coli (E-coli) reported.
- The environment in which treatment and care was delivered was found to be subject to high levels of cleaning by suitably trained staff.

Good

Surgery

- The operating theatres had been subject to a deep clean on 8 and 30 April 2016.
- Our observations of the wards indicated areas were clean, tidy and well organised.
- In the patient-led assessment of the care environment (PLACE) audit in 2015, the hospital scored 98% for cleanliness, equal to the national average for independent hospitals.
- Within the theatre area was a sterile store room which contained a number of very dusty trolleys and out of date equipment. We escalated this to the theatre manager who swiftly organised cleaning and checking of the trolleys and equipment.
- Staff who spoke with us described the arrangements for cleaning areas, including the process for deep cleaning patient rooms in the event that a patient subject to isolation precautions had vacated.
- Cleaning equipment in use reflected the recommended national colour codes, which helped to minimise risks of cross contamination.
- Guidance for the frequency, methods of cleaning and products to be used were available to staff.
- Staff with direct cleaning duties confirmed they had been subject to supervisory training as part of their induction, which ensured they understood the requirements of the role.
- Minutes from health and safety meetings reviewed by us indicated incidents related to waste management and cleanliness were discussed.
- Throughout the hospital we observed there was a high level of provision to personal protective equipment (PPE), and staff were seen to use it. Items available to staff included gloves and plastic aprons. However, an anaesthetist was observed in the anaesthetic room inserting a peripheral cannula into a patient without wearing gloves, which is contrary to NICE guidance.
- The disposal of used sharps items was generally done so safely. It was noted a used giving set with blood contaminant was protruding from a sharps box in the sluice room of ward two.
- Testing of water on-site for Legionella bacteria was carried out twice weekly on the wards by housekeeping, and yearly hospital wide checks are undertaken by an external specialist company.
- Commodes checked by us were found to be clean.
- The director of clinical services was the designated director for infection prevention and control (DIPC).
- The DIPC was supported by a lead for infection prevention and control (IPC), and there were designated link staff representatives from each clinical area and housekeeping.
- The IPC lead was undertaking an associated degree to support their role.
- The ward link nurse had 10 hours a week designated for IPC activity, including audits and data management.
- Monthly link meetings had commenced in October 2015 for IPC, and minutes reviewed by us confirmed a range of matters were discussed. For example, audit findings, new policies, sharps awareness, waste management, and training, as well as patient satisfaction feedback. Where actions were required, these were identified with a responsible owner assigned. Subsequent meeting minutes indicated updates on actions were discussed.
- Care setting rapid improvement tools were used to monitor various IPC elements. We reviewed a number of reports and noted for example, the first floor ward results for May 2016 achieved an overall score just below 93%. In physiotherapy they scored 70%. The scores for imaging in July 2016 were 100%.
- Various care bundles were expected to be monitored as part of patient safety, including IPC. Monitoring included the insertion of peripheral cannula and ongoing assessment of these, as well as urinary catheters.
- The first floor ward scored 80% in June 2016 audit for the peripheral cannula care bundle. We noted the same audit undertaken in theatres in May 2016 identified only 50% compliance for the hand hygiene component of the peripheral cannulation care bundle. An action plan accompanied the report and this was followed up in June 2016, with a result achieved of 100%.
- Results from IPC audits carried out in theatres and on the wards were reviewed by us. For example, hand hygiene outcomes for theatres in April 2016 showed 100% of observed staff were bare below elbows and 90% of staff were observed to follow hand hygiene practices. In May 2016 theatre staff scored 80%, for being bare below elbows, and 90% for hand hygiene.
- The incident reporting system was used to report post-operative infections; blisters associated with wound dressings, and positive wound swab cultures associated with a Surgical Site Infection occurring within 30 days or a year for total hip or total knee replacements

- We asked for information about the post-operative infection rates, which were noted to be higher than expected. The information provided indicated these had been fully reviewed, and no trends had been identified to suggest practice related concerns.
- Staff had access to up to date electronic and hard copy IPC policies and procedures, a sample of which we reviewed.
- Mattress audits were undertaken at regular intervals. Where mattresses were deemed to have lost their impermeable protection, they were escalated to the IPC lead for action. Action taken included destruction and replacement.

Environment and equipment

- Clinical hand basins were not provided in patient rooms. This did not comply with Health and Building Notice (HBN) 009 (2013). There were clinical hand basins however in the two bariatric extended recovery rooms.
- The flooring in some patient rooms was not compliant with HBN (2013), 0010 part a, as it was carpet and not a sheet system type of flooring. The management were aware and a phased replacement was planned over the coming year.
- The wards and theatres had mobile resuscitation trolleys for use if a patient had a cardiac arrest. Records showed staff checked the trolleys daily in line with professional guidance to ensure equipment was available and in date. The paediatric resuscitation trolley was checked on days when paediatric patients were scheduled and placed in the location where those patients would be.
- The theatres had paediatric recovery areas but we were told the staff did not like to draw the curtains leading to concerns about privacy and dignity. There was also the concern the children may be visible to other patients and/or see and hear things which may disturb them.
- In the patient-led assessment of the care environment (PLACE) audit in 2015, scored 97% against the national average of 92% for condition, appearance and maintenance.
- The risk register identified an environmental red rated risk within surgery, which concerned the scrub sinks in anaesthetic rooms one and two, which did not have the right taps, and overflows. It has been identified additional funds would be required to correct the scrub sinks. The hospital action plan had scheduled completion of this task for September 2016.
- Although generally clean and tidy the theatres and anaesthetic rooms appeared dated and in need of maintenance. There were defects to paint on the walls and scuffs to paintwork. Some wall edging in the scrubs room was coming away from the wall.
- All decontamination of surgical instruments and endoscopy equipment was carried out off-site.
- Equipment within the hospital was asset tagged and basic maintenance was carried out by the on-site engineers. There were two specialised companies contracted to provide routine checking of equipment and more in depth maintenance and repair.
- There was an annual validation of the theatres by an external contractor. The laminar flow filters were changed every quarter and the chlorination system every six months.

Medicines

- On the ward and in theatre, medicines including controlled drugs, and intravenous fluids were stored securely in locked cupboards and inside locked rooms. The lead nurse on duty kept the keys for the controlled drugs on her person. Staff on the ward kept medicine trolleys locked and secured when not in use. Pharmacists held BMI private prescription pads securely.
- Staff monitored fridge and room temperatures and took appropriate action when temperatures were outside the recommended range to store medicines safely.
- Pharmacy and nursing staff monitored and managed stock levels of medicines and controlled drugs appropriately. Staff completed the controlled drugs registers in line with current national guidance and the hospital policy.
- Out-of-hours the RMO together with a nurse and a porter could gain access to stock items from the pharmacy.
- There were piped medical gases in the theatres and piped oxygen in each patient room. Portable oxygen was also available for patient transfer between ward and theatre if required.

Records

- The hospital used patient records in paper format in the form of standardised pre-formed booklets. These provided a clear colour coded pathway for staff to follow from pre-operative assessment to discharge and post care contact, although these records were not always properly completed.

Good

Surgery

- We reviewed seven patient records and found there were areas not properly completed in three of them such as incomplete patient details, incomplete pre-op checklist and anaesthetic records, and incomplete pre-op verification list. Two of the records had just a few incomplete items but the third record had over 17 areas not completed.
- A post-operative care 48 hour follow-up telephone call was part of the inpatient care pathway document. However, we found the calls relating to paediatric patients were completed but not documented on the records we reviewed.
- We observed the records store on the second floor was always kept locked unless occupied.
- GP patient referrals under the 'choose and book' scheme were emailed to the admin suite and subsequently triaged by clinical staff.
- The records of patients not seen for a year were kept securely off-site, with protocols in place to ensure their timely retrieval if required. The records are scanned within 10 days and are accessible via an online system to key staff.
- There was a BMI audit programme supported by an audit calendar, which included medical and nursing records. The hospital patient health record audit in January, February and March 2016 were 98%, 89% and 92% respectively.

Safeguarding

- The director of clinical services was the overall lead for safeguarding adults and children (level 3 trained).The lead paediatric nurse was the safeguarding lead for children (level 4/5 trained) and attends the Bromley London safeguarding children's board (LSCB) four times a year.
- Figures provided by the hospital stated there were three staff trained to level 3 and 22 trained to level 2. The remainder of the staff were trained to level one.
- NHS England provides guidance on the required level of safeguarding training. The number of staff trained to level 3 did not meet the recommended guidance.
- A paediatric nurse accompanied each child patient who was undergoing surgery as far as the anaesthetic room, and then attended the recovery area with the child's parents after the procedure.
- The director of clinical services confirmed the hospital was putting measures in place to ensure all clinical staff were trained to at least safeguarding level 2.
- The director of clinical services confirmed the paediatric consultants were trained to safeguarding level 3.
- Up to date policies on safeguarding for both adults and children were available to all staff on the hospital's intranet.

Mandatory training

- A role-specific mandatory training plan was automatically assigned to each staff member in the BMI e-learn system. Staff completed most training electronically but this was supplemented by practical training where appropriate.
- At the time of our inspection 90.7% of staff were fully compliant with mandatory training, which included; adult basic life support, infection prevention and control amongst many others.
- Individual training records were kept and staff could access this information online.

Assessing and responding to patient risk

- Theatre staff used the 'five steps to safer surgery' WHO checklist; this is a nationally recognised system of checks before, during and after surgery, designed to prevent avoidable harm and mistakes during surgical procedures. However, its use was described as perfunctory by our specialist advisor. On one observed occasion Step 3 'time out' was not completed prior to surgery but it was later seen to be documented as having been done. A senior theatre practitioner told us there was no standardisation of practice as clinicians came from different trusts, and used the WHO checklist in different ways. However staff regularly audited completion of the checklist and results for January, February and March 2016 showed 100% compliance as reflected in the hospital's quarterly clinical report. The audit results did not correspond with our observations but may be explained by the completion of a checklist after the event as witnessed by our inspector.
- Patients completed a health questionnaire, which nursing staff reviewed at pre-assessment to assess the suitability of patients for surgery at the hospital. Staff confirmed if the pre-assessment raised concerns they would escalate the issue to the surgeon or anaesthetist by telephone or email for further assessment. Patients had to meet certain criteria before the hospital accepted them for surgery. For example, the hospital did not accept NHS patients with a body mass index (BMI) greater than 40 as part of the exclusion criteria within the contract.

- We observed a pre-admission consultation in which a thorough medical history was taken from the patient. The procedure to be done was fully explained along with expected outcomes, aftercare and the importance of post-op mobility. The patient had bloods and swabs taken in privacy behind a curtain. He was given a safety leaflet as he left.
- Procedures to monitor patients for any deterioration in their health were used by staff. The hospital used the national early warning system (NEWS) after surgery to record patient observations, and a standard scoring system was used across all patient pathways. Staff initiated the NEWS scoring in recovery and continued it on the ward. Staff we spoke to knew how to escalate concerns if a patient's observations deviated from expected ranges.
- A paediatric early warning system (PEWS) was used for children and young people; although it was noted the PEWS scores were not consistently added up. The lead nurse audited PEWS and informed staff of any poor completion.
- Staff had access to detailed guidance, including the required action to take in the event of a patient, including children deteriorating and requiring transfer out of the hospital. The Emergency Transfer of Patient policy provided an outline of responsibilities of consultants and senior clinical team members.
- An Escalation and Transfer of Patient standard operating procedure provided further guidance and instruction to staff for the transfer of patients needing a higher level of care. Such transfer decisions were made subject to the outcomes of the patient vital signs as recorded on the NEWS. The arrangements for transfer were set up with a local NHS trust location and the relevant ambulance service details and contact numbers were provided.
- The aforementioned policy indicated all registered nurses and health care assistants (HCA) working on the ward were required to complete training in Acute Illness Management (AIMs) every three years.
- The resident medical officer (RMO) confirmed in discussion with us the nursing staff would alert them to any concerns about the patients. Assessment and immediate action would take place and they would make the patients admitting consultant aware. Whilst the RMO did not know the actual procedure or which hospital transfer agreement was set up with, they said decisions about transfer would be made in conjunction with the consultant.

Nursing staffing

- The hospital used the BMI Patient Dependency and Nurse Planning Tool to plan the skill mix of staff four weeks in advance, with continuous review on a daily basis. Theatres were currently only planning rosters two weeks in advance.
- We were told the recruitment of permanent theatre staff was challenging. The theatre staff establishment was fifteen whole time equivalent (WTE). This was supplemented with long term bank staff familiar with BMI practices.
- Paediatric patients were planned admissions to ensure the required specially trained staff were available. Patients under the age of 12 required two paediatric specialist nurses.
- We observed a morning ward handover. There were seven members of staff in attendance and they took notes against the handover sheet. Patient names, room number and preferred names to be called were given for all patients. Good details on each patient were given including pain, mobility and allergies. Details of the day admissions and tasks were spoken about before the handover concluded.
- The 'dashboard' displayed on the ward showed the required staff and the actual staff on duty as being equal.
- We found the induction programme for theatre agency staff, which had been reviewed and updated by the interim theatre manager, very comprehensive. For contracted staff, depending on the individual, the induction took place over a three month period. All of the staff were consulted and contributed to the programme. In the recovery area we also witnessed excellent support by a recovery practitioner for an Italian nurse who had just obtained her registration pin.

Medical staffing

- Consultants with admitting rights were responsible for overseeing the treatment and care of their patients. They were not based in the hospital but were expected to review their patients and be available to respond to nursing or medical staff questions or concerns.
- The hospital had an RMO, who was provided through an agency under a corporate agreed contract. The RMO worked on two weekly rotations, covering the service 24/7, with sleep-in facilities provided.

Good

Surgery

- All children were looked after by consultant medical staff, whose practising privileges included paediatrics. The consultant in charge was accessible via the telephone and based within 10 miles of the hospital according to their practising privileges.
- An anaesthetist with paediatric practising privileges was also available during the day and on call at other times.
- Verbal handover between outgoing and incoming RMO was said to cover in-patients and any particular requirements.
- The RMO confirmed they had been working at the hospital for two months. Their shifts commenced at 8am, when they reviewed patients and undertook interventions, such as blood samples for testing. They had a break of one hour at lunchtime and then commenced an afternoon shift from 1pm to 6pm. An evening review of patients according to need took place before retiring for the night. Nursing staff were able to contact the RMO during the night if needed, but they had not experienced frequent disturbance. They added the experience of the nursing staff affected the amount of disturbance, sighting agency staff as not always having the same level of experience.
- Staff reported variation in the RMOs, with regard to language skills and understanding of the medicines used.
- In line with the consultant practising privileges requirements the admitting consultants were responsible for the patients care management for the duration of their stay. For surgical patients the anaesthetists were also responsible for the patients prior, during and after surgery. They were expected to be contactable twenty four hours a day, seven days a week if required, or to arrange cover if they were not available.

Major incident awareness and training

- The hospital staff had access to two separate policies to support the delivery of service. The Business Continuity Policy provided strategic and operational information for preparedness and response to adverse situations or events. Roles and responsibilities were defined, along with risk assessments and planning arrangements. The Business Continuity Plan defined location related information, and identified the locations quality and risk lead as the nominated person for this area.

Are surgery services effective?

Good

We rated effective as good. This was because:

- Staff provided care and treatment that took account of nationally recognised evidence based guidance and standards.
- Patients reported staff managed their pain effectively and they had access to a variety of methods for pain relief.
- Patients were advised about pre-surgery fasting times and the hospital aimed to ensure they were kept to a minimum to help prevent dehydration and post-operative complications.
- There were formal systems for managing and facilitating the revalidation of both the consultants and registered nursing staff.
- The hospital held daily '10@10' staff meetings where information from all departments was shared and cascaded to the remaining staff in their respective departments.

However,

- The majority of patient notes reviewed showed consent on the day of treatment, and we were not clear from records if patients had been given sufficient information to enable them to reflect on the surgical procedure beforehand.

Evidence-based care and treatment

- Staff provided care to people based on national guidance, such as the National Institute for Care Excellence (NICE) guidelines. We saw evidence of discussion of updated NICE guidelines and drug alerts and recalls in clinical governance meetings.
- There was a hospital program of audits undertaken, which included audits such as theatre medicine management (85% compliance), ward medicine management (96% compliance), urinary catheter insertion 10 patient sample (100%) compliance. We saw action plans with dated completion requirements for those audits with less than 100% compliance.
- Patients over 50 years of age, those undergoing a procedure requiring a longer than one day hospital stay and those under 50 having a major procedure will all have a pre-assessment. Patients not meeting these criteria may not have a face to face pre-assessment.

- Paediatric patients were triaged booked into outpatients for an initial consultation. Those requiring surgery were then pre-assessed by one of the paediatric specialist nurses.
- There were different care pathways for staff to follow dependent on the type of clinical procedure, such as the Adult Inpatient Day Case pathway and the Endoscopy pathway. They were all documented and evidence based. Paediatric care pathways were used for paediatric patients.
- The hospital followed NICE guidelines for preventing and treating surgical site infections (SSIs) using the SSI bundle. There were five SSIs in the reporting period April 2015 to March 2016. A review of these did not suggest any evidence to indicate poor hygiene or infection control practices were a contributory factor to SSIs.
- The hospital was moving towards accreditation by the Joint Advisory Group on gastrointestinal endoscopy (JAG). This is a quality improvement and service accreditation programme for gastrointestinal endoscopy.

Pain relief

- Nurses discussed post-operative pain relief with patients at pre-assessment, and gave them information leaflets about pain control and anaesthesia. This included information about different types of pain relief and pain scoring. We also observed anaesthetic consultants discussing post-operative pain relief with patients.
- Pain scores were recorded in recovery and the patients were not discharged from recovery until the anaesthetist had controlled the pain. Nursing staff completed the day care pathway which included pain assessment and score recording. We spoke to patients who were happy with their pain control measures.
- Pharmacy staff conducted a daily ward round and reviewed all new patients' medicine care plans. They also discussed pain control and informed patients about take home medications.
- A pain assessment tool featuring smiley faces was used for paediatric patients.

Nutrition and hydration

- Staff advised patients about fasting times prior to surgery at pre-assessment and in their booking letter. The hospital aimed to ensure fasting times were as short as possible before surgery to prevent dehydration and reduce the risk of post-operative nausea and vomiting.
- Intravenous fluids were given as required and monitored as part of the day adult day case pathway.
- The Malnutrition Screening Tool (MUST) was used as part of the adult risk assessment documentation. Patients had access to a dietitian if required.
- The hospital offered light snacks and drinks for day care patients before discharge home.

Patient outcomes

- There were nine unplanned returns to theatre in the year to March 2016. This was a rate of 0.2 per 100 theatre visits. In the year to March 2016 there were 18 unplanned readmissions within 28 days of discharge. This was not high when compared with other independent hospitals.
- The rate of unplanned transfers of inpatients to another hospital was better than other similar independent hospitals. There were five cases during the same reporting period. These were reviewed and did not indicate any underlying themes.
- NHS Patients participated in the patient reported outcome measures (PROMS) data collection if they had undergone surgery for hip or knee replacement and inguinal hernia repair. PROMS measures the quality of care and health gain received from the patient's perspective. There was insufficient data available for the period April 2014 to March 2015 (reported February 2016) to calculate the average adjusted health gain score for either primary knee or hip replacement.

Competent staff

- Staff confirmed they received an annual performance review in October, regardless of start date. They told us they also had a half year review. Appraisals were recorded electronically.
- We were told by the interim theatre manager all theatre staff had appraisals completed between December 2015 and January 2016.
- The resident medical officer (RMO) was provided through a contractual arrangement with an external body. The agency was required to provide evidence of their training, competencies and professional records.
- Consultants who worked in the NHS were required to submit evidence of their appraisal. For consultants who had retired from the NHS, we were told their appraisal was undertaken by the medical director or someone appropriate. This was managed at head office.

- We saw there was a database for recording when consultant appraisals and other essential evidence was due to expire, had been received or was overdue.
- Information related to appraisals was submitted to the regional manager as part of the monitoring of required standards.
- The service was actively supporting nurses to achieve their revalidation and a number of nurses had already done so. A formal database identified when revalidation was due, and the director of nursing and clinical services supported the process.
- Revalidation was part of consultant fitness to practice and agreeing practising privileges of consultants. We saw there was a formal system for managing both these elements. Documentation was provided for consultants and held in their personnel files. A designated member of staff had responsibility for chasing records when due, unless provided by the individual.
- The Medical Advisory Committee (MAC), reviewed new applicants, and those who were removed as a result of the required information not being provided.
- The paediatric lead nurse attends the BMI children's steering committee three times a year.

Multidisciplinary working

- The hospital held daily '10@10' staff meetings where information from all departments was shared and cascaded to the remaining staff in their respective departments.
- We observed a theatre briefing involving seven staff, a consultant surgeon, an anaesthetist and nursing staff. Staff introduced themselves, and were given the chance to raise any concerns or issues. The consultant led the briefing, which covered the day's list, and each patient was discussed.
- Physiotherapy staff supported effective recovery and rehabilitation, including an appointment at pre-assessment for patients having orthopaedic surgery, and follow up at outpatient clinics. They visited the ward daily including weekends. They also had a good relationship with the local respite centre. Physiotherapy staff did not attend any MDT meetings but took part in the ward handovers.
- There were monthly ward meetings during which information from the clinical governance meetings was shared. Staff signed to indicate they had read the minutes of the meetings, which were also available on the hospital's shared drive.
- The hospital had a service level agreement (SLA) with a local trust and a private ambulance service for the transfer of deteriorating patients from Chelsfield Park. There was also the option of using the standard 999 system, depending on the circumstances.

Seven-day services

- Nursing staff were available on the ward seven days a week.
- The normal operating hours for theatre one Monday to Friday were 7am and 9pm Monday to Friday, Saturday 8am until 4pm and 8am until 2pm on Sunday. Theatre two began an hour later during the week and was closed on Sunday. Weekend operating was only according to planned activity. Theatre three's normal operating hours were 7am to 11am on Monday, Wednesday and Friday. An on call surgery team was available outside normal working hours.
- Consultants provided 24 hour on call cover for their patients or organised cover by a consultant colleague if they were not available. Those with patients on the ward conducted daily ward rounds.
- A resident medical officer (RMO) was available on site 24 hours a day, seven days a week.
- Physiotherapists were available during the working day, evenings and at weekends.
- Pharmacy services were available 8.30am until 4pm Monday to Friday. They provided a service 8.30am -1pm on a Saturday. Basic packs of some take home medicines were available on the ward in a designated cupboard. If needed a nurse, the RMO and a porter could access pharmacy for stock items out of hours.

Access to information

- The hospital kept records on site for a year after admission, after which they were sent to an offsite storage facility. Staff could access paper records stored offsite within 24 hours. Key staff also had access to scanned records within 10 days of the records being sent off-site.
- Staff were able to access hospital policies and procedures via the intranet as well as contact details for consultants and other staff.
- There was a general information folder within the theatre area available for all staff to communicate.

Good

Surgery

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- From the majority of the patient notes reviewed we noted consent for the surgical procedure had been obtained on the day of the operation, although it was likely there would have been a verbal discussion with the consultant earlier in the process. Patient's consent should ideally be secured in advance, so they have plenty of time to obtain information about the procedure and ask questions. The Royal College of Surgeons offers the following guidance in its booklet 'Consent – Supported Decision-making 2016', "Patients should be given enough time to make an informed decision regarding their treatment, wherever this is possible and not adverse to their health".
- Patients received information prior to their endoscopy procedure. This allowed patients to read the information and, if understood, give informed consent when they came for their procedure. Consent forms appropriately detailed the risks and benefits to the procedures, and were signed.
- Staff assessed patients' mental capacity to make decisions about their care and treatment at pre-assessment. Staff were clear about the processes to follow if they thought a patient lacked capacity to make decisions about their care.
- The hospital provided training in the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS) as part of mandatory training. DoLS are to protect the rights of people, by ensuring any restrictions to their freedom and liberty have been fully considered and authorised by the local authority.
- Staff were aware of the Gillick test and the Fraser guidelines, which relate to a child's capacity to give independent consent to medical procedures. There were specific consent forms for children but during our inspection the paediatric patients were young children and consent had been obtained from their parents or guardians.

Are surgery services caring?

Good

We rated caring as good. This was because:

- We observed staff treated patients with kindness and compassion during our visit. Staff maintained patients' dignity and respect at all times.
- Feedback from patients about their care and treatment was consistently positive.
- Patients told us they had sufficient information about their treatment, including costs, and were involved in making decisions about their care.
- Staff provided good emotional support to patients and their relatives. They went out of their way to ensure their individual needs were met.

Compassionate care

- We observed compassionate and caring interactions from all staff. Patients were positive about the care and treatment they received. They described staff as friendly, helpful, caring, considerate, kind and respectful. Patients said, "Staff are lovely, as expected" and "Excellent, all the staff are lovely, in the ward and theatre. The "anaesthetist's a charmer".
- Feedback from parents of paediatric patients was also positive. One parent said she especially liked that the nurse who had taken care of her son previously asked to take over from the assigned nurse on the most recent visit.
- We observed staff referring to patients by their recorded preferred name. Patients were seen to be treated with dignity and their privacy respected. This view was confirmed by the patient's themselves.
- Both the hospital manager and the director of clinical services made time to 'walk the hospital' speaking to staff and patients.
- The hospital participated in the 'friends and family test' (FFT). During the reporting period October 2015 to March 2016 the hospital reported 100% of patients would recommend the hospital to their friends and families. The amount of patients who responded to the test was moderate (between 30% and 58%).
- In the Patient Led Assessments of the Care Environment (PLACE) between February 2015 and June 2015, results for privacy, dignity and wellbeing scored 92% compared to an England average of 87% for independent acute hospitals.

Good

Surgery

Understanding and involvement of patients and those close to them

- Patients, and their relatives, where appropriate, were fully involved in the discussion of treatment and care. They were encouraged to actively participate in the programme of recovery, and were enabled to do so by having open visiting.
- We observed a full and detailed handover from recovery practitioner to the ward nurse. The patient declared they were happy with all of the treatment received.
- The parents of paediatric patients (children and young people) could accompany their child into the anaesthetic room and then were called to recovery when the patient awakes.
- The costs of treatment were discussed fully with patients, including what was covered within the cost including tests, investigations and follow up visits, should they be required.
- Information related to different payment methods was available on the hospital web site, as well as via the hospital.

Emotional support

- There was open visiting on the wards to allow patients to have emotional support from family and friends.
- Staff recognised and responded to patient's emotional needs, including the specific needs of children and young people in ways that were respectful, kind and reassuring
- As part of the discharge pathway patients could be referred to aftercare, rehabilitation support groups and counselling.

Are surgery services responsive?

Good

We rated responsive as good. This was because:

- The provider and clinical commissioning groups determined the range of surgical and other services provided.
- The provider planned and delivered services in a way which met the needs of the local population. The service reflected the importance of flexibility and choice.
- Staff assessed patient's needs, and the hospital was able to take the needs of different people into account when planning and delivering services.
- The hospital dealt with complaints and concerns promptly, and there was evidence the hospital used learning from complaints to improve the quality of care.

However,

- There was an issue with gynaecological patient flow, reflected in the higher than average day case to inpatient conversions.

Service planning and delivery to meet the needs of local people

- The hospital developed NHS services in conjunction with the local clinical commissioning groups (CCGs). The CCG checked the hospital provided NHS patients with services in line with agreed quality criteria at quarterly contract meetings.
- The hospital pre-planned all admissions to allow staff to assess patients' needs prior to surgery or medical care. They accepted patients for treatments with low risks of complication, and whose post-operative or medical care needs were met through ward-based nursing.
- Children could visit the ward and meet staff in advance if they wished.
- There were no facilities for emergency admissions and commissioners and the local NHS trust understood this.
- The paediatric lead manages the surgical list to ensure there are no more than three tonsillectomies per day to mitigate the risk from postoperative haemorrhage.

Access and flow

- There were 3194 surgical procedures carried out during the period April 2015 to March 2016. The hospital reported it cancelled 15 procedures during that time for non-clinical reasons; of those 14 patients were offered another appointment within 28 days of the cancelled appointment.
- The hospital met the target of 92% of all admitted NHS surgical patients beginning treatment within 18 weeks of referral to treatment (RTT) during the reporting period, apart from May and July 2015 when it fell to 88%.
- In the reporting period, 1168 of the surgical procedures were gynaecological in nature. During the inspection pre-planning it was noted the overnight stays for NHS funded patients was 45.4% compared to 24.4% for other funded patients, yet NHS patients only accounted for 18% of the total number of patients. This was raised during the inspection and we were told part of the reason was many of the gynaecological procedures

were carried out during the afternoon or later as the surgeons completed their NHS hospital work in the mornings. Certain post-surgery milestones needed to be completed before the patient could be discharged, which would often mean for patient safety they would stay overnight.

- The hospital's quarterly clinical report for the quarter ending March 2016 reported a total of 52 day case to inpatient conversions, of which 35 were gynaecology patients. The director of clinical services confirmed no additional cost was passed on to the NHS in those circumstances.
- The two main theatres were open each weekday and theatre one opened on Saturday and Sunday, and theatre two opened on Saturday, both according to planned activity.
- The paediatric surgical list started at 7.30am to enable recovery during normal working hours and discharge home the same day.

Meeting people's individual needs

- We heard nursing staff discuss discharge plans at pre-assessment to ensure the post-surgical patient needs were properly in place before surgery. This meant staff were assured when offering surgical admissions there would be no unnecessary delays in discharge due to obtaining specialist equipment or organising a care package.
- Patients could access wheelchairs available in the main reception area. There was a lift available for use by less mobile patients to enable easy access to the first and second floors.
- The physiotherapy department aimed to give appointments within 48 hours. Each patient was seen for a pre-operation assessment and current and post operation needs were discussed.
- Physiotherapy was involved with the enhanced recovery programme, which aimed to enable orthopaedic patients to be discharged three days after major joint replacement. They saw the patient twice a day, had a good relationship with the consultant's and would escalate if the patient required longer recovery time.
- There was a variety of menu options available for inpatients and the chef catered for the needs of patients with special diets, and children's meal choices.
- All patients we spoke to felt staff had given them sufficient information about their procedure, and were able to discuss it with their consultant and nursing staff. Staff gave patients information about their procedure at pre-assessment. This included procedure specific information leaflets and a patient information booklet about their stay. Staff discussed their care in detail and explained what to expect post-operatively including length of stay, and involved patients in their plans for discharge. Ward staff gave patients a discharge pack with specific post-operative instructions and a copy of the discharge letter sent to their GP and district nurse if required.
- The parents/guardians of children undergoing surgical procedures were able to accompany them to theatres and recovery areas.
- There was a recent decrease in hospital patient satisfaction survey scores with meal provision, due to a change in the catering provision. The hospital is aware of the situation and is working with COMPASS, the new provider, to return the survey scores to their pre-out-sourced levels.
- In the Patient Led Assessments of the Care Environment (PLACE) for the period February to June 2015 the hospital scored 93% for food, equal to the England average for Independent Acute hospitals and 96% compared to 94% for ward food.
- The children and young people's feedback form introduced by the lead nurse resulted in 27 forms received at the time of our inspection. The complaints were about slow wi-fi, requests for more food choices, more television channels and better ventilation/air conditioning. The children liked the staff, the rooms, the speed of care and the doctors and nurses.

Learning from complaints and concerns

- A formal electronic system was used to collect complaints information. Each complaint was assigned a reference number and a tracker was kept up to date throughout the subsequent management.
- We reviewed in full five complaints, selected by the inspector. From our review we found there was a robust system for managing complaints, which included acknowledgement, investigation, interim holding letters and a final response. The latter included details of any investigation and actions taken. Letters contained a formal apology.
- Complaints information was presented to the Medical Advisory Committee (MAC) as part of the hospital management report. We saw for example in the Minutes

of the January 2016 MAC meeting, 24 complaints had been received; the majority (14) were non-clinical in origin, six of which related to financial or consultant issues.
- Information about complaints discussed in the April 2016 MAC indicated 20 complaints had been received, half of which were clinical in origin. Three of these were attributed to nurse/ HCA or consultant.
- Learning from complaints or concerns was communicated to staff through meetings with heads of departments (HODs). Minutes reviewed by us confirmed this, for example the theatre team minutes (April 2016) reflected feedback was given on the wrong site block and incorrect lens incidents.

Are surgery services well-led?

Good

We rated well led as good. This was because:

- There was effective and responsive leadership at the local executive level, and staff commented favourably on the hospital manager and other senior leaders
- Staff across the service enjoyed working at the hospital. They described an open culture, felt supported and positive about the recent changes in management at the hospital.
- Governance arrangements ensured that incidents, complaints, audit results and policy development were reviewed and learning was shared appropriately.

However,

- The risk register lacked review dates for many of the identified risks.

Vision and strategy for this service

- The local strategy underpinned the broader organisational vision, which was to provide the best patient experience, best outcomes and the most cost effective. The local vision had been communicated to staff
- During our inspection staff told us they were aware and fully engaged with the hospital plan. Information was shared with staff through the '10@10' gatherings, staff meetings where information was cascaded and discussed and the intranet.
- Operational priorities had been identified for the financial year, and included closing the loop on incidents, focus on patient satisfaction related to discharge procedures and food services. People priorities centred on recruitment, appraisals, revalidation of nurses, internal staff development, and included management development.
- In terms of business growth and maximising efficiencies, the executive team had identified priorities which included; the enhanced recovery programme, stock management and capacity, specialty focus, NHS and GP working and engagement, ambulatory care and development of outpatients.

Governance, risk management and quality measurement

- The hospital had its own governance structure, which reported into the regional committee. We found there were 'Terms of Reference', which underpinned the purpose and functions of respective committees. Departments reported through their respective meetings into the head of departments,(HODs), and they in turn, along with the Hospital Clinical Governance Committee, and Hospital Health and Safety Committee reported to the Executive Team. The latter reported into the Medical Advisory Committee, (MAC).
- Business Development, Operational Performance, and People and Performance reported directly to the local Executive Team.
- The frequency of meetings varied, with weekly local Executive Team meetings, monthly HODs and Regional Committee meetings. All others were indicated as taking place bi-monthly on documented information provided to us. However, we had conflicting verbal information about the frequency of the MAC meetings, the chair of which confirmed took place every two months. The hospital manager indicated they currently took place quarterly, and minutes reviewed confirmed this. We noted in the minutes dated 26 April 2016 the MAC agreed to move to bi-monthly meetings.
- The MAC membership was made up of the hospital manager, director of clinical services, surgeon, physician, and anaesthetist representatives. There was a consultant paediatrician who represented children and young people on the MAC. This was confirmed by the MAC chair.
- With the exception of MAC meetings, minutes of meetings reviewed by us contained standard agenda

items, such as, hospital activity, finance, legislation and corporate policies, significant events and complaints, and updates to the risk register. Actions had been identified with ownership, date for delivery, and the status.

- The MAC chair met with the hospital manager prior to the formal meeting, where they reviewed the agenda and items for discussion. Meeting minutes indicated practicing privileges were reviewed, as well as removals and suspensions. The management report was shared with attendees, followed by any other business. Resulting actions were summarised.
- Data from quality reports and dashboards provided oversight in relation to safety, effectiveness and performance in general.
- Monthly Clinical Governance meetings were attended by managers from each area, as well as consultant representative. We reviewed several sets of minutes from such meetings and noted there was a detailed agenda, which addressed a wide range of subjects, relevant to governance, safety and quality.
- There were procedures for ensuring only consultants with approved practising privileges worked at the hospital. We reviewed five randomly selected consultant files and saw evidence of checks on fitness to practice, professional indemnity and registration. Appraisals and re-validation was monitored and requested where re-newal was required. MAC minutes confirmed discussion of the removal of individuals where they had not provided the required information.
- There was an open culture of staff being able to identify and raise risks.
- A copy of the risk register was provided to us, along with an archived version. We noted risks were categorised using a traffic light system, red down to green. There were eight red rated risks out of 44, and the rest were amber. We did not identify any green rated risks. The date each risk was entered onto the register was stated, along with existing controls, if further action was required, the committee with responsibility and key lead. Review dates had not been entered for 32 of the risks. Because of this it was difficult to know what progress had or was being made.
- Some risks had been on the register since 2009, and included risks associated with slips, trips and falls, and related to manual handling. In the further action section, the commentary indicates further risk assessments to be completed. There were no dates for review and we did not know if the required action had been taken.
- We noted a risk related to the driveway external to the hospital had been put on the risk register in July 2014. Despite there not being a review date, we observed the driveway had been resurfaced.
- In our discussion with the quality and risk lead, we were told the risk register would be changing to a new system as from December 2016.
- We were told risks were discussed in health and safety meetings, and we saw examples of minutes accordingly. In addition, we saw evidence of some risks discussed in the minutes of clinical governance committee meetings. The identified top five risks formed part of the quarterly presentation and discussion at the MAC meetings.

Leadership of service

- There was effective and responsive leadership at the local executive level, and staff commented favourably on the hospital manager and other senior leaders. A number of staff told us the hospital manager and the director of clinical services had made a big difference for the better at the hospital. The executive team were very visible and staff said they were approachable. The size of the hospital helped staff to know one another and contributed to a feeling of 'family'. Staff told us there was a high level of comradery.
- There were heads of department (HOD), who were reported to work well together. They provided leadership and support to staff, as well as to the executive team. HOD met monthly and reviewed a range of subject areas, ensuring they were able to cascade information to their teams.
- A '10@10' meeting took place daily, where a staff representative from each area had the opportunity to update the hospital manager and colleagues with respect to their department. We attended one of these and witnessed the communication of information, such as activity, equipment matters, staffing and cover for holidays.
- Clinical department managers had various leadership responsibilities. For example, the pharmacy manager oversaw medicines optimisation. They also chaired the

Drug and Therapeutic Committee, and were a member of the Clinical Governance Committee. This enabled effective oversight and engagement with staff at all levels.

- Pharmacy leadership was proactive and ensured safety, improvements to the service, and patient experiences were at the heart of the departments' objectives.
- In the absence of departmental leaders, deputy staff had been given the designated responsibility for leading their teams, and we heard very positive and passionate information related to the physiotherapy services. In particular, the way the service worked and areas of focus aimed at optimising patient outcomes. Less senior staff commented favourably on their line managers and deputies in the majority of areas. Theatre staff gave very positive feedback about the new interim theatre manager saying that morale and standards had improved and staff were much happier. However, staff felt the ward manager on the first floor could be difficult to approach and had little respect for paediatric services.
- We were told the recruitment process included checks on key skills, and interviewers would include someone with relevant expertise to ensure a fair and consistent approach.
- Performance which was not consistent with the values and expected behaviours was line manged, with action plans and time scales. Regional Human Resources were available to support where needed, and an on-line system was accessible for HOD, where they could be talked through the process if needed.

Culture within the service

- Staff felt confident to recommend the hospital as a safe place, with caring staff. One staff member told us their relative had had treatment in the hospital and it stood out as having caring staff.
- Our observations and discussion with staff indicated a culture of openness, a willingness to report concerns, incidents or errors, and to learn from the subsequent investigations.
- An equal opportunities approach was applied to recruitment and selection. Information provided to us showed the workforce, was in the main (76%) white British, 16% were of Asian ethnicity, 3.5% Black African, 0.80%, Black Caribbean, and 0.80%, Chinese. Other ethnic groups accounted for 2%, and 0.40% were mixed White. The remaining were not stated.
- Although a small number of ward nurses and healthcare assistants reported not receiving information about incident outcomes, we found detailed evidence which showed information was shared through meetings. We also saw a folder kept by the first floor ward manager containing meeting outcomes. Staff were required to sign they had read them. Minutes of meetings were also available on the hospital intranet.
- The requirements related to duty of candour were met through the processes for investigating incidents, and reviewing and responding to complaints. All the staff we interviewed were able to properly articulate how the duty of candour was to be implemented. Staff were able to tell us how important it was to be open and honest with people and to apologise when things went wrong.

Public engagement

- Patient-led assessments of the care environment (PLACE) feedback from the hospitals NHS patients rates the hospital higher or equal to the independent hospital England average in every area except for organisational food.
- Patients are encouraged to complete feedback forms either in paper format or on-line. The latest published results (Jan – Dec 2015) show 99% of patients rated the quality of care was very good or excellent. All of the other measures were over 90% with the exception of catering which was just below at 89.4%.
- A child friendly pain score assessment has been introduced using smiley faces. A children and young people's feedback form has also been introduced.

Staff engagement

- The hospital manager told us they ensured they walked the floor and spoke with staff, asking about the challenges they had. They also met with the heads of department (HOD) team and received corporate feedback with regard to performance.
- Open forums enabled staff to bring matters to the attention of managers, although staff reported it was dependent on the manager.
- Staff reported having diverse roles, and of having equal opportunities. One administrative staff member told us they were able to make the role "their own."
  Non-national staff were said to be welcomed in the hospital and supported to progress as they so wished.

- Exit interviews were arranged either face to face or via an on-line method. Feedback from recent leavers in the theatre department had related to the management and leadership style of the former manager there.

Innovation, improvement and sustainability

- The hospital manager told us continuous learning and improvement was engendered through access to training and development opportunities. The ethos was of encouraging studies, and auditing what it looks like for patients.
- The availability of capital helped the service to improve and develop services. The hospital manager confirmed they had money to use as they saw fit, for example, the purchase of bariatric operating table, new theatre stacker and scopes. Other requests over and above this would be considered on a risk basis.
- The hospital had been approved for Bariatric surgery, although this was limited to procedures which would not require high dependency care. Equipment to support this service was in place, and a designated team of specialty trained staff worked with the consultant to ensure patients received the required standards of treatment and care.
- The enhanced recovery program provided a comprehensive rehabilitation program for orthopaedic patients, including specialised physiotherapy to achieve earlier mobilisation and discharge.
- The pharmacy manager had been proactive in ensuring measures to minimise adverse events and optimise medicines management were implemented. This included having a pharmaceutical care plan, modified following incident reviews. An antibiotic care plan had also been introduced to improve practices.
- JAG Accreditation is the formal recognition an endoscopy service has demonstrated it has the competence to deliver against the measures in the endoscopy GRS Standards. The JAG Accreditation Scheme is a patient centred and workforce focused scheme based on the principle of independent assessment against recognised standards. The scheme was developed for all endoscopy services and providers across the UK in the NHS and Independent Sector. The hospital was not currently JAG accredited but was working towards it. They have reported capital expenditure investment remains a priority in this area to achieve accreditation. All decontamination of endoscopy equipment had recently been outsourced and was carried out off-site.
- The hospital was using new capsule endoscopy technology to replace more invasive techniques. Capsule endoscopy is a camera housed within a large 'pill' that is swallowed and takes pictures of a patient's digestive system.
- Work had been concluded with regard to identifying and changing previously admitted patients to day care. For example, women having a colposcopy were admitted to an in-patient bed, as were patients having hernias and laparoscopies. These patients had their procedures as day cases, when previously they had been admitted to a bed.
- The hospital was now working towards ambulatory care, although the MAC had raised concern about one category of patient, who they felt this would not be appropriate for.
- The recent upgrade of the OPD had meant there was now provision of a minor procedures room, for dermatology procedures.
- The service was continuing to work with external Clinical Commissioning Groups, GP and Clinical Service Users to ensure best experience for the patients. Discussion with representatives of CCG indicated they received a service to the expected level and there were no concerns identified.

Good

Outpatients and diagnostic imaging

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

Information about the service

The outpatient (OPD) and diagnostic imaging (DI) department are located on the ground floor of the hospital. There are seven consulting rooms and a minor operations room. There are a variety of OPD clinics every week including gynaecology, cardiology, gastroenterology, paediatrics, dermatology, neurology, and orthopaedics. The main hospital reception is located within the OPD and receives patients for the OPD as well as those visiting other areas of the hospital.

Between April 2015 and March 2016, the OPD had 29005 attendances. Of these 11% were NHS funded and 89% were funded by alternative means. Adults between the ages of 18 and 74 years of age accounted for 81% of activity, with 27,643 OPD visits, and 4,089 (12%) over the age of 74.

During the same period there were 2037 children and young people seen in the OPD, represented by 406 (1%) aged nought to two years of age, 1,567 (5%) aged three to 15 years of age, and 309 (1%) 16 and 17 years old.

The diagnostic imaging department is located at the far end of the outpatient department. It provides X-Ray, fluoroscopy, ultrasound, mammography (breast screening) and magnetic resonance imaging (MRI) scans. Diagnostic imaging is important in the diagnosis and treatment of trauma and disease and diagnostic radiographers and radiologists produce and interpret images of the body. Diagnostic Imaging has a separate waiting area.

There is a dedicated Physiotherapy department treatment for outpatients as well as access to an off-site hydrotherapy pool, providing extensive pre and post-operative treatments and rehabilitation,

There are separate clinical managers for the OPD, diagnostic imaging, and physiotherapy.

We inspected the outpatient services and diagnostic imaging department on the 12 and 13 July 2016. We spoke to six patients and one family member. We also spoke to eight members of staff including consultants working in the OPD, the department managers, nurses, radiographers, and health care assistants.

The oncology department provided treatment for patients as day cases and so we have included our inspection of this service within outpatients. We spoke with the two members of staff and two patients.

Before the inspection, we reviewed information provided to us by the hospital. We spoke to clinical commissioners and reviewed external stakeholder information where provided. We observed processes, the environment, care, and the culture, and looked at records during our inspection.

Good

Outpatients and diagnostic imaging

Summary of findings

Overall, we rated the outpatients department, diagnostic imaging, which included oncology, and physiotherapy services as good. However, we rated safety as requires improvement, and there was insufficient evidence to rate the effectiveness of services.

- The outpatients, physiotherapy, and diagnostic imaging departments provided a broad range of services for both privately funded and NHS funded patients. The patients we spoke with were complimentary about the care, treatment, and service they had received in both departments. Patients we spoke with told us they were treated with dignity and respect. All patient feedback on the inspection was positive. They described the service as 'very good' and 'professional', and described the process of making an appointment as easy.
- The oncology department provided treatment for cancer patients by means of chemotherapy, monoclonal antibodies therapy, and supportive therapies. The service was provided by Chemotherapy specialist trained nurses.
- Staff were competent and worked to national guidelines, ensuring patients received the best care and treatment.
- The culture within both departments was patient focused, open, and honest. The staff we spoke to felt valued and worked well together. Staff followed policies and procedures to manage risks and made sure they protected patients from the risk of harm.
- There were short waiting times for appointments. Private patients were seen within one week, and NHS patients were usually seen within four weeks of referral. We found patients could get appointments with their chosen consultant and most clinics started on time.
- The departments, including oncology, were visibly clean, well equipped and we observed staff using personal protective equipment (PPE) appropriately.

However;

- Some staff involved in the direct care of children and young people had not received the required level of safeguarding training. Non clinical staff had not been trained to identify patients who may become unwell whilst awaiting their appointment.
- Nursing staff receiving patient calls to the out of hour's oncology service did not include an assessment of the patient's temperature. This is an important indicator for sepsis diagnosis.
- Oncology patient notes did not always contain a summary of the multidisciplinary team (MDT) held at the consultants NHS trust. As a result, staff did not have up to date information on the patient.
- Information about obtaining leaflets in alternative languages was not available, and information to advise patients how to raise a concern or complaint was not obviously displayed in public areas.
- The pre-appointment arrangements for seeing patients who had specific needs related to learning disabilities or a cognitive impairment were not sufficiently clear.
- Information regarding costs and fees was not sufficiently clear, resulting in patients complaining when they received their bill.

Good

Outpatients and diagnostic imaging

Are outpatients and diagnostic imaging services safe?

Requires improvement

We rated the services as requires improvement for safety because:

- Although a suitably trained safeguarding nurse was present during the treatment or care of children in the outpatient department, other staff involved in the treatment and care of children had not all been trained to the best practice guidance level for safeguarding.
- We found two handwashing sinks in the diagnostic imaging department to be non-compliant with infection prevention control guidelines. The sinks were recorded on the hospital's risk register to be replaced.
- Out of hour's oncology patient calls did not always include assessing and reporting of their temperature, which is an important indicator for sepsis diagnosis. Further, oncology patient notes did not always contain a summary of the multidisciplinary team (MDT) held at the consultants NHS trust, which meant staff did not have up to date information.

However;

- Patients received harm-free care and treatment in the outpatients, physiotherapy, and diagnostic imaging department.
- Staff reported incidents appropriately. Incidents were investigated, and lessons were learned and then shared across the hospital.
- Staff had received safety related mandatory training. They knew the procedure for reporting safeguarding concerns.
- There were enough clinical and medical staff within the both departments to ensure patients received safe care and treatment.
- The environment in which patients received treatment and care were visibly clean and safely organised.
- Equipment was well maintained and there was enough equipment to ensure patients safely received the treatment they needed.

Incidents

- Staff had access to information related to duty of candour. This was in the form of the corporate 'Being Open and Duty of Candour Policy'. The policy indicated training on duty of candour was incorporated into risk management training, and staff also had access to e-learning through the National Reporting and Learning Service, (NRLS). 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.
- Between April 2015 and March 2016 there were 22 clinical incidents and 15 non-clinical incidents. They were rated as low or no harm incidents. This is lower than the average of other departments in similar hospitals.
- Staff knew how to report incidents and felt confident in doing so. The quality and risk lead entered these forms onto the hospital's electronic system.
- All of the staff we spoke to understood 'duty of candour' and were able to describe its principles related to adverse events or serious incidents.
- Staff received regular feedback on incidents at monthly team meetings. Feedback included incidents from their department, from the wider hospital and from other hospitals in the group. Staff described the department as having a learning culture around incidents.
- There had been no reported incidents to the Care Quality Commission under the Ionising Radiation (Medical Exposure) Regulations 2000 (IRMER) Regulation 4(5). The regulation is intended to protect patients from unintended, excessive, or incorrect medical exposure to radiation.
- A clinical incident occurred within oncology in November 2015. The patient began to deteriorate and was eventually transferred to a local NHS hospital. The root cause analysis (RCA) we reviewed was sufficiently detailed and identified the main causes of the incident as poor communication of test results. The patient's family complained and this was appropriately handled. In accordance with the duty of candour, a final letter was sent with an apology, an explanation, and details of the investigation and actions taken.

Cleanliness, infection control and hygiene

- The director of clinical services was the designated director for infection prevention and control (DIPC).

Good

Outpatients and diagnostic imaging

- The DIPC was supported by a lead for infection prevention and control (IPC), and there were designated link staff representatives from each clinical outpatient area and housekeeping.
- The IPC lead nurse was embarking on academic and professional studies to support their role.
- All staff had access to infection prevention and control guidance, which reflected best practice guidelines and local standards.
- We observed the clinical and public areas visited were visibly clean and tidy, and were safely organised.
- Domestic staff had responsibility for cleaning clinic rooms daily and had guidelines with respect to the required standards. Colour coded cleaning equipment was provided for the various tasks, and areas of the hospital, which reflected national guidance. We saw completed checklists indicating areas had been cleaned.
- The hospital's Patient-Led Assessments of the Care Environment (PLACE) scores were the same as the England average for cleanliness, at 98%.
- Staff told us each nurse and healthcare assistant had responsibility for an allocated clinical room. They completed a weekly cleanliness audit and ensured each clinical room was stocked with the correct equipment. We were shown audits, which indicated the monitoring of the required standards.
- We checked six consulting rooms and found all the curtains were visibly clean and had labels with the date when they were last changed.
- Staff had access to guidance for cleaning equipment used by patients. We found 'I am clean labels' were being used across the department to indicate when equipment had been cleaned and was safe to use.
- There were hand washing facilities and hand gel dispensers in every consulting room. We did find the sinks in rooms one and two in diagnostic imaging were non-compliant, as they did not have elbow operated taps. These were on the hospitals' risk register. This had been incorporated into the budget for the next financial year and would be undertaken early in the financial year commencing Oct 2016.
- The risk register identified two environmental red rated risks, one of which related to carpets in oncology, and the potential for contamination if medicines were spilled. At the time of our inspection we found the carpet had been replaced with hard flooring, which met IPC standards, in that the floor could be easily cleaned and maintained.
- Care setting rapid improvement tools were used to monitor various IPC elements. We reviewed a number of reports and noted for example, in physiotherapy they scored 70%. The scores for imaging in July 2016 were 100%.
- A hand hygiene observational audit conducted in May 2016 indicated 80% of the staff observed were bare below the elbows and met hand hygiene decontamination standards. The staff we observed during our inspection were all bare below the elbows
- Staff complied with infection control and prevention policies, using supplied personal protective equipment (PPE), such as gloves and aprons. They followed best practice guidance with respect to waste disposal.
- Clinical and domestic waste, as well as 'sharps' were disposed of in the correct manner. There were separate waste and sharps bins in all of the clinical rooms. Sharps bins were found to be less than half full and dated.
- All staff in the OPD and diagnostics department had completed their mandatory training on infection prevention and control.

Environment and equipment

- Adult and children's resuscitation equipment was available in tamper proof trolleys. The trolleys and equipment on the top of the trolley was checked daily. Diagnostic imaging shared the resuscitation equipment with the outpatients department but the equipment was not stored near the midway point of the two areas. This meant staff in diagnostic imaging had further to travel to access the resuscitation equipment in an emergency than was necessary.
- Staff told us they had all necessary equipment to provide safe and effective treatment.
- Specific specialised items of equipment, such as the bariatric hoist was demonstrated and practiced in manual handling training. The manual handling training was facilitated by an experienced on site physiotherapist.
- The minor operations room had the necessary equipment to provide safe and effective treatment. It shared the resuscitation trolley with the main OPD.
- Radiology staff had access to appropriate protective clothing to prevent any harmful exposure to radiation.

Good

Outpatients and diagnostic imaging

- Signage was actively used to alert the public and staff when radiation was in use.
- We were told the hospital outsourced services in relation to Radiation and Laser protection from a local NHS Foundation Trust. The services they provided included overseeing safety in the diagnostic imaging department, and compliance with regulations. Staff told us these individuals were always available for advice.
- We found the viewing room in the diagnostic imaging department was not fit for purpose. Staff told us the air conditioning unit had been broken for 18 months. Frequent high temperatures in the room caused a risk to the equipment's performance in the viewing room and made the working environment unbearable at times. This was on the hospital's risk register but no replacement had been approved. Whilst not in a clinical area, the carpet in the viewing room looked old and dirty despite being recently cleaned. The manager had asked for a replacement but was still waiting for a response.
- In the OPD, staff felt the space for administrative duties was limited. In diagnostic imaging, there was a lack of adequate desk provision for staff to work safely.

Medicines

- There was safe management and storage of medicines in locked cupboards in the outpatient and diagnostic imaging department. Medication refrigerators temperatures were checked daily and were within correct limits. Ambient temperatures of rooms where medicines were stored were checked and recorded. These measures ensured the medicine's potency. No controlled drugs were kept in the department.
- The diagnostic imaging department kept flammable medicines in a lockable fireproof cabinet.
- Emergency drugs were kept on the resuscitation trolley and were checked daily.
- Diagnostic imaging had a separate emergency anaphylaxis drug kit. Anaphylaxis is a life threatening allergic reaction that requires immediate treatment.
- Prescription pads for each clinic room were kept in a locked drawer by the nurse in charge and were audited at the end of every clinic. This ensured that no prescriptions went missing. Doctors wrote prescriptions at the time of the patient's consultation.
- The oncology department had their own secure storage and drug fridge, which was properly monitored and audited. Chemotherapy drugs were ordered from the on-site pharmacy after obtaining the patient's blood test results. Any take home drugs were also provided on the day.
- Oncology medicines requiring cold storage were kept in oncology in a locked fridge. Records showed nursing staff checked the temperature each day to ensure medicines were stored at a safe temperature. Nursing staff were aware of actions to take if the fridge temperatures were not within an acceptable range.
- In the event of chemotherapy not being used for a patient because of their health status, it was disposed of by pharmacy and no charge was applied to the patient whether insurance or self-funded.
- Chemotherapy spillage kits were available in the Oncology department and staff used designated purple bins for chemotherapy waste.
- The on-site pharmacy was in the process of developing an e-prescribing system for chemotherapy drugs, which they believed would lead to even better safety by standardising the way the different trust oncologists prescribed.

Records

- Records for NHS patients were stored securely in the medical records department. The notes were available for clinics and then taken back to medical records.
- All staff had separate logins for accessing any patient identifiable information. This was mandatory requirement by BMI healthcare.
- Staff told us records for patients were always available for clinics. Information provided to us prior to the inspection was there had not been any times when patient notes were not available for their consultation or treatment for the period January to March 2016.
- Individual consultants retained private patient's notes with copies held in medical records. Consultants were required to adhere to information governance policies.
- Physiotherapy notes of the patients using the off-site hydrotherapy pool were transported in a lockable box, which was fire and water proof. The notes were taken in a private car with the physiotherapy staff to the pool where the box was unlocked. The notes remained the responsibility of the physiotherapy staff for the duration of the session before the box was relocked and returned to the hospital for filing.
- We were provided with information in advance of the inspection indicating 'Choose & Book' NHS notes were

delivered to the department the day prior to a clinic appointment and were returned the following day. Notes for follow up appointments after surgery were available on request from onsite medical records.

- All imaging, histology, and blood results were available electronically. Consultants could be provided with paper copies if they required.
- Diagnostic imaging used a picture archiving and communication system (PACS) which meant images could be viewed on any computer connected to the intranet in all BMI hospitals and via a remote access facility. This meant the radiologists could report quickly in case of an emergency. PACS is a nationally recognised system used to report and store patient images securely.
- Clinic letters were kept on site for three months, and then scanned for electronic storage. This meant there was a good system enabling retrieval of information should this be required at a later date.
- We were shown audits within oncology to track the effectiveness of out-of- hour's patient calls, and we noted the patient's reported temperature was not always recorded. This was an important indicator for sepsis diagnosis.
- Multidisciplinary team (MDT) meetings for oncology patients did not take place at the hospital as the consultants tended to discuss treatment plans at their main NHS hospitals. A summary of the MDT meeting was not always written in the clinic review record template, meaning nursing staff did not have up to date information. We were told the hospital was currently working with the consultants and surgeons to establish a more robust mechanism for this.

Safeguarding

- The director of clinical services was the overall lead for safeguarding adults and children (level 3 trained).The lead paediatric nurse was the safeguarding lead for children (level 4/5 trained) and attended the Bromley London safeguarding children's board (LSCB) four times a year.
- The hospital safeguarding lead was available should staff need advice or guidance, and staff knew who the safeguarding leads were for adults and children. They knew their responsibilities regarding safeguarding and knew how to escalate concerns.
- Up to date policies on safeguarding for both adults and children were available to all staff on the hospital's intranet. These reflected the 'safeguarding children and young people: roles and competences for health care staff Intercollegiate Document, 2014'. Level 3 training was required of clinical staff, including diagnostic staff and physiotherapists working with children, young people and/or their parents/carers and who could potentially contribute to assessing, planning, intervening and evaluating the needs of a child or young person and parenting capacity where there are safeguarding/child protection concerns.
- Figures provided by the hospital stated there were three staff trained to level 3 and 22 trained to level 2. The remainder of the staff were trained to level one.
- NHS England provides guidance on the required level of safeguarding training. The number of staff trained to level 3 did not meet the recommended guidance.
- We were told staff received level one adult and children safeguarding training as part of their mandatory training, at induction and two yearly intervals thereafter. Department managers had to undertake level two training. A programme to train all nurses to level two was due to be implemented. Staff told us that level three trained staff were on duty caring for children when they attended the hospital.
- During the inspection we did see a child in clinic who had received an X-Ray and had bloods taken for testing. None of the staff who saw this child had level three safeguarding, which did not reflect the intercollegiate guidance.
- The department's clinical manager told us there had been no safeguarding issues in the 18 months they had been in post.
- Staff knew about what action to take if they suspected a patient may be or at risk of abuse. One nurse told us they had arranged an unplanned overnight stay for a patient who they felt was unable to follow pre procedure instructions.
- The hospital had an up to date chaperoning policy. Staff were available for any patient requiring chaperoning. Records of chaperoning were kept in a log, and included in patient's notes.
- Staff told us they felt confident challenging any concerning practices or behaviours.

Good

Outpatients and diagnostic imaging

Mandatory training

- We were told a role-specific mandatory training plan was automatically assigned to each staff member in the BMI e-learn system. Staff completed most training electronically but this was supplemented by practical training where appropriate.
- Mandatory safety training was required to be completed by all staff. This included for example health and safety, manual handling, PREVENT (Protecting people at risk of radicalisation), infection prevention and control and equality and diversity.
- The outpatient's clinical manager showed us that all the staff in the department were up to date with their mandatory training. In diagnostic imaging, two members of staff were newly employed and were yet to completed their mandatory training, and 95% of the oncology staff had completed their training. Information provided to us indicated 100% of physiotherapy staff had received their mandatory safety training.
- Training was automatically monitored online and each member of staff had a password protected training account. Staff received automated reminders when a module was due for completion and the manager regularly reviewed the staffs' compliance with mandatory training.
- Training could be delivered through e-learning and face-to-face sessions. Staff reported that they were given sufficient time and support to complete their training.
- It was mandatory for staff working with children to have either paediatric Basic Life Support (BLS) or Immediate Life Support (PILS), and this had been provided to 100% staff. Three staff had undertaken Advanced Paediatric Life Support.

Assessing and responding to patient risk

- Staff had access to detailed guidance, including the required action to take in the event of a patient, including children deteriorating and requiring transfer out of the hospital. The Emergency Transfer of Patient policy provided an outline of responsibilities of consultants and senior clinical team members.
- When patients arrived in the reception area, reception staff greeted them. The department manager told us if the staff on reception had concerns that a patient was at risk, they would immediately alert a nurse who would assess the patient. Further, reception staff had received training in basic life support and were aware of the procedures to follow when alerting staff to concerns about the wellness of patients.
- Nursing staff told us if a patient was identified as having any health related risks then they would move the patient from the main reception area and a trained staff member would remain with the patient.
- Staff told us they did not routinely take patient's base line observations, as patients didn't usually require this. However, they would record the patients observations if requested to do so, or if they assessed the patient as unwell. They would then report this to the consultant immediately.
- Staff in diagnostic imaging confirmed they would not carry out a scan on a female patient of childbearing age unless the patient had signed a declaration confirming their pregnancy status. This was not subject to any audit at the time of our visit.
- The imaging department used an adapted safety checklist, as outlined in the World Health Organisation (WHO) Surgical Safety Checklist and the Safe Surgery initiative. The imaging department had carried out an audit on WHO check list compliance.
- In consulting rooms, the WHO checklist was incorporated within the patient pathway. These pathways had been used since the minor treatment room was first used. Audit forms part of the monthly medical records audit going forward.
- The hospital had a trained emergency 'Crash' team, all of whom carried a bleep to respond to emergencies in the department. Alarm activation was via the telephone or from a button in each clinic room.
- There were two standard operating procedures (SOPs), one for cardiac arrest in imaging and the other for cardiac arrest for MRI.
- We observed all clinic rooms and toilets had emergency alarm button and pull cords.
- The department had regular practice scenarios on responding to emergencies, staged by an outside company. Staff received no warning ahead of these scenarios, in order to make them as realistic as possible. Consulting rooms held the last scenario on 23 May 2016, and this was a paediatric scenario.
- If a patient required urgent transfer to an NHS Emergency Department then they would use the 999 system to call an ambulance and alert the receiving hospital.

Good

Outpatients and diagnostic imaging

Nursing staffing

- There were sufficient nursing staff to meet the needs of patients attending the department. Staff told us they felt staffing levels were adequate for the number of clinics running in the department.
- The department was fully staffed with both qualified nurses and healthcare assistants. There were 3.57 whole time equivalent (WTE) registered nurses, and 2.37 WTE healthcare assistants. There were always a minimum of two qualified nurses on duty. Healthcare assistants (HCAs) assisted in clinics. The manager told us they covered vacancies with their pool of 11 permanent and bank staff and never have to use agency staff. No bank or agency staff nurses or healthcare assistants were used in outpatient departments in the reporting period (Apr 15 to Mar 16).
- Senior staff nurse completed staffing rotas four weeks in advance and there was a mix of early and late shifts, in response to planned clinics.
- The department had a trained paediatric nurse for paediatric clinics, trained to level three for Children's Safeguarding, and we saw the rotas to confirm this arrangement.

Medical staffing

- There were procedures for ensuring only consultants with approved practising privileges worked at the hospital. We reviewed five randomly selected consultant files and saw evidence of checks on fitness to practise, professional indemnity, and registration.
- Every clinic was run by a consultant who saw each patient on their specific list.
- We reviewed records, which showed the named consultant for each clinic had been available. Staff were able to tell us of an incident when a consultant was unable to attend their clinic due to sickness and staff were able to get another suitably qualified consultant to cover at short notice.
- The manager kept an audit of clinics that started late and would fill in an incident report if they did not start within 30 minutes of their scheduled time. We saw records, which showed the clinics in the majority of instances started on time.
- We spoke to patients who all said they had been able to get an appointment with their chosen consultant.
- The resident medical officers (RMO) were supplied by a third party, and as such information about the RMO, including their CVs and training records were provided by the agency. The Director of Clinical Services and a Consultant Anaesthetist who was a member of the Medical Advisory Committee (MAC) reviewed the CV's from the agency and individual applicants for assurances that training had been undertaken. It was the agencies responsibility to ensure all RMOs had completed their mandatory training; however, the location checked the agency documentation to ensure they were fully up to date. We were told a full corporate / hospital induction for all new RMO's was undertaken at the start of their contract at site.

Major incident awareness and training

- The hospital staff had access to two separate policies to support the delivery of service. The Business Continuity Policy provided strategic and operational information for preparedness and response to adverse situations or events. Roles and responsibilities were defined, along with risk assessments and planning arrangements. The Business Continuity Plan defined location related information, and identified the locations quality and risk lead as the nominated person for this area.
- A copy of the Business Continuity Plan was available in the main reception. It included Action cards, which explained roles in the event of a wide variety of incidents and scenarios, but was not specific to individual staff or departments.
- We looked at records to show that back-up generators were serviced and tested regularly.
- Staff knew what to do in the event of a fire or emergency evacuation. Each department had a fire warden. An evacuation drill in association with the local Fire and Rescue Service had recently been conducted.
- Radiation incidents, should they occur were expected to be reported and managed in accordance with safety procedures.

Are outpatients and diagnostic imaging services effective?

We do not currently rate the effectiveness of the outpatient and diagnostic service.

- The outpatients and diagnostic imaging department were providing effective treatment for patients. Patients received diagnostic imaging results promptly.

- Treatment was always consultant led and used evidence based best practice from the World Health Organisation (WHO), the National Institute for Health and Care Excellence, and the Royal Colleges.
- All staff had an appraisal in the past year, and the hospital supported them through the Nursing and Midwifery Council's (NMC) revalidation process.
- Systems were set up for revalidation of medical staff and for the effective management of doctors' practising privileges.
- Staff knew their responsibilities in relation to consent and the Mental Capacity Act (2005).

Evidence-based care and treatment

- Clinical staff knew of and used of the relevant NICE guidelines for their department along with relevant Royal College guidelines. These guidelines could be accessed easily through the intranet, such as guidance around consent, resuscitation and clinical procedures.
- Both departments undertook numerous clinical and non-clinical audits. These included infection prevention and control, cleaning, hand hygiene, medicines management, waiting times, revenue, image quality, WHO surgical checklist (a system of checks for ensuring safe management of surgical procedures), and X-Ray audits. Results of these audits were fed back to both staff and senior management. We saw that where areas needed to improve action plans were agreed, and these were followed up at subsequent audit.
- A recent audit of clinic start times in OPD resulted in two consultants being referred to the hospital manager, with a view to making improvements.
- The radiation protection supervisor (RPS) annually reviewed the diagnostic reference levels and these were quality assured on a daily/weekly/monthly basis. All reference levels were established at the beginning of the year by the radiation protection advisor, the RPS and head of department. Documented evidence of quality assurance and reference levels were maintained.
- The service had one BV Libre image intensifier and a corporate policy/ionisation radiation policy, as well as a local standard operating procedure for the handling of the image intensifier.
- An audit of the use of markers (a point of reference or a measure to aid interpretation) in images produced in diagnostic imaging resulted in the purchase of new metal markers and all images were subsequently to be approved by the imaging manager.
- All standard operating procedures (SOP) within diagnostics were within review dates. A new SOP for minor treatment room in use, ratified at Clinical Governance meeting. Any new SOP's, local or corporate were cascaded to staff and a signature sheet kept.
- Staff working in the minor operations room used an adapted WHO surgical checklist, which met national guidelines. We saw examples of these having been completed in records reviewed.

Pain relief

- Staff told us that external requests to the outpatients department for pain relief were infrequent. They told us they would contact the patient's consultant or refer them to their GP if necessary. The Resident Medical Officer (RMO) was also available in the event of a patient requiring a review of their pain management.
- Consultants discussed pain management within the consultation process for patients who were going to be booked in for a surgical procedure.

Nutrition and Hydration

- Staff advised patients about fasting times prior to surgery at their pre-assessment and provided additional information in their booking letter.
- During oncology treatment nutritional needs were met with the provision of hot/cold beverages as well as snacks and light meals.
- There was access to water and other drinks could be provided if required.

Patient outcomes

- Staff told us diagnostic test results were available promptly. Most tests were available electronically and could be viewed on terminals in each consultation room. The diagnostic imaging manager told us reports would be completed within a few minutes when a radiologist was on duty. This meant that in most cases the patient's results were available during the consultation.
- When radiologists were unavailable, they had a 48-hour standard for completing reports. If a report was required urgently then they had a rota of on call radiologists that could either attend the hospital or report remotely.
- The hospital did not participate in imaging accreditation schemes or improving quality in physiological services scheme. The Imaging Services Accreditation Scheme (ISAS) is a patient-focused assessment and

accreditation programme designed to help diagnostic imaging services ensure their patients consistently receive high quality services, delivered by competent staff in safe environments.

- Patient outcomes in physiotherapy were monitored by recognised outcome measures such as range of movement, pain scores and the quality of life measures in order to establish the effectiveness of treatment.
- The standard national tool used throughout the physiotherapy arm of the company was the EQ5D. This is a key measure chosen by the Department of Health in England in the current patient reported outcomes measures (PROM's) programme. It has been used since 2009 to evaluate and benchmark various elective surgical pathways, such as total knee replacement, total hip replacement. We were told the outcome data was comparable to the NHS.

Competent staff

- Nursing staff could operate across all the speciality areas allowing them to cover any adult clinic. There was a paediatric nurse for children's clinics. There were two radiographers who had additional training in mammography.
- An outside company supplied the mobile Magnetic Resonance Imaging (MRI) scanner. The diagnostic imaging department did not staff the scanner, but managed the scanner's appointments.
- There was a radiation protection supervisor on site, who was also a senior radiographer. They had a certificate of competence and had attended the required training.
- All staff had received an appraisal in the past 12 months except newly employed staff. Appraisals were reflection on the previous year's performance against set objectives, new objectives for the year ahead and any training requirements staff felt would benefit their development.
- New members of staff had completed both a hospital and department induction programme, to give an overview of the policies and procedures. They had supernumerary time and reported feeling supported in their new roles by all members of staff. New members of staff were required to complete mandatory training.
- We were told the RMO agency was asked to provide evidence of their training. With regard to resuscitation, although the RMOs undertake this training with their agency prior to arrival at the location, the RMO was included in all resuscitation scenarios to ensure they were familiar with the team and equipment available.
- The department was aware of the importance of the NMC's revalidation of nursing staff and the staff reported feeling supported in the process. Revalidation ensures that nurses are practising safely.
- Many staff had worked in the hospital for a long time and described a good working relationship with the consultants. They felt confident in helping patients clarify points about their treatment with the consultants. Newer staff said they had felt welcomed by both the medical and nursing staff.
- Paediatric nurses within the hospital supported children attending for x-ray and the corporate Children and Young People's policy was available to reference and adhere to.
- Revalidation was part of consultant fitness to practise and agreeing practising privileges of consultants. We saw there was a formal system for managing both these elements. Documentation was provided for consultants and held in their personnel files. A designated member of staff had responsibility for chasing records when due, unless provided by the individual. The Medical Advisory Committee (MAC), reviewed new applicants, and those who were removed as a result of the required information not being provided.
- Medical Advisory Committee minutes confirmed discussion of the removal of individuals where they had not provided the required information.
- The reporting radiologist reported on the patient procedure and a copy went to the referring clinician. Imaging staff did not send patient discharge letters.
- Clinicians were responsible for management of their patients' discharges and updates and had time allocated to write reports if necessary.
- The consultant was responsible for OPD letters. Copies were available in the patient record.

Multidisciplinary working

- There were no specific multidisciplinary meeting. However, staff told us they were able to call on the expertise from other departments in the hospital if required. They described a good working relationship with other departments, such as oncology and surgery.

Good

Outpatients and diagnostic imaging

- We were unable to observe any minor operations during our visit, but both the consultants and nursing staff described a good working relationship.
- The diagnostic imaging manager described an excellent working relationship with the external company that provided the MRI. The radiologists reported on MRI scans.
- There was a one-stop breast clinic, supported by specialist breast care nurses and imaging.
- Physiotherapy staff supported effective recovery and rehabilitation, including an appointment at pre-assessment for patients having orthopaedic surgery, and follow up at outpatient clinics.

Access to information

- Staff had access to corporate and location specific policies and guidance.
- Patient notes and relevant information was accessible. Medical notes included all information pertaining to their assessment and treatment plans included details of treatment and care. Copies of all external communications, including GP letters were also stored in the patient's notes.
- Staff also had access to contact details for consultants, the RMO and senior managers.
- The results of diagnostic tests were available on the hospitals intranet system. Staff could only access information via a secure log in.
- Diagnostic imaging used a picture archiving and communication system (PACS) which meant images could be viewed on any computer connected to the intranet in all BMI hospitals and via a remote access facility.
- There was no evidence of records being unavailable at consultations in the department.
- Clinic information was shared with patients' GPs in letter format. These were produced by the clinician following the appointment and copies sent to GPs and patients.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff we spoke with knew about consent procedures and discussed any issues with others involved in the patient's care and with the patient's family. The Mental Capacity Act 2005 (MCA) contains the law that applies to anyone who lacks the mental capacity needed to make their own decisions about their medical treatment.
- The consent policy and Children's and Young person's policy defined how a child could show they were Gillick Fraser competent.
- Staff told us patients were not routinely consented for inpatient procedure while in the outpatients department.
- We saw evidence that procedures undertaken in the minor operations room were consented appropriately.
- Patients told us they had been asked for their consent before a procedure.
- Mandatory training included the MCA. Staff knew how to obtain consent from patients with limited capacity. One staff member was able to tell us how they referred at patient living with dementia needs back to the consultant as there were concerns about their capacity. They told us they were subsequently praised by the manager.
- Nursing staff were aware of Deprivation of Liberty Safeguards, but could not recall an incident in the outpatient department when they had needed to be used.
- A patient's cognitive and perceptual ability was assessed by oncology staff. Consent forms for chemotherapy treatment in oncology were fully completed and signed.

Are outpatients and diagnostic imaging services caring?

Good

We rated the services as good for caring because:

- Patients told us and we observed staff treating them with compassion, dignity, and respect.
- All patients were very positive about their experience in the department, and the staff ensured the patients received a positive experience as far as they were able.
- Patients and their families felt involved in decision around their treatment, and feedback from patient response postcards indicated high levels of satisfaction with outpatient services.
- Information was provided by consultants and clinical staff in order to ensure choices and decisions could be made about investigations, treatment and care.

Good

Outpatients and diagnostic imaging

Compassionate care

- We observed staff treated patients and their accompanying relative or companion with care, dignity, and respect. Staff welcomed the patients into the OPD and explained the process for new patients. Staff offered patients complimentary refreshments and directed them to the waiting area.
- We observed staff introducing themselves by name and addressing the patients in a respectful and dignified manner.
- Patients who wished to have a chaperone were supported by staff during their visit to outpatient departments. Information about chaperones was provided in hospital literature and could be arranged in advance or on arrival.
- All of the patients we spoke to said they had a very positive experience, most describing it as 'very good'. They said the staff were very polite, caring, and professional.
- All consultations were conducted in private clinic rooms with the doors closed, with clear signs on the door indicating the name of the consultant and whether the room was in use. We saw no evidence of staff having clinical discussions either with or without patients in public areas.
- The diagnostic imaging manager had installed a new curtain in the ultrasound room that shielded the examination bed from the door to protect patient's dignity.
- The oncology patients we spoke with were both receiving chemotherapy treatments. Both were very complimentary about the staff and the facilities.
- Patient satisfaction information was collected through a dashboard. We reviewed the March 2016 dashboard, which showed results for the previous three months, and included feedback from inpatients and day cases. For outpatient services the percentage of satisfaction ranged from 92% for physiotherapy, 97% for diagnostic imaging.
- Outpatient Friends and Family postcard results for February 2016 indicated 95% of the 35 respondents who were NHS patients recommended the service. Of the 274 insured or self-pay patients 98% recommended the service.
- There were numerous positive comments indicating the provision of a compassionate service and naming individual staff, such as: 'All staff were very helpful and friendly. Clear explanations from the doctors, who was exceptionally patient and kind', 'Kind and caring staff, very professional', and 'Such a friendly, helpful department. Radiographers so helpful'.

Understanding and involvement of patients and those close to them

- Patients we spoke to said they felt they were involved in their care. They told us the consultants had explained differing treatment options clearly, and what they could expect from their treatment. They told us when a consultant prescribed medication they explained any possible side effects.
- Patients said their families or friends were welcomed at consultations. One patient described the compassionate way her consultant had listened to the concerns of her husband during her appointment, and took the time to answer all of his questions.
- We reviewed feedback made by patients in the outpatient Friends and Family postcards for February 2016. Comments included; 'I was treated fairly. I felt listened to and made comfortable, even though I was a NHS patient'; Staff were polite and very friendly - consultant gave very helpful advice, and 'Everyone was so kind and attentive and explained everything'.
- Imaging costs were discussed with patients upon arrival. Patients were given an "Outpatient Charge Arrangement" leaflet upon arrival. Staff were also able to provide a price in advance of their appointment. All imaging staff were able to refer to the imaging department charge master.
- Where physiotherapy patients enquired through the national enquiry booking centre, they were informed of the self-pay rates when making the appointment.
- Should a patient speak to an administrator in the physiotherapy department they were informed of the tariff when they booked their appointment.
- As staff did not know what the private cover was for each individual or the BMI agreed price with their insurance companies, they ensured the patients had all their details to hand to be able to authorise their treatment. If not, they were made aware they may be liable to receive an invoice for any insurance shortfall. This was confirmed on the registration form the patient signed. If consumables were offered or sold, it was made clear to the patient they may not be covered for by their insurer and they may incur the cost.

Good

Outpatients and diagnostic imaging

- Consulting room prices were available on the computer system for reference. Information was given to all patients explaining that tests / procedures may have additional cost implications. Costs were discussed at point of booking. Additionally, patients were given an “Outpatient Charge Arrangement" leaflet upon arrival, before their consultation.
- Consultation fees were separate to treatment costs and were invoiced separately by the consultant. We noted there was detailed information on the fees and costs attached to services, including fixed price packages, spreading the cost with a hospital card, as well as different methods for paying.
- The hospital website also provided a range of patient information for national and overseas patients, and those using the services via the NHS.

Emotional support

- Cancer patients and their families have urgent needs for information and support especially in the early stages of the cancer journey. To meet those needs the oncology team aimed to provide continuity and co-ordinated care. This included emotional and psychological support. Staff liaised with other healthcare professionals including GPs and palliative care teams.
- Staff told us that upsetting or unexpected news would be delivered sensitively and in appropriate private surroundings. They said they would try to arrange a friend or family member to accompany the patient.
- A comment made on patient feedback in respect to their consultation was: ‘Very open and forthright consultation’.
- The outpatient department did not have a dedicated service to refer patients, if they required additional emotional support. There were clinical nurse specialists who would see patients as required to offer support. Staff told us they would try to give patients information on groups and charities that may be able to offer support or refer them back to their GP.
- Patients told us consultants spoke to them sensitively but they ensured the patient understood the information.
- Patients were able to telephone the ward or the out of hour’s oncology staff after discharge for further help and advice about any concerns or questions on their return home.

Are outpatients and diagnostic imaging services responsive?

Good

We rated responsive as good because:

- Patients did not experience long wait times to see their chosen consultant, and clinics ran mostly as planned. The OPD met the 18-week Referral to Treatment target for NHS patients of 92% for the year April 2015-March 2016.
- The departments were fully accessible and were organised to facilitate a responsive service. There was flexibility in appointments, and in general patient’s choices were taken into account when making appointments.
- The outpatient departments had a range of services, which were fully established to meet the specific needs of patients, including children, young people and adults.
- Patients were happy with their experience in outpatients and diagnostic imaging.
- There was a process for receiving, responding to and investigating complaints, and staff learnt from information arising from these.

However;

- Information informing patient about raising a concern or complaint was not readily available, and patients were not made aware is they could obtain literature in other languages.

Service planning and delivery to meet the needs of local people

- Staff told us that clinics were run on fixed days and patients were usually seen within one week of referral.
- Monthly clinical waiting times were audited, which indicated 10 clinics were reviewed each month. Where a clinics showed delays it was re-audited the following month. We reviewed the audit results for May and June 2016. The results for June 2016 showed expected and actual start and finish times, the number of patients seen and number of minutes late by. Across the 10 clinics six clinics were late, one by five minutes, two by 10 and fifteen minutes respectively, and one by twenty minutes.

Good

Outpatients and diagnostic imaging

- The manager told us that if a clinic had to be cancelled at short notice, patients would be contacted at the earliest opportunity. They would be offered of an alternative consultant to see, or the next available appointment with their chosen doctor.
- During our inspection, we observed a relaxed atmosphere in the outpatient area. The waiting areas were not overcrowded and clinics were running on time.
- Most consultants scheduled their patients for the following week's clinic for minor procedures. However, in some circumstances treatment was required sooner and therefore, if requested by the consultant, the patient had the procedure is completed at that visit.
- There was a range of opening times for outpatient services, which allowed greater accessibility. The outpatients department was open from 8am to 9pm Monday to Friday and from 8am to 4pm on Saturday.
- The diagnostic imaging department was open from 8am to 8pm Monday to Friday and from 8am to 1pm on Saturday.
- The MRI unit was available four days per week from 8am to 5pm.
- The oncology services were open from 8.30am to 5pm Monday to Friday but if "longer treatments were booked in, the department flexed to accommodate these. The department was covered by on call outside of the standard opening hours.
- Outpatient physiotherapy was available Monday, Tuesday and Wednesday 8am to 8.30pm, and Thursdays 8am to 8pm. On Fridays the service was available 8am to 5pm, and Saturday between 8am and 11am.
- Physiotherapy services were provided to patients from age four years and above. This included pre-operative assessments, a 'Joint School' for orthopaedic patients, and group work. An external hydrotherapy pool was in use via physiotherapy, and this was open on Mondays and Thursdays between 5pm and 8pm.

Access and flow

- Access to appointments for clinics was satisfactory. All the patients we spoke to told us they were happy with the length of time they had waited to be seen following referral and had been offered times convenient to them.
- NHS 'choose and book' patients were seen within the 18-week referral to treatment time target for NHS patients. We saw evidence the hospital was consistently above the 92% target for the year April 2015 – March 2016.
- The physiotherapy department provided access to children aged four and over, and they were seen for musculoskeletal problems only. The department did not see neurological problems or complex presentations, which was made clear when they received any referrals.
- Children could be seen in the majority of clinics by consultants who regularly treated children in their NHS practice. These clinics were supported by paediatric nurses. Paediatricians were also supported by paediatric nurses.
- We examined records from NHS patients, and these showed that waiting times for an outpatient appointment was between two and four weeks. Private patients waited between one and two weeks, but this was not audited by the hospital.
- Orthopaedic outpatient activity was the most used service, accounting for 16% of throughput, followed by gynaecology, at 11.8%, and surgery 13.5%. Paediatrics, including surgery accounted for 2.5% of OPD activity.
- Paediatric patients were initially booked into outpatients via the GP for an initial consultation. At consultation they were seen by a consultant and paediatric nurse. If the child required surgery, they were invited to come back to be pre assessed by the pre assessment paediatric nurse, who covered the pathway of the patient journey.
- Children's clinics were grouped together and the specialist paediatric nurse would be on duty to oversee these clinics.
- All staff reported clinics generally started on time and ran on schedule. The manager monitors late starting clinics and completes an incident form for any starting more than 30 minutes late. Any consultants who were consistently late would be reported to senior management.
- The patients we spoke to said they were seen either at, or very close to their appointment time.
- Did not attend (DNA) patients under the Choose & Book scheme were logged and reviewed by an external company. For Private patients, although they were recorded on an electronic system if they DNA, this was not audited.

- In physiotherapy, DNAs were recorded on the patient paper records and also on the electronic booking systems. If the patient DNA and no response or contact was made, this would track a DNA on the referral tracker used for all patients when the patient was discharged.
- There were very few private patient DNA's, and these were followed up with a telephone call.

Meeting people's individual needs

- There were parking spaces for those with mobility issues and for patients in a wheelchair. Staff told us they often helped patients out of vehicles and into the department and would provide a wheelchair if required.
- Outpatient services were planned, delivered, and co-ordinated to accommodate patients with complex needs. This included patients living with dementia, learning difficulties or physical disabilities.
- Outpatient areas were on one level on the ground floor. The outpatient area was accessible to all patients. Patients had access to wheelchairs, which were available in the main reception.
- Chairs at different heights were available in the waiting rooms. There were sufficient numbers of chairs in the waiting area to suit individual needs.
- The oncology rooms were located at the end of the corridor, which contributed to privacy and consisted of the main treatment room with two chemotherapy chairs, secure drug storage and staff office space. There was also a private room opposite the treatment room available for patients having longer treatments or those wishing greater privacy.
- A member of the oncology staff was in attendance during the patient's initial consultation, allowing for introduction to be made early. After consented to chemotherapy a pre-treatment appointment was made, which included pre-chemotherapy bloods, ECG and MRSA screening as well as discussions about the therapy, side effects and any concerns they may have. Vein assessment and arrangements for Picc lines or Portacaths was also be initiated. Literature was provided, along with a tour of the unit, and 24 hour contact numbers were shared.
- Oncology treatments were usually administered on weekdays, with most being on Tuesdays, Wednesdays and Thursdays. Flexibility allowed the patient to lead as normal a life as possible around their treatment. Reflexology is available from the physiotherapy team.
- Staff told us that patient referral identified those patients who needed extra support at their appointment, and this was flagged with clinic staff so they could organise this.
- We found changing facilities in the diagnostic imaging department had curtains providing privacy. Patients who wished to change behind a locked door had to use one of the imaging rooms. There was appropriate clothing to change into, including dressing gowns. There were no lockers provided, patients had to carry their clothes in supplied plastic bags, with them into the imaging rooms, which guaranteed the safety of their personal items
- We saw there was a range of information leaflets available to patients in the waiting area on wide variety of topics. The BMI group had produced most of these and others had been produced by professional organisations. We did not see any of these available in alternative languages.
- The hospital did not provide in house interpreting services, but staff knew where to find information in order to obtain an interpreter. Staff told us they were normally made aware of whether English was not a patient's first language in the patient's referral letter, and would plan accordingly. Language line was used to arrange either face to face or telephone interpretation.
- Staff told us if they identified a patient as having needs associated with dementia or learning difficulties, then they would ensure the patients' needs were met. For example, organising a suitable waiting area. They told us that in the past they had arranged for patients to wait in unused clinic rooms if appropriate. Staff attended patients with complex needs at all times when necessary.
- Staff were trained in chaperoning and had access to a policy to support this. All chaperones were recorded using the BMI recommended chaperone form, which was also evidenced by recording on the Imaging referral form. This was then scanned onto the patient number on the CRIS system. A chaperone audit was in progress in diagnostics.
- In the physiotherapy department there were wall posters to encourage patients to request a chaperone if desired. Patient information posters were visible both in the outpatient reception area and in all consulting rooms. Chaperones documentation was undertaken as per the chaperone policy in the chaperone register, although the register was not currently audited.

Good

Outpatients and diagnostic imaging

- A dedicated children's nurse ran the children's clinics. While there was no specific children's waiting area, they did have some appropriate toys and books for the children to play with while waiting. There was a range of stickers and certificates they could give to children for being well behaved and brave.
- Diagnostic imaging rooms used wide tables to accommodate bariatric patients. Bariatrics is the branch of medicine that deals with the causes, prevention, and treatment of obesity. They employed techniques enabling bariatric patients to have an X-Ray without lying down if required. The MRI scanner used by the hospital could accommodate bariatric patients.
- Oncology patients were given 24 hour contact numbers of a member of the oncology team for any questions or concerns they may have had.
- The patient-led assessment of the care environment, (PLACE) was above the England average for privacy and dignity, scoring 92%, against a score of 87%.

Learning from complaints and concerns

- We observed there was no information on how to complain available in the public areas. The hospital had published a leaflet entitled; 'We'd Like To Hear From You', which did contain correct information on the complaints procedure. This leaflet was available in a rack with other leaflets in the waiting area, but its content was not obvious.
- The hospital had a complaints policy, which provided a framework within which complaints were to be responded to.
- The Quality and Risk Lead with the Hospital Manager were responsible for co-ordinating and managing the complaints procedure. The Quality & Risk Lead acted as the lead investigator.
- The complaint investigation file was reviewed, along with the response to the patient by the Hospital Manager, who then approved the complaint response letters.
- Complaint could be raised by telephone, in person, in writing or made verbally. We found from our review of the complaints process, a letter of acknowledgement was sent out within two working days of receipt of a complaint letter. Full response was sent within 20 working days or if the investigation required further time, an update letter went out to the patient.
- For serious complaints, a holding letter was sent at least every 20 working days until final response.
- The director of clinical services was responsible for ensuring a comprehensive investigation was undertaken on clinical aspects of complaints and for ensuring the recommendations made from complaints were shared and acted upon.
- We saw from information reviewed complaints were discussed at head of department meetings, the Medical Advisory Committee, at clinical governance meetings, and departmental meetings. We saw for example in the Minutes of the January 2016 MAC meeting 24 complaints had been received, the majority(14) were non-clinical in origin, six of each related to financial or consultant issues. The department manager told us most complaints were about fees, such as not appreciating the cost of tests.
- Staff who spoke with us in OPD knew the process should a patient want to complain, and told us they would try to resolve any informal complaints immediately. They told us they could refer the patient to the department manager if required.
- The department manager told us if the complaint could not be resolved, they would launch a formal investigation. The department manager would be responsible for any subsequent investigation, under the direction of the hospital manager.
- Staff confirmed they received feedback from complaints at the monthly team meeting. The manager required staff to sign that they had read and understood the information and feedback given to them in their monthly team meetings. This included staff who could not attend the meeting.

Are outpatients and diagnostic imaging services well-led?

Good

We rated well led as good because:

- A formalised daily meeting provided opportunities for staff to update colleagues with respect to their department, and to be informed of other service related developments.
- Staff felt well supported by their line manager and senior managers. Staff told us, senior managers were visible, engaging, and approachable, and there was an open culture for raising matters and shared learning.

Good

Outpatients and diagnostic imaging

- The outpatient services engaged with staff and patients. They gave them the opportunity to provide feedback about their experiences of the services.
- Staff told us they felt care and treatment was patient focused, and they enjoyed working in the outpatient and diagnostic imaging departments. All felt part of a wider team.
- There was a well-defined governance structure aimed at improving patient services.
- The managers of the OPD and diagnostic imaging were enthusiastic and proud of their departments.
- E-prescribing was being introduced for chemotherapy drugs which would enhance patient safety.

However;

- Some staff did not have a full awareness of the hospitals strategic priorities.
- Information about patient feedback on the services provided was not visibly displayed.

Vision and strategy for this this core service

- The local hospital strategy underpinned the broader organisational vision, which was to provide the best patient experience, best outcomes and the most cost effective.
- The local vision had been shared with staff, although some staff were not fully aware of the specific aspects related to the outpatients.
- Operational priorities had been identified for the financial year, and included closing the loop on incidents, focus on patient satisfaction related to discharge procedures and food services. People priorities centred on recruitment, appraisals, revalidation of nurses, internal staff development, and included management development. In terms of business growth and maximising efficiencies, the locations executive team had identified priorities, which included; stock management and capacity, NHS and GP working and engagement, and the development of outpatients.
- All staff we spoke to told us they thought that their respective department was patient rather than profit focused.
- The manager told staff of plans for the hospital in their monthly meetings, for example the recent upgrade of the outpatients, and plans for e-prescribing chemotherapy.

Governance, risk management and quality measurement for this core service

- The hospital had its own governance structure, which reported into the regional committee. We found there were 'Terms of Reference', which underpinned the purpose and functions of respective committees. Departments reported through their respective meetings into the Head of Departments (HODs), and they in turn, along with the Hospital Clinical Governance Committee, and Hospital Health and Safety Committee reported to the Executive Team. The latter reported into the Medical Advisory Committee, (MAC)
- Business Development, Operational Performance, and People and Performance reported directly to the Executive Team.
- The frequency of meetings varied, with weekly Executive Team meetings, monthly HODs and Regional Committee meetings. All others were indicated as taking place bi-monthly on documented information provided to us. The hospital manager indicated the MAC currently took place quarterly, and minutes reviewed confirmed this. We noted in the minutes dated 26 April 2016 the MAC agreed to move to bi-monthly meetings.
- The MAC membership was made up of the executive director, director of clinical services, surgeon, physician, and anaesthetist representatives. This was confirmed by the MAC chair.
- With the exception of MAC meetings, minutes of meetings reviewed by us contained standard agenda items, such as, hospital activity, finance, legislation and corporate policies, significant events and complaints, and updates to the risk register. Actions had been identified with ownership, date for delivery, and the status.
- There were procedures for ensuring only consultants with approved practicing privileges worked at the hospital. We reviewed five randomly selected consultant files and saw evidence of checks on fitness to practice, professional indemnity and registration. Appraisals and re-validation was monitored and requested where renewal was required.
- The MAC chair met with the hospital manager prior to the formal meeting, where they reviewed the agenda and items for discussion. Meeting minutes indicated practicing privileges were reviewed, as well as removals and suspensions. The management report was shared with attendees, followed by any other business. Resulting actions were summarised.

Good

Outpatients and diagnostic imaging

- Data from quality reports and dashboards provided oversight in relation to safety, effectiveness, and performance in general.
- Monthly Clinical Governance meetings were attended by managers from each area, as well as consultant representative. We reviewed several sets of minutes from such meetings and noted there was a detailed agenda, which addressed a wide range of subjects, relevant to governance, safety and quality.
- The hospital had a risk register and managers updated this accordingly. Managers in both the outpatient and diagnostic imaging department were aware of their department's risks, and these were correctly recorded on the hospitals risk register.
- Information provided to us indicated the lead paediatric nurse sat on the Clinical Governance Committee and represented children and young people services. The lead nurse also represented the paediatric committees, which incorporated resuscitation meetings and they attended the corporate safeguarding and best practice group for paediatrics.
- Children's services were audited through Quality Health and patient feedback.
- A Radiation Protection Advisor from a local Hospital NHS Foundation Trust oversaw the management of potential risks in diagnostics. A laser protection audit had been undertaken and an action plan was generated to meet this.
- The managers knew they were responsible for performance of their departments and received feedback from Clinical Governance and Heads of Department meetings and at individual performance reviews.
- The department managers attended a daily '10@10' meeting where a staff representative from each area had the opportunity to update the hospital manager and colleagues with respect to their department. We attended one of these, and witnessed the communication of information, such as activity, equipment matters, staffing and cover for holidays.

Leadership / culture of service

- There was effective and responsive leadership at the location executive level, and staff commented favourably on the hospital manager and other senior leaders. The executive team were very visible and staff said they were approachable. The size of the hospital helped staff to know one another and contributed to a feeling of 'family'. Staff told us there was a high level of comradery.
- There were heads of department (HOD), who were reported to work well together. They provided leadership and support to staff, as well as to the executive team. HOD met monthly and reviewed a range of subject areas, ensuring they were able to cascade information to their teams.
- We observed a good level of visibility and engagement of the departments senior teams, Staff we spoke with understood the departmental structure and knew who their line manager was. They reported feeling able to discuss issues with their line manager, and told us how they felt they could contribute to the running of the department.
- Staff told us the senior management were extremely visible and approachable. Staff were confident in the ability of senior management. All reported that either the hospital manager or the director of clinical services would visit the department daily and engage with staff, and managers of both departments were described as enthusiastic.
- We observed and it was confirmed by staff that the hospital was patient focused and staff arrangements and resources enabled them to provide a high level of care for patients. All staff who spoke with us felt there was an open culture in the department, and felt engaged as a part of a close team.
- We found the morning operations meeting, attended by the hospital's senior management team and heads of department, provided opportunities to discuss operational issues, incidents and other issues of relevance to the hospital each day leading to a healthy reporting culture.
- Our observations and discussions with staff confirmed with us an open culture where they felt confident to share ideas and to highlight any concerns, incidents, or errors and learn from the subsequent investigations.
- The requirements related to duty of candour were met through the processes for investigating incidents, and reviewing and responding to complaints. Staff were able to tell us how important it was to be open and honest with people when things went wrong. One staff member

told us that she had telephoned a patient to inform and apologise after she realised that she had performed the wrong blood test. She was able to arrange for her to be seen again at the patient's convenience.

- An equal opportunities approach was applied to recruitment and selection. Information provided to us showed the workforce, was in the main (76%) white British, 16% were of Asian ethnicity, 3.5% Black African, 0.80%, Black Caribbean, and 0.80%, Chinese. Other ethnic groups accounted for 2%, and 0.40% were mixed White. The remaining were not stated.
- We found there was positive and active management of staffing. For example, sickness rates for nurses working in outpatient departments in the reporting period (Apr 15 to Mar 16) were not high when compared to the yearly average of other independent acute hospitals, except for January 2016, when the rate of sickness was above the average. Sickness rates for outpatient health care assistants in the reporting period (Apr 15 to Mar 16) were not high when compared to the yearly average of other independent acute hospitals, except in April 2015, January, and March 2016, when sickness rates were above the average.
- There were no vacancies for nurses or health care assistants. Many staff had been working in the department for a long time. There had been a 1.3% staff turnover for outpatient nurses in the reporting period (April 2015 to March 2016). This rate was low when compared to other independent acute hospitals. There had not been any staff turnover for outpatient health care assistants. These figures suggested staff were happy working at the hospital, as was reported by staff.
- Most staff were aware the hospital had a whistleblowing policy. The manager was aware that she could whistle blow directly to the Care Quality Commission.

Public and staff engagement

- Patients attending the outpatient department had the opportunity to provide feedback through cards available in reception. In order to increase the number of responses, the staff had started giving these cards to all new patients during their appointment. We saw 64 completed cards and the overwhelming majority were positive.
- To the question 'How likely are you to recommend our service to friends and family if they needed similar care and treatment' for NHS patients, 100% of patients responded that they would recommend the service.
- Feedback cards were analysed and a report published by an independent company. The report was discussed with staff every month at their team meetings, which did included individualised feedback for positive comments. Negative feedback was given anonymously.
- We could find no evidence of the results of the patient survey on display in public areas in the department. Patients visiting the department were unaware of how well the department performed.
- The hospital provided placements for nursing students from a local university, as well as work experience for school children.
- We were told about a number of staff engagement activities, which included for example; monthly charity "Give it Up", 'fairy cakes' on Friday, Easter and Christmas competitions, Inspirational 'Quote of the week', a free birthday lunch. Staff were also named and received reward recognition letters.
- The hospital manager told us they ensured they walked the floor and spoke with staff, asking about the challenge they had. They also met with the HOD team and received corporate feedback with regard to performance.

Innovation, improvement and sustainability

- The recent upgrade of the OPD had meant there was now provision of a minor procedures room, for dermatology procedures. This had a positive impact on the patient journey, for example dermatology patients could have minor procedures carried out without the need for a new appointment or admission to a bed.
- The service was continuing to work with external Clinical Commissioning Groups, GP and Clinical Service Users to ensure best experience for the patients. Discussion with representatives of CCG indicated they received a service to the expected level and there were no concerns identified.
- Staff were proud of the impact of the recent refurbishment programme, aimed at improving the outpatient environment.
- The department had introduced a new more user-friendly diagnostic heart monitor. Plans for e - prescribing for Oncology patients were in progress.
- BMI Healthcare was shortlisted as a finalist in the IT innovator of the year category of the 2016 Health Investor awards for this system, which was being introduced throughout the group.

Outstanding practice and areas for improvement

Outstanding practice

The arrangements to engage with staff were acknowledged as a very positive and proactive approach to effective team work, and for respecting and valuing staff.

Areas for improvement

Action the provider SHOULD take to improve

- Improve compliance with the World Health Organisation (WHO) 'five steps to safer surgery' procedures.
- Improve consultant compliance with the use of personal protective equipment during invasive procedures, in line with NICE guidelines and BMI policy.
- Improve the completion of patient records to enable the availability of a fully detailed record.
- Consider how professional guidelines can be applied to support the safeguarding training further.
- Improve the use of the risk register with the incorporation of review dates for all identified risks.
- Consider having leaflets available in other languages as well as in English.
- Staff involved in the treatment and care of children and young people should have the required level of safeguarding training.
- Where oncology patients call the advice line, nursing staff should include an assessment and recording of patient temperature in the record.
- Provide a means of ensuring the summary of oncology patient MDT meeting are available in patient records.
- Review the accessibility of the resuscitation trolley for diagnostic staff.
- Undertake regular auditing with regard to the completion of pregnancy status declarations
- Review its position with regard to participate in imaging accreditation schemes or improving quality in physiological services scheme.
- Make it possible to obtain patient information leaflets in alternative languages.
- Make sure information to advise patients how to raise a concern or complaint more obvious in public areas.
- Review how information is communicated with regard to fees, so that patients do not find themselves complaining when they received their bill.
- Review the administrative facilities in the ODP and diagnostics.
- Consider how staff may be better informed of the hospitals strategic priorities.