BMI The Shirley Oaks Hospital

Quality Report

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

Ratings

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

Summary of findings

Letter from the Chief Inspector of Hospitals

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. It was a routine planned inspection.

We inspected the following two core services at the hospital: surgery, which included endoscopy, and outpatients and diagnostic imaging. The latter included both adult and children's outpatient services. We carried out the announced part of the inspection on 17 and 18 August 2016.

We report on whether they are safe, effective, caring, responsive to people's needs, and well-led. We have highlight areas of good practice and areas for improvement.

Overall, we found despite being well-led, and the staff providing a caring service,there were areas for improvement related to safety, effectiveness and the responsiveness of the service.

We rated the hospital as requires improvement overall. Surgery, which included endoscopy was rated as requires improvement and outpatient and diagnostic imaging was rated as good. For the hospital overall we rated the key questions as follows:

Are services safe at this hospital

We rated safety as requiring improvement overall because; safety procedures were not undertaken to a consistent standard. Surgical safety checks were not completed in a consistent manner, and some patient risk assessments had not been undertaken. Further, staff did not always undertake an assessment of patient risks in the outpatient department, by way of the recording of patient physiological observations before and after minor procedures. Patient information in the form of records were not always managed safely and securely.

We assessed the rates of clinical incidents in surgery and inpatients as being higher than the average of other independent acute hospitals, per 100 patient bed days.

Some clinical staff were not provided with the required level of safeguarding training.

Access to the operating theatre department was not restricted, and there was insufficient evidence of the servicing of theatre equipment. The safe storage of fluids used for patient treatment was not sufficiently managed.

However;

There were established systems to ensure incident were reported, investigated and lessons learned were shared with staff. Patient mortality and morbidity was reviewed as part of the safety procedures.

Staff understood the duty of candour. 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.

The hospital appeared clean and tidy, and staff had guidance in the form of infection prevention and control policies to support them in ensuring a safe environment and practices. There was an awareness where the environment required updating to meet infection control standards.

Summary of findings

The majority of staff had been provided with mandatory safety training. Technical and emergency equipment was available to support the safe delivery of treatment and care. Staff had processes to follow where the safety needs of patients required further interventions. Medicines were generally managed in accordance with professional guidelines.

There were sufficient staff available to support the needs of patients, and staffing was based on projected occupancy and overall activity levels. Consultants took overall responsibility for their patients, and they were supported by an on-site resident medical officer(RMO). The resident medical officer (RMO) was based in the hospital and provided medical cover 24 hours a day. We reviewed RMO cover and found it was sufficient.

Are services effective at this hospital

We rated effective as requires improvement overall because; consent processes were not sufficiently robust in surgery and the outpatient department. Consent forms were not always completed with clear and detailed information. Further, where patients did not have English as their first language, consent was obtained without the use of an approved interpreter.

Local audits and action plans were not available in all the departments visited. In particular, the outpatient department did not have a robust audit process, and lacked evidence of action plans.

However;

Patient outcomes were monitored and reviewed. There were no concerns identified with regard to unplanned re-admissions following surgery, un-planned returns to theatre. Between April 2015 and March 2016, there were 10 unplanned transfers of inpatients to another hospital because their condition had deteriorated. Investigation of these did not indicate any trends with regard to types of surgery or individual surgeons.

The hospital provided data to national Patient Reportable Outcomes Measures (PROMS). PROMS used patient questionnaires to assess the quality of care and outcome measures following surgery. The small numbers of patients involved, meant these findings could not be compared to national data.

Staff provided care to people based on national guidance, such as the National Institute for Care Excellence (NICE), and professional guidelines. We found evidence of staff following best practice with regard to patient surgery, pain management, nutritional needs, including pre-operative fasting, and pre-operative assessments. An enhanced recovery programme formed part of the care pathway for knee and hip replacement patients.

Radiology service had protocols and guidelines to assess and monitor patient risk such as a new World Health Organisation (WHO) checklist for radiological intervention procedures. They followed appropriate professional guidelines and were subject to monitoring by skilled practitioners.

The hospital was Joint Advisory Group on gastrointestinal endoscopy (JAG) accredited.

Staff had access to training and development opportunities, including practical based scenarios. Competencies were assessed, and nursing staff were being supported through revalidation.

Medical staff were required to provide information to the hospital in order to meet the requirements of assessing fitness to practice, and to gain approved practising privileges.

Are services caring at this hospital

We rated caring as good overall because; patients were cared for compassionately and with dignity and respect. Patients spoke positively about care and treatment and felt involved in the planning of their care. We observed staff providing patients with emotional support when patients were worried or anxious by holding their hand and spending time talking to them. Chaperones were provided when required.

Summary of findings

The friends and family test and internal patient survey scores showed the vast majority of patients would recommend the service to their friends and family. Patient-Led Assessments of the Care Environment (PLACE) results for the period February to June 2015, indicated a score of 91% for privacy and dignity, which was above the England average of 87%. We found the facilities enabled patients to be cared for in privacy, and there was open visiting, which enabled family and friends to provide support as required.

Patients were made aware of costs and fees associated with their consultation and subsequent treatment. There were a range of methods for making payment.

Are services responsive at this hospital

We rated responsive as requires improvement overall because; translation services were not always arranged in advance, and there was a reliance on family members to translate, which was not best practice. Information was not available in alternative languages.

Outpatient clinics were sometimes cancelled with 72 hours, and we were not assured that patients would be rebooked quickly.

However;

Services were generally arranged to meet the needs of patients. There was a degree of flexibility around appointments and agreeing admission dates for elective surgery. An admissions policy set out the criteria for admission acceptance, including where the hospital was not able to safely provide the expected required levels of treatment and care.

The service was accessible and arrangements were made to take account of patients individual needs. Patient needs were identified at consultation and during pre-assessment.

Physiotherapy, pharmacy and diagnostic services were arranged to support patient needs.

Staff in the outpatients department told us there were short waiting times of one to two weeks for privately funded appointments and NHS patients would wait from one to six weeks to be seen.

Surgical cancellations were low during the period from April 2015 and March 2016. The proportion of patients treated within the 18 week referral to treatment target was 98%.

Where complaints were raised, these were acknowledged, investigated and responded to. Learning from complaints or concerns was communicated to staff through meetings with heads of departments.

Are services well-led at this hospital

We rated well-led as good overall because; there was a philosophy based on the aim to continuously improve quality and enhance patient experience. Key priorities had been identified for the financial year, which staff were aware of and contributed to achieving. Progress on business plans were continuously reviewed.

Clinical governance was well established, and meetings provided opportunities to review quality of services, key indicators and performance. Governance information was communicated to staff via the 'Clinical Governance and Quality & Risk Bulletin'. These bulletins contained details of safety alerts related to medical devices, medicines and patient safety.

A daily communication meeting was held, which provided staff representative from each area the opportunity to update the hospital manager and colleagues with respect to their department.

There was a culture of transparency and honesty amongst staff. Staff felt supported and that there was an open door policy. Staff were focused on providing patient centred care and ensuring a good patient experience. The majority of staff reported they enjoyed working at the hospital, and were proud to do so.

Summary of findings

Staff told us managers were visible and the leadership at executive and department levels were found to be effective and responsive. Staff commented favourably on the senior leadership team.

Staff told us practice was benchmarked against other BMI hospitals and they received feedback on patient comment cards.

However;

Audits and associated action plans related to outpatients were not sufficiently robust. As a result improvements could not always be evaluated. Senior members of staff dealing with risk management could not locate audit action plans or evidence improvements, and there was a lack of support for staff in the OPD to improve on audit practise.

There was an absence of local risk registers available and staff did not always understand the top risks in their departments.

The regular morning engagement meeting was well established. This provided representative staff from each area the full opportunity to share and discuss information.

There were areas of poor practice where the provider needs to make improvements.

Importantly, the provider must:

- Ensure the consent processes take into account best practice. The use of an interpreter must be arranged for all patients who do not speak English. Family members should not be used to translate for patients.
- The OPD must ensure consent is being completed in line with policy and legislation. Patients must have risks and benefits of procedures discussed with them and documented.

Action the provider SHOULD take to improve

- Assess the content and provision of training, along with staffs understanding of the Mental Capacity Act and Deprivation of Liberty Safeguards.
- Store all patient identifiable records securely.
- Provide information leaflets in other languages when required.
- Review the screening rates for the risk of developing a venous-thromboembolism (VTE) and improve this to the 95% target.
- Include patient physiological assessments when they are having minor procedures.
- Increase staff adhere to hospital policies with regard to protecting patients from the risk of acquiring a hospital related infection.
- Review surgical site infection rates for primary hip arthroplasty and breast surgery rates to identify and act on possible improvements.
- Review access to the operating theatre to make secure.
- Consider how data on the servicing of equipment can be kept up to date and made available.
- Improve the consistency of labelling on fluids kept in the warming cabinets in theatre.
- Gain assurance of the resident medical officers (RMO) level of safeguarding training to the required level.
- Provide level 3 safeguarding training to relevant staff in line with the local policy and Royal College of Paediatrics and Child Health document “Safeguarding children and young people: roles and competences for health care staff intercollegiate document 2014”.
- The ODP along with the risk manager should develop a robust audit structure and a risk register.

Professor Sir Mike Richards
Chief Inspector of Hospitals

Summary of findings

Overall summary

Overall, we rated the services at this hospital as requires improvement.

- We had concerns around consent processes in outpatients and for patients undergoing surgical procedures, particularly where patients did not have English as their first language. Information leaflets were not available in alternate languages. Family members were used to translate for patients, and the interpretation services were not routinely used.
- Safety checks, including the recommended World Health Organisation (WHO) surgical checklists were not always fully completed.
- For the time period April 2015 to March 2016, the assessed rates of clinical incidents in surgery, and inpatients per 100 bed days was higher than the average of other independent acute hospitals we hold this type of data for.
- Some staff had not been trained to the required level of safeguarding vulnerable children.
- Despite the provision of training, staff knowledge of the principles of the Mental Capacity Act 2005 and deprivation of liberty safeguards was variable.
- Although there was evidence of local audits and action plans in most clinical department, the OPD did not have a formalised audit structure. We were unable to view completed action plans for the OPD audits.
- Screening rates for the risk of developing a Venous Thromboembolism (VTE) were far below the 95% in all four quarters of the period April 15 - March 16. Ranging from 64% to 71% over the four quarters. Further, an assessment of patient risk was not always completed in the OPD. Nursing staff rarely undertook and recorded clinical observations for patients undergoing minor procedures.
- There was unsecured access to the theatre environment, and equipment servicing data was not readily available in theatres. Some medical items stored in a temperature controlled environment in theatres were not suitably labelled.
- Patient identifiable information was not always managed safely or in accordance with confidentiality and data protection guidance.
- Patients reported experiencing long waiting times for follow up appointments, and long waits once they had arrived at the clinic. Further, clinics in the OPD were cancelled as little as 72 hours beforehand.
- There was a lack of risk register in the OPD and staff were not aware of the local risks impacting on their patients.

However;

- Incidents were reported, investigated and lessons learned were shared with staff. Staff understood the requirements of the duty of candour, including informing people about the incident, providing reasonable support, providing truthful information and an apology when things go wrong.
- We observed good infection prevention and control (IPC) practices. There were arrangements to update the patient rooms where carpeting was used, as this did not meet IPC standards.
- Medicines were managed safely and clinical equipment was readily available, appeared clean and was functional. Emergency resuscitation equipment checks were regularly undertaken.
- The training information provided showed most staff had attended mandatory safety training. All staff had a minimum of basic life support training and there were paediatric-trained staff to care for children under the age of 18 when children's clinics were running.
- We saw use of evidence based practice and national guidelines in all departments. This included care of patients with respect to nutritional needs and pain management.
- There were sufficient levels of staff, with appropriate skills and experience to care for patients. These individuals provided dignified, compassionate and respectful care. Patients and their families were

Summary of findings

positive about the care they received at BMI The Shirley Oaks Hospital. Such care took into account their cultural and religious needs, as well as individual choices.

- Access and flow was generally good, with low cancellations of surgical procedures. The service was meeting the 92% target for NHS referral to treatment time of 18 weeks most months. Privately funded patients rarely waited to see a consultant for an initial consultation.
- Patients views were sought and where complaints were raised, these were investigated and responded to. Staff understood the hospital's aim to continuously improve quality and enhance patient experience. Staff felt the ongoing refurbishment plans would further enhance the patient's experience.
- There was effective and responsive local leadership at the executive level, and staff commented favourably on the senior staff. 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'.
- A local business plan underpinned the broader organisational vision to provide the best patient experience, best outcomes and the most cost effective. The local vision was understood and applied in practice by staff in their interactions with patients.
- There was a culture of transparency and honesty amongst staff. Staff told us managers encouraged and supported them to report incidents.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Surgery	Requires improvement 	Overall, we rated Surgery and Endoscopy as requires improvement. We rated safe and effective as requires improvement and caring, responsive and well led as good. • There were concerns around consent for people for who English was not their first language. Information leaflets were not available in any other languages. Family members were used to translate for patients, and the interpretation services were not routinely used. • World Health Organisation (WHO) surgical checklists were not always fully completed. • There were systems to ensure incident reports were investigated and lessons learned were shared with staff. Staff understood the duty of candour. The duty of candour regulation sets out specific requirements to be followed when things go wrong with care and treatment. This includes informing people about the incident, providing reasonable support, providing truthful information and an apology when things go wrong. • We observed good infection prevention and control (IPC) practices. A programme of work was in place for addressing the replacement of carpet in patient rooms, in order to meet IPC standards. Clinical equipment appeared clean and functioning. Daily monitoring of resuscitation equipment had taken place. • The training information provided showed most staff had attended mandatory safety training. • The Resident Medical Officer (RMO) had training via their employment agency. All staff had a minimum of basic life support training and staff told us they could ask for additional courses and managers would support them. • We saw use of evidence based practice and national guidelines in all departments.

Summary of findings

- Staff provided dignified, compassionate and respectful care. Patients and their families were positive about the care they received at BMI the Shirley Oaks Hospital.
- All surgery carried out at the hospital was elective and staff reported it was easy to plan the workload. Operating theatre lists for surgery were available in advance and patients could select times and dates to suit their family and work commitments.
- There were high levels of staff stability and low rates of sickness within the surgical teams.
- Surgical staff understood the hospital's aim to continuously improve quality and enhance patient experience. Staff felt the ongoing refurbishment plans would play a greater role in enhancing patient's experience.
- There was effective and responsive local leadership at the executive level, and staff commented favourably on the senior staff. 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'.
- There was a culture of transparency and honesty amongst staff. Staff told us managers encouraged and supported them to report incidents.

Outpatients and diagnostic imaging

Good

Overall, we rated the outpatients department and diagnostic imaging as good. We rated safe as requires improvement, and caring, responsive and well led as good. We do not currently provide a rating for the effective domain in the OPD.

- There were systems to ensure incident reports were investigated and lessons learned were shared with staff. Staff understood the duty of candour.
- We observed good infection prevention and control (IPC) practices but, some chairs in consulting rooms did not meet IPC standards.
- Clinical equipment was serviced, appeared clean and functioning. Daily monitoring of resuscitation equipment had taken place.

Summary of findings

- The training information provided showed between 85% and 100% of staff had attended mandatory safety training.
- The Resident Medical Officer (RMO) had training via their employment agency.
- All staff had a minimum of basic life support training and there were paediatric-trained staff to care for children under the age of 18 when children's clinics were running.
- Staff told us they could ask for additional courses and managers would support them.
- We saw use of evidence based practice and national guidelines in all departments.
- Assessment of patient risk was not always completed in the OPD, as observations were rarely done for patients undergoing minor procedures.
- There was an admitting criterion for patients whose conditions were complex.
- The radiology service had protocols and guidelines to assess and monitor patient risk such as a new World Health Organisation (WHO) checklist for radiological intervention procedures. There was no use of a WHO checklist for patients undergoing minor surgical procedures such as skin biopsies in the OPD.
- We saw consent was poorly completed in the OPD, with no documentation that risks were explained to the patient.
- Although there was evidence of local audits and action plans in the physiotherapy and imaging departments, the OPD did not have a formal audit structure. We were unable to view completed action plans for the OPD audits.
- Staff provided dignified, compassionate and respectful care. Patients and their families were positive about the care they received at BMI the Shirley Oaks Hospital. They told us they felt involved in their care and staff were very helpful.
- The service was meeting the 92% target for NHS referral to treatment time of 18 weeks most months.

Summary of findings

- Privately funded patients rarely had a wait to see a consultant initially. However, several patients told us they had experienced long waiting times for follow up appointments, and long waits once they had arrived at clinic.
- The BMI Shirley Oaks Hospital was benchmarked against other BMI hospitals and staff told us they were attempting to improve their current low standing of 47 out of 55.
- Staff were positive about working in the service and felt encouraged to make suggestions for improvement.
- Staff told us there was strong teamwork and managers were visible and easy to talk with.

Summary of findings

Contents

Requires improvement

BMI Shirley Oaks Hospital

Services we looked at

Surgery, which included endoscopy; Outpatients and Diagnostic Imaging.

Summary of this inspection

Background to BMI The Shirley Oaks Hospital

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.

The hospital is located near to Croydon, within easy access of public transport and major roads. It is a purpose built hospital, situated close to a residential area. Parking, including disabled spaces is provided.

BMI The Shirley Oaks Hospital has 42 beds, two operating theatres, an extended recovery area, and separate endoscopy suite.

The outpatients department (OPD), which includes consultation rooms has 10 rooms, two minor procedure rooms, one audiology screening booth and a cardiology screening room.

A standalone physiotherapy department provides a range of therapies including, hand therapy, men and women's health clinics and Pilate's classes.

The diagnostic imaging department is located on the first floor of the hospital. It provides a range of imaging facilities including x-rays, computerised tomography (CT), and ultrasound scanning. Radiographers provide a 24-hour service for inpatients. MRI scanning is provided by a separate private company, which we did not inspect on this occasion. There are interventional procedure clinics on a weekly basis.

Our inspection team

Our inspection team was led by Stella Franklin, Inspection Manager, and a team of inspectors for The Quality Commission, supported by two specialist advisors.

Why we carried out this inspection

We carried out this inspection as part of our planned programme of regulatory visits.

How we carried out this inspection

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

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

We visited BMI The Shirley Oaks Hospital during an announced inspection on 17 and 18 August. We spoke to 28 members of staff including managers, consultants, physiotherapists, nurses, and healthcare assistants. We spoke with 14 patients and two relatives. We looked at 26 sets of patient records, made observations of the environment and staff interactions with patients and other people using the services.

Summary of this inspection

Information provided to us prior to the inspection was fully considered, in addition to supplementary information provided during the visit.

Information about BMI The Shirley Oaks Hospital

BMI The Shirley Oaks Hospital is registered with the commission to provide the following regulated activities;

Diagnostic and screening procedures

Family Planning

Surgical procedures

Treatment of disease, disorder or injury

The hospital is registered for 50 beds, although at the time of the inspection only 42 beds were in use on the ground and first floor wards, within the Extended Recovery Unit and Endoscopy. All ward rooms offered privacy and comfort of en-suite facilities, satellite flat screen TV, a telephone and Wi-Fi guest internet service. The hospital has two theatres, one of which has ultraclean airflow (laminar flow). The outpatients department provides a wide range of services and is open until 9.00 pm and 1.00 pm Saturdays. The Endoscopy Suite is JAG accredited and offers diagnostic services within a discrete unit with a dedicated procedure room.

The Extended Recovery Unit is used for planned Critical Care Level 1 patients who require additional extended recovery post-surgery or for patients who become unwell and need increased care for a short period. Patient services are supported by Pharmacy, Physiotherapy and Radiology services. Wide bore MRI and CT scanning are available on site.

BMI The Shirley Oaks Hospital attracts over 100 Consultants, who provide consultation services to patients who required elective surgery or other diagnostic procedures.

Elective adult surgical procedures included; orthopaedic, gynaecology, ophthalmic and general surgery. Surgical services were provided to both insured and self-pay private patients and to NHS patients through both GP referral and hospital referral.

There were 4,221 visits to the theatre between April 2015 and March 2016. Patients were admitted under a named consultant and the Resident Medical Officer (RMO) was available 24 hours a day.

BMI The Shirley Oaks Hospital provides outpatient clinics for adults, as well as children and young people, aged 3-17 years old. From April 2015 to March 2016 there were 31,176 OPD attendances. NHS patients accounted for 33% of these attendances, whilst 67% had private funding or were self-paying. The OPD offers a range of clinics including orthopaedics, urology, gynaecology and cardiology.

From April 2015 to March 2016 there were 715 attendances of children and young people. They have a service level agreement with a paediatric nurse from another BMI hospital to attend during the paediatric clinics. The resident medical officer (RMO) is trained in advanced paediatric life support.

What people who use the service say

People who spoke with us told us they were happy with the services provided, the attention of staff, and their caring nature. Staff were said to be kind, considerate and ensured their dignity and respect was upheld.

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 

We rated safe as requires improvement because;

- Safety checks, including the recommended World Health Organisation (WHO) surgical checklists were not always fully completed.
- Some staff had not been trained to the required level of safeguarding vulnerable children.
- Despite the provision of training, staff knowledge of the principles of the Mental Capacity Act 2005 and deprivation of liberty safeguards was variable.
- Screening rates for the risk of developing a Venous Thromboembolism (VTE) were far below the 95% in all four quarters of the period April 15 - March 16. Ranging from 64% to 71% over the four quarters. Further, an assessment of patient risk was not always completed in the OPD. Nursing staff rarely undertook and recorded clinical observations for patients undergoing minor procedures.
- There was unsecured access to the theatre environment, and equipment servicing data was not readily available in theatres. Some medical items stored in a temperature controlled environment in theatres were not suitably labelled.
- Patient identifiable information was not always managed safely or in accordance with confidentiality and data protection guidance.

However;

- Incidents were reported, investigated and lessons learned were shared with staff. Staff understood the requirements of the duty of candour, including informing people about the incident, providing reasonable support, providing truthful information and an apology when things go wrong.
- We observed good infection prevention and control (IPC) practices. There were arrangements to update the patient rooms where carpeting was used, as this did not meet IPC standards.
- Medicines were managed safely and clinical equipment was readily available, appeared clean and was functional. Emergency resuscitation equipment checks were regularly undertaken.

Summary of this inspection

- There were sufficient staff on duty to provide the required level of treatment and care. Consultants were responsible for patient treatment and a resident medical officer provided support to clinical staff.
- The training information provided showed most staff had attended mandatory safety training. All staff had a minimum of basic life support training.

Are services effective?

Requires improvement

We rated effectiveness as requires improvement because;

- We had concerns around consent processes in outpatients and for patients undergoing surgical procedures, particularly where patients did not have English as their first language. Family members were used to translate for patients, which was not best practice.
- Although there was evidence of local audits and action plans in most departments, the OPD did not have a formal audit structure. We were unable to view completed action plans for the OPD audits.
- We saw use of evidence based practice and national guidelines in all departments. This included care of patients with respect to nutritional needs and pain management.
- Staff had appropriate skills and experience to care for patients. They had access to training and development opportunities, and had their performance reviewed periodically.
- Nursing staff working with children had appropriate training, including paediatric life support. Paediatric trained nurses were on duty when children used the outpatient services.
- Consultants using the service were required to provide evidence of fitness to practice along with other supporting information before they had practising privileges agreed.

Are services caring?

Good

We rated caring as good because;

- Staff provided dignified, compassionate and respectful care.
- Patients and their families were positive about the care they received at BMI the Shirley Oaks Hospital. They told us they felt involved in their care and staff were very helpful.

Are services responsive?

Good

We rated responsiveness as requires improvement because;

- Patients told us they had experienced long waiting times for follow up appointments, and long waits once they had arrived at outpatient clinics.

Summary of this inspection

- The hospital was benchmarked against other BMI hospitals and staff told us they were attempting to improve their current low standing of 47 out of 55.
- Information leaflets were not provided in alternative languages, and the interpretation service was not always used when important information needed to be shared with patients whose first language was not English.

However;

- Access and flow was generally good, with low cancellations of surgical procedures. The service was meeting the 92% target for NHS referral to treatment time of 18 weeks most months. Privately funded patients rarely waited to see a consultant for an initial consultation.
- Patients views were sought and where complaints were raised, these were investigated and responded to. Staff understood the hospital's aim to continuously improve quality and enhance patient experience. Staff felt the on-going refurbishment plans would further enhance the patient's experience.

Are services well-led?

Good

We rated well-led as good because;

- There was effective and responsive local leadership at the executive level, and staff commented favourably on the senior staff. 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'.
- A local business plan underpinned the broader organisational vision to provide the best patient experience, best outcomes and the most cost effective. The local vision was understood and applied in practice by staff in their interactions with patients.
- The local governance arrangements ensured the services were continuously monitored and where actions were required, these were taken.
- Risk management procedures were generally embedded across the service, although the lack of an outpatient risk register meant staff in that area could not identify potential and actual risks.
- Arrangements were sufficiently organised to ensure only consultants with approved practising privileges worked at the hospital.
- There was a culture of transparency and honesty amongst staff. Staff told us managers encouraged and supported them to report incidents.

Summary of this inspection

- Staff were listened to and encouraged to continuously develop their skills and experiences.
- Feedback from patients and staff contributed to service improvements.

Detailed findings from this inspection

Overview of ratings

Our ratings for this location are:

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

Notes

Requires improvement

Surgery

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

Information about the service

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.

The hospital has 42 beds, two operating theatres, an extended recovery and separate endoscopy suite.

Surgical services at BMI The Shirley Oaks Hospital consisted mainly of adult elective surgery, including orthopaedic, gynaecology, ophthalmic and general surgery. Surgical services were provided to both insured and self-pay private patients and to NHS patients through both GP referral and hospital referral.

The inpatient rooms were contained on two wards; however, one ward was closed for refurbishment when we visited. Each single room has ensuite facilities with a shower. There were two operating theatres (one with laminar air flow). One operating theatre was closed for refurbishment when we visited.

There were 4,221 visits to the theatre between April 2015 and March 2016. The five most common surgical procedures performed were:

- Diagnostic endoscopic examination of bladder (915)
- Phako-emulsification of lens with implants - unilateral (844)
- Diagnostic oesophago-gastro-duodenoscopy (OGD) (679)
- Diagnostic colonoscopy, including forceps biopsy (509)
- Therapeutic colonoscopy with snare loop biopsy (331)

Patients were admitted under a named consultant and the resident medical officer (RMO) was available 24 hours a day. Patients were cared for by a team of nurses and a pharmacist who were supported by dedicated administrative staff.

We carried out an announced inspection over two days on the 17 and 18 August 2016 and visited the wards, pre-assessment unit and the operating theatres. We spoke with 15 members of staff (medical, nursing, allied health professional, housekeeping and administrative) and six patients, and their relatives. We also reviewed five patient records as well as a number of policies and guidelines

Requires improvement

Surgery

Summary of findings

Overall, we rated Surgery and Endoscopy as requires improvement. We rated safe and effective as requires improvement and caring, responsive and well led as good.

- Consent processes were not sufficiently rigorous, in that documentation was not always completed fully and clearly. Patients whose first language was not English were not always provided with an authorised interpreter so that they could be fully informed of the benefits, risks and treatment plan.
- World Health Organisation (WHO) surgical checklists were not always fully completed.
- Between April 2015 and March 206, the assessed rates of clinical incidents in surgery, and inpatients per 100 bed days were higher than the average of other independent acute hospitals we hold this type of data for.
- There were systems to ensure incident reports were investigated and lessons learned were shared with staff. Staff understood the duty of candour. 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.
- We observed good infection prevention and control (IPC) practices but some patient rooms had carpet which did not meet IPC standards. Clinical equipment appeared clean and functioning. Daily monitoring of resuscitation equipment had taken place.
- The training information provided showed most staff had attended mandatory safety training.
- The resident medical officer (RMO) had training via their employment agency. All staff had a minimum of basic life support training and staff told us they could ask for additional courses and managers would support them.
- We saw use of evidence based practice and national guidelines in all departments.
- Staff provided dignified, compassionate and respectful care. Patients and their families were positive about the care they received at BMI The Shirley Oaks Hospital.
- All surgery carried out at the hospital was elective and staff reported it was easy to plan the workload. Operating theatre lists for surgery were available in advance and patients could select times and dates to suit their family and work commitments.
- There were high levels of staff stability and low rates of sickness within the surgical teams.
- Surgical staff understood the hospital's aim to continuously improve quality and enhance patient experience. Staff felt the on going refurbishment plans would play a greater role in enhancing patient's experience.
- There was effective and responsive local leadership at the executive level, and staff commented favourably on the senior staff. 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'.
- There was a culture of transparency and honesty amongst staff. Staff told us managers encouraged and supported them to report incidents.

Requires improvement

Surgery

Are surgery services safe?

Requires improvement

We rated the service as requires improvement for safety. This was because:

- The assessed rates of clinical incidents in surgery and inpatients per 100 bed days was higher than the average of other independent acute hospitals we hold this type of data for.
- Screening rates for the risk of developing a Venous Thromboembolism (VTE) were far below the 95% in all four quarters of the period April 2015 - March 2016. Ranging from 64% to 71% over the four quarters.
- Arrangements to protect patients from the risk of acquiring a hospital related infection were not always followed by all staff. This included staff lack of adherence to hospital policies.
- There was no controlled access to theatre.
- Equipment servicing data was not easily available and we were not assured the equipment had been serviced in a timely manner. There were out of date servicing stickers from the old servicing provider on all theatre equipment.
- Fluids kept in the warming cabinet were not consistently labelled.
- The recommended practice of completing World Health Organisation (WHO) surgical checklists was not undertaken to a consistent level.
- Theatre register, implant book and old theatre lists were stored in an unlocked trolley. These documents contained patient identifiable information.

However;

- There was a clearly defined process to investigate incidents and to share learning from such events.

Incidents

- Incidents were reported through a database. These were then reviewed and investigated where necessary. There had not been any serious incidents in surgery for the period April 2015 to March 2016. A total of 374 clinical incidents occurred in the reporting period, of which 92% (345 incidents) occurred in surgery or inpatients.
- For the time period, April 2015 to March 2016, the assessed rates of clinical incidents in surgery, inpatients and other services (per 100 bed days), were higher than the average of other independent acute hospitals we hold this type of data for. However, the rate of clinical incidents was below that of the comparator group within BMI.
- There were 21 non-clinical incidents in the reporting period April 2015 to March 2016. Of these, 29% (six incidents) occurred in surgery or inpatients. The rates of non-clinical incidents in surgery, inpatients and other services were lower than the average of other independent hospitals we hold this type of data for.
- There had not been any Never Events during the year leading up to our inspection. 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 saw detailed information demonstrating learning had led to improved training and responsiveness to resuscitation. Auditing of child and adult resuscitation had improved significantly when unplanned skills drills had been carried out following the implementation of improvement measures, arising from an adverse event.
- 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.
- In our discussion with the director of clinical services (DoCS) they could not provide any examples where the duty of candour regulation had been applied in practice. They provided us with a record of an apology in response to a complaint.
- There were three deaths in the reporting period (April 2015 to March 2016); of these one was unexpected. A further two deaths were reported to the CQC since March 2016. Mortality was rare at the hospital; therefore all deaths were investigated fully to identify if any

lessons needed to be learned. Only one patient died whilst receiving treatment in the hospital and the death was an expected outcome. Two further deaths of patients were also the expected outcome but the patients did not die whilst receiving treatment in the hospital

Cleanliness, infection control and hygiene

- We saw copies of the BMI Healthcare group's hand hygiene policy, standard infection control precautions policy, and clinical uniform policy. All these policies were in-date and referred to national guidelines, for example the World Health Organisation (WHO) Guidelines on Hand Hygiene in Health Care (2010).
- The hospital had policies and procedures to manage infection prevention and control. Staff had access to the policies on the hospital's intranet and could demonstrate how to access these. As of June 2016 infection prevention control (IPC) training on BMI learn – awareness was at 86%, IPC In Healthcare training was at 72% of staff and aseptic non touch techniques and care bundle training was at 75% all against a training programme target of 90%.
- We met the IPC lead, who told us a hand hygiene audits were carried out monthly and showed compliance between 90% - 100% with hand hygiene processes. The IPC lead gave immediate feedback to staff so they knew if they needed to improve their practice.
- However, we saw examples of non-compliance with infection prevention and control (IPC) policies. We saw one member of staff enter the theatre, anaesthetic room and recovery area in outdoor clothes, contrary to BMI Healthcare clinical uniform policy. The policy stated, "All personnel who enter the restricted area of the theatre suite should don the attire intended for use within the surgical environment".
- We saw staff cleaning the theatre, anaesthetic room and recovery area and viewed the weekly cleaning rotas, which were completed. Green "I am clean" stickers were in place throughout the operating suite.
- The operating theatres and endoscopy suite were tidy and clutter free and were visibly clean.
- The ward environment, pre-assessment area and theatre had dedicated cleaning staff and we observed these areas to be visibly clean. Cleaning staff had received appropriate training and were supplied with nationally recognised colour- coded cleaning equipment. This enabled them to follow best practice with respect to minimising cross-contamination. Cleaning staff understood cleaning frequency and standards and said they felt part of the team.
- There was easy access to personal protective equipment (PPE) in all areas we inspected and staff used PPE during their activities as required. We observed most staff were bare below the elbow.
- In the Patient-Led Assessment of the Care Environment (PLACE) audit between February 2015 and June 2015, the hospital scored 98% for cleanliness, equal to the national average for independent hospitals.
- The six patient rooms had carpeted floors in use in the ward environment. This did not meet the requirements of Health Building Notice (HBN) 00-09: Infection control in the built environment. The provider recognised this risk and we were informed about the refurbishment programme, which was currently underway, and the plan was to replace all the carpeted floorings.
- During our visit the theatre with laminar flow, a system of circulating air that reduces the risks of airborne contamination, was closed for refurbishment of the flooring. No orthopaedic work was undertaken whilst the flooring in the theatre was being replaced.
- The hospital reported five surgical site infections (SSI's) between April 2015 and March 2016. Of these, four related to primary hip arthroplasty and one breast.
- There was one case of meticillin Sensitive Staphylococcus Aureus (MSSA) and one case of meticillin Resistant Staphylococcus Aureus (MRSA) during the period April 2015 to March 2016. There were no reported cases of Clostridium difficile (C.diff) or Escherichia coli (E-Coli) during the same period.
- 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. We observed staff correctly handling waste and using sharps bins.

Environment and equipment

- All patients were accommodated in en-suite private rooms, which were located off the main ward corridors. All rooms were equipped with a nurse call bell and emergency buzzers within the main bedroom area and the en-suite bathroom.
- Theatres were located on the first floor near ward two and upstairs from the second ward. There was no controlled access via keypad lock. One of the operating

theatres had laminar flow, which is considered best practice for ventilation within operating theatres. Staff explained all joint replacement surgery took place in the laminar flow theatre.

- There were dedicated rooms on the ward for the storage of equipment, which were found to be tidy and equipment was stored safely. Equipment was labelled with a green sticker to show it had been cleaned and was fit for use.
- Sharps bins were located appropriately throughout theatres, recovery and the surgical wards. All bins inspected had been labelled correctly and none were overfull.
- All equipment we checked appeared clean and was stored appropriately. There was evidence of equipment safety checks having been undertaken. However, we were not able to ascertain servicing for the equipment in the operating suite. Most pieces of equipment had out of date servicing information relating to the previous servicing contractor, and had not been updated by the new servicing contract holder. We were not able to obtain sufficient information from the manager in charge of service to assure us the equipment had been serviced on time.
- There was adequate storage for consumables in recovery and on the ward; items were stored in labelled drawers to allow efficient access for staff.
- We saw resuscitation equipment readily available on the ward and in theatre, with security tabs present on each. Systems were in place to check equipment daily and weekly to ensure it was ready for use. We saw from records staff had mostly complied with these checks.
- We observed some of the patient bedrooms on ward two had carpets. Carpets in clinical areas prevent the effective cleaning and removal of bodily fluid spillages and therefore pose an infection control risk. The Department of Health's HBN00-09 states, "Carpets should not be used in clinical areas". We were informed of the refurbishment schedule, which was in place for the removal of carpet from patient bedrooms.

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.
- Medicines, including intravenous fluids, which needed to be stored in a refrigerator, were stored correctly. Ambient temperature of medicines' storage rooms and fridge were recorded on the ward and in the operating theatre department, and were within acceptable limits. We noted recording of fridge temperatures in the operating department had not been very consistent but had improved in the month prior to our visit. There was a procedure to follow should temperatures fall out of the defined range, and staff were aware of this process.
- Fluids kept in the warming cabinet were not consistently dated, we observed some fluids without dates, some fluids dated with the date they were placed in the cabinet and some dated with the date for removal from the cabinet.
- We reviewed six medication administration charts and saw they were fully completed, including details of any missed doses and the reason for this. Allergies were also clearly documented on each chart.
- An on-site pharmacy service was provided for inpatients and outpatients during the opening hours of Monday to Friday 8:30am to 4:30 pm and an on-call service was available out of hours. The pharmacy team comprised of a pharmacist who was also the manager, two bank pharmacists and one pharmacy technician. There were specified arrangements for staff to gain emergency access to the pharmacy out of hours, with the resident medical officer (RMO) holding keys.
- 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.
- Basic packs of some take home medicines were available on the ward in a designated cupboard. If needed the RMO could access pharmacy for stock items out of hours.

Requires improvement

Surgery

Records

- The hospital used a paper based record system to record all aspects of patients care. Patient records contained information of the patient's journey through the service including pre assessment, investigations, test results and treatment and care provided.
- Patient pathways and care plans were comprehensive and contained risks assessments such as manual handling, bed rails and pressure ulcers. We saw all care plans and risks assessments were completed in the 10 records we reviewed.
- We saw evidence some World Health Organisation (WHO) surgical checklist were incomplete. Of the six records reviewed we found there were no dated signatures at the end of the list. There was no evidence of oversight of these matters and we did not see any actions plans for improvement.
- Medical records were held on site in a secure department on the ground floor of the hospital. When they were sent to the theatre, ward or endoscopy they were kept in a locked cupboard when not in use.
- Both private and NHS notes were kept in the hospital and all staff we spoke to said there was no issue with obtaining notes when required. We were told there were rarely times when notes were not available.
- Staff stored notes securely in the nurses' office to prevent unauthorised access to confidential patient data. We examined the records for six patients on ward two, and found a good standard of documentation in most areas, including the completion of individual care plans. However, although patients and staff had fully completed surgical consent forms, in four sets of patient notes staff had not securely filed the consents. We also saw loose pathology results in four sets of patient notes. Failure to effectively file paperwork risked confidential patient data falling out. This risked unauthorised access to confidential data and accidental loss of essential medical information.
- The theatre register, implant book and old theatre lists were stored in an unlocked trolley in theatre. Patient identifiable information was contained within these books and documents.

Safeguarding

- The hospital had up-to-date safeguarding policies and procedures for both children and adults. Staff knew the safeguarding leads in their hospital and how to contact them. Staff we spoke with were aware of their responsibilities in relation to safeguarding vulnerable adults and could locate and describe the hospital's safeguarding policy. Nursing staff told us they would rarely need to make a safeguarding referral but were aware of who the safeguarding lead was and had contact details for the local authority safeguarding team.
- Safeguarding training was mandatory for all staff and all registered nurses were required to complete level two as a minimum. Non-clinical staff completed level one safeguarding.
- Information provided pre-inspection showed 96% of staff were trained to level two. The RMO had safeguarding training but could not tell us what level this was. When we looked at training certificates from the agency this did not state the level of training.
- The hospital had a chaperone policy, which was visible in all patient care areas.
- We reviewed the 'BMi learn' training system and noted staff had access to safeguarding training, which included deprivation of liberty safeguarding (DoLS), the Mental Capacity Act (2005), and PREVENT (Prevent is part of the Government's counter-terrorism strategy, CONTEST. Its aim is to stop people becoming terrorists or supporting terrorism).We were told there were two consultants with practicing privileges who had safeguarding responsibilities. We reviewed their personnel files and noted there was a lack of information to demonstrate training for this responsibility. We saw minutes from a wider community safeguarding children board, which the director of clinical services (DoCS) participated in.

Mandatory training

- Training in safety related subjects were completed via the BMi learn system, which staff accessed via a designated password. We noted subjects covered included for example; consent, infection prevention and control, fire, waste management.
- As a result of an adverse event all clinical staff were required to complete intermediate or advanced life support, applicable to their role. This was monitored via the electronic learning system.

- Information we received pre-inspection showed that between 85% and 100% of staff in the departments we inspected had completed their mandatory training up to May 2016. The target for this training was 90% and managers told us they would give staff protected time for learning to ensure they reached their targets.
- Training was monitored online; this meant the staff could be alerted when a module was due to be completed. Managers had access to this, and would remind staff if they had not completed their training. We were told completion of training was linked to the annual pay increment.
- We were told the RMO completed all mandatory training through their agency including advanced life support for both adults and children. We saw certificates for these courses during our inspection.

Assessing and responding to patient risk

- We observed theatre staff carrying out the WHO Surgical Safety Checklist for three procedures. The WHO checklist was a national core set of safety checks for use in any operating theatre environment. The checklist consisted of five steps to safer surgery. These were team briefing, sign in (before anaesthesia), time out (before surgery starts), sign out (before any member of staff left the theatre), and debrief. For all three procedures, we saw staff fully completed all the required checks. In the endoscopy suite, we observed one procedure and the WHO checklist was not carried out during the procedure we observed. We raised this concern with staff at the time of our inspection.
- All patients attended a nurse-led pre-operative assessment prior to their surgery. We observed a pre-operative clinic and found the assessment to be thorough. Any concerns identified during pre-assessment was highlighted to the anaesthetist or referred back to the patient's GP for further investigation.
- During the pre-operative assessment, the nurse recorded the patient's observation, reviewed their medical and drug history and discussed the procedure they were being admitted for and the discharge arrangements.
- All patients had their level of risk assessed for Venous Thromboembolism (VTE), falls and malnutrition, which was reviewed at regular intervals. We saw evidence of these in the records we reviewed.
- However, the VTE screening rates were below 95% in the period April 15 to March 16. With screening being at 64% in two quarters and at 65% and 71% in the other two quarters. We did not see an action plan to address this issue.
- The hospital reported no cases of VTE or Pulmonary Embolism (PE) during the period April 2015 and March 2016.
- Ward staff used the National Early Warning Score (NEWS) to identify deteriorations in a patient's condition. We saw the NEWS was consistently recorded for all patients. Staff told us they would escalate to the RMO in the first instance.
- The RMO was available on site 24 hours a day and reviewed any deteriorating patients immediately. Each patient's room had an emergency call bell.
- The practising privileges agreement required the designated consultant to be contactable at all times when they had inpatients in the hospital. They needed to be available to attend within an appropriate timescale according to the level of risk of medical or surgical emergency. This included making suitable arrangements with another approved practitioner to provide cover in the event they were not available, for example whilst on holiday.

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. Ward staff were working on a four week roster.
- The theatre staff establishment was 19.4 whole time equivalent (WTE). This included 12.3 WTE nurses and 7.1 WTE operating department practitioners (ODPs) and health care assistants (HCAs).
- Low use of bank and agency staff for nurses working in the theatre department was reported for the period April 2015 to March 2016.
- We found the induction programme for theatre agency staff, which had been reviewed and updated by the interim theatre manager, was very comprehensive. Administrative assistants were employed in the operating theatre and on the ward to support nursing staff and enable them to concentrate on patient care.

Requires improvement

Surgery

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 a 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. A change in the RMO took place on the second day of our inspection.
- We were told a verbal handover between outgoing and incoming RMO covered information about in-patients and any particular requirements, as well as general information. Additional induction information was provided by the hospital following a check list, a copy of which we were shown.
- The RMO confirmed they had been working at the hospital for two years. 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.
- The RMO we spoke with during the inspection felt they were adequately supported by the consultant and nursing staff. They were encouraged to contact the consultant for advice and felt the consultants were supportive when they were contacted.
- Consultants were required to be within 30 minutes journey of the hospital if they had patients under their care at the hospital. If, on occasions, this was not possible, they were required to nominate another named consultant (with practicing privileges) to provide cover. Up to date contact numbers for consultants were available to nursing staff in wards and operating theatres.

Major incident awareness and training

- Staff told us that the major incident policy was available on the intranet and paper format. We were shown the document when we requested it of two staff members.
- The provider had a business continuity plan in place with various scenarios that may affect the day-to-day running of the ward and theatres such as a lift breakdown. Copies of the business continuity plan were available on the ward and in theatres and staff were aware of these plans. We were shown the document when we requested it of two staff members.

Are surgery services effective?

Requires improvement

We rated the service as requires improvement for effective. This was because:

- Consent of a patient was taken when the patient did not speak English and without the use of an approved interpreter. We were concerned that patients were not able to sufficiently understand the risks associated with surgery because translation services were not used.

However;

- Staff provided care to people based on national guidance, such as the National Institute for Care Excellence (NICE), and professional guidelines.
- The hospital was Joint Advisory Group on gastrointestinal endoscopy (JAG) accredited.
- Staff had access to role related training and development opportunities, as well as scenario-based training exercises. They had their performance reviewed.
- Patients felt that their pain was well managed.
- Fasting time were discussed and malnutrition assessments were undertaken at pre-assessment appointments.

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.
- Staff had access to a range of corporate guidelines via the intranet. We saw these guidelines were up to date and referenced to current best practice from a combination of national and professional guidance such as the National Institute of Health and Care Excellence (NICE) and Royal College guidelines.

- All staff knew how to access policies online and were able to show us how they accessed the policies when we asked them to.
- The hospital was Joint Advisory Group on gastrointestinal endoscopy (JAG) accredited (The JAG ensures the quality and safety of patient care by defining and maintaining the standards by which endoscopy is practised.), which was due for a review in November 2016.
- The hospital provided scenario-based training exercises for major incidents for example if the hospital was subjected to a flood. Nursing staff told us they found this a useful exercise. The RMO also told us they took part to help keep their skills up-to-date.
- The service was compliant with NICE guidance CG 74: Surgical site infections: prevention and treatment in the preoperative, intraoperative and postoperative phases of care.
- Best practice guidance advises the use of enhanced recovery programmes (ERP) for certain types of surgery. ERPs were part of the care pathways used on the wards for knee and hip replacements. We did not observe any orthopaedic surgery due to the laminar flow theatre refurbishment during our visit.

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. The patients we spoke with told us that they were happy with how their pain was controlled and that staff responded quickly when they said they were in pain.
- Nurses on ward two asked patients whether they had any pain as part of their hourly ward rounds. We reviewed 10 sets of patient notes, which showed evidence of pain assessment as part of hourly ward rounds.
- Chronic pain clinics were held twice a week and run by two consultants.

Nutrition and hydration

- Pre-assessment and ward nurses advised patients of fasting times before surgery and we observed this was in line with the Royal College of Anaesthetists (RCOA) guidelines.
- The hospital used the Malnutrition Universal Screening Tool (MUST) as part of pre-assessment screening. The MUST tool enabled staff to identify patients at risk of malnutrition and make adjustments to mitigate any risk where appropriate. We reviewed ten sets of patients notes, which all provided evidence of MUST assessment.

Patient outcomes

- Between April 2015 and March 2016, there were 10 incidents of unplanned transfers of inpatients to another hospital because their condition had deteriorated. There were no trends, with regards to types of surgery, or concerns with individual surgeons, identified.
- Between April 2015 and March 2016 there were four unplanned readmissions within 28 days of discharge. This was low when compared with other independent hospitals of a similar size.
- There was one unplanned return to the operating theatre between January and March 2016. This was a rate of 0.01 per 100 returns to the theatre, and was not high when compared to a group of independent acute hospitals which submitted performance data to CQC.
- The hospital provided data to national Patient Reportable Outcomes Measures (PROMS). PROMS used patient questionnaires to assess the quality of care and outcome measures following surgery. The hospital provided PROMS data from three areas: hip replacements (Oxford Hip Score), knee replacements (Oxford Knee Score) and groin hernia (EQ-5D and EQ VAS indexes). However, the hospital did not have enough data available to calculate average health adjusted scores for PROMS in any of the three areas in 2014-15. This was because PROMS was an NHS programme, and therefore providers could only collect PROMS data for NHS-funded patients.
- The hospital's PROMs data showed 20 out of 20 patients reported health improvements under the Oxford Knee Score criteria following primary knee replacement between April 2014 and March 2015. This was the most recent confirmed data available at the time of inspection.

- In the same period, 10 out of 10 patients reported health improvements following primary hip replacement under the Oxford Hip Score criteria.
- For the 10 NHS-funded patients treated for groin hernia in 2014-15, three reported their health had improved following surgery, four felt their health had worsened, and three reported no change in their health under the EQ-5D criteria. Under EQ VAS measures for 12 patients during the same reporting period, the health of four patients had improved, six had worsened, and four were unchanged following groin hernia repair.
- Due to the small numbers of patients involved, these findings cannot be compared to national data. The PROMs programme required at least 30 patients in each category to calculate average health adjusted scores and compare these outcomes to other hospitals.

Competent staff

- Consultants who worked in the NHS were required to submit evidence of their appraisal. For consultants who had retired from the NHS, their appraisal was undertaken by the medical director or someone appropriate. This was managed at head office. We reviewed five consultant files and saw requests for updated appraisals had been requested in three of these.
- 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. The personal assistant to the executive director was responsible for overseeing the data base and requesting information. We were shown the database and saw there were a number of letters, which were sent out at varying intervals to request information.
- The chair of the medical advisory committee (MAC) told us they were made aware of consultants who were having their practising privileges removed as a result of not providing the required information. They also had a role to review new applicants practising privileges, which included checking their suitability, and appropriateness for the level of activity expected to be provided.
- Information related to appraisals was submitted to the regional manager as part of the monitoring of required standards.
- Staff appraisals were completed on the BMi learn system and we saw examples to corroborate this. We were told bank staff had a review once a year and contracted staff every six months. The business areas reported almost 100% compliance with appraisals; three staff out of 51 were awaiting their review.
- The service was supporting nurses to achieve their revalidation, although we were told none of the nurses had been required to be revalidated at the time of our visit. The BMi learn system had a specific section related to re-validation for nurses to access and we were able to view this.
- 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.
- BMi learn also provided access to additional training for staff, including, legal aspects of documentation, equality and diversity, as well as development training. The latter could be identified through the performance review, and staff could then search the availability of opportunities.

Multidisciplinary working

- Theatre teams met for 'sign in' prior to commencement of the surgery list, which we observed and performance was in accordance with policy.
- The hospital held a daily senior staff meeting at 9:30am. These meetings were observed and were undertaken to a set protocol where the issues of the day were discussed from an operational, clinical and estates perspective.
- Pre-operative assessment nurses worked closely with individual consultants to ensure any issues identified was clearly communicated and necessary actions, such as an anaesthetic assessments or additional tests, were taken promptly.

Access to information

- Staff had access to electronic and paper copies of hospital policies and guidelines on the ward and in theatres.
- The hospital held patient notes on-site. As well as keeping confidential patient data safe, this ensured timely access to information needed for patient care. We reviewed 10 sets of patient notes. All 10 contained sufficient information to enable staff to provide appropriate patient care. This included diagnostic test results, care plans and risk assessments.

- Staff were able to access records for all discharged patients as these were stored on-site. Staff told us of examples of when they had to do so and told us the process was straightforward.
- Communication from senior management was usually cascaded to staff via team meeting, emails or through the hospital and BMI newsletters.
- There was a general information folder within the theatre area available for all staff to communicate.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- The records we reviewed showed all patients had been consented for their surgical procedure. Consent forms fully described the procedure completed as well as risks associated with it and full signatures from the consenting clinician and patient. Consenting generally took place on the morning of the surgery. This is not considered to be best practice as patient's consent should ideally be secured well in advance, so they have plenty of time to obtain information about the procedure and ask questions.
- We did highlight an area for concern, with regards to consenting patients whose first language was not English. On ward two to we spoke to a woman awaiting day surgery, who did not speak English. The staff told us they would use sign language to gain consent. They told us they would not us the hospital's language line interpreting service. The patient was consented for surgery without the use of an interpreting service. When we spoke to the surgeon, we were informed the patient had been consented and they were assured the patient knew the risks for the surgery because they had had the same operations previously. The surgeon was challenged by the theatre staff regarding the patients consent and told them that she was assured.
- We reviewed the patients' record and saw the previous surgery had been performed at least three years previously at another hospital. Given the time scale between this and the surgery undertaken, we were concerned they patient may not have received most up to date information on the risks and benefits of the procedure.
- Procedure information leaflets were not available in languages other than English, and when questioned the surgeon told us they had given literature to the patient, despite them not being able to read English.
- 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.

Are surgery services caring?

Good

We rated the service as good for caring. This was because:

- High friends and family test and internal patient survey scores showed that the vast majority of patients would recommend the service to their friends and family.
- The patients we spoke with felt they were well cared for. Staff were polite and courteous with patients. Staff provided patients with emotional support when patients were worried or anxious by holding their hand and spending time talking to them.

Compassionate care

- Between October 2015 and March 2016, friends and family test scores ranged between 97% and 100%. This showed the vast majority of patients would recommend BMI The Shirley Oaks Hospital to their family and friends. For every month except one during this period, response rates were the same as, or better than, the average England response rates for NHS patients.
- The internal inpatient friends and family postcard results for May 2016 indicated between 98.2% and 100% of patients would recommend the service to others.
- Patient feedback was good generally good across the areas we visited.
- Patients we spoke with told us they felt "well cared for" and staff were "very friendly and kind".

- We observed ward and theatre staff being polite and courteous to patients. We observed patients were treated with dignity, respect and kindness during all interactions with staff.
- Patient-Led Assessments of the Care Environment (PLACE) results for the period February to June 2015 indicated a score of 91% for privacy and dignity, which was above the England average of 87%.

Understanding and involvement of patients and those close to them

- In all interactions apart from one, we observed staff being caring and respectful to patients and their loved ones. They explained treatments in ways patients and relatives could understand and kept them informed about their care. Patients told us they felt well supported and were given appropriate and timely information to participate in their care and treatment right from their first meeting with the consultant to discharge.
- The service involved patients' relatives and people close to them in their care. Patients told us, and we saw for ourselves, that staff provided their visitors with hot and cold drinks. We saw staff involved patients' relatives in their treatment at all stages of their hospital visit, from admission to discharge.
- Costs of treatment were discussed fully with patients, including what was covered by within the cost including follow up visits should they be required,

Emotional support

- We saw staff in theatres providing emotional support to patients who were worried or anxious. For example, we saw a member of staff holding a patient's hand during a procedure to provide comfort and reassurance.
- Patients were given appropriate and timely support and information to cope emotionally with their care, treatment or condition. Patients we spoke with informed us staff were supportive and reassuring and gave them and their family the reassurance to ease their anxiety before and after their procedure.
- There was open visiting on the wards to allow patients to have emotional support from family and friends.

Are surgery services responsive?

Good

We rated the service as good for responsive. This was because:

- Patients were generally able to select times and dates to suit their other commitments.
- Surgical cancellations were low during the period from April 2015 and March 2016
- Of the patients referred to the service, 98% of patients were treated within the 18 week referral to treatment target.
- Information on special cultural, religious or dietary needs was gathered at the pre-assessment stage and this information was passed onto the ward and theatre teams.
- Learning from complaints or concerns was communicated to staff through meetings with heads of departments.

However

- Translation services were not always arranged in advance, and there was a reliance on family members to translate, which was not best practice. Language line interpreting service was only used 10 times in the last year.

Service planning and delivery to meet the needs of local people

- All surgery carried out at the hospital was elective and staff reported it was easy to plan the workload.
- NHS patients were referred to the hospital by local Clinical Commissioning Groups (CCGs) via the Choose and Book system.
- Private patients were generally referred to a consultant by their GP.
- Operating theatre lists for surgery were available in advance and patients could select times and dates to suit their family and work commitments.
- 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 who's post-operative or medical care needs were met through ward-based nursing.

- There were no facilities for emergency admissions. We saw the facilities in theatres were appropriate for the services provided. For example, there were sufficient operating theatres and recovery space for the number and type of operations.
- Services available to support patient treatment and care included diagnostics. The department was open from 9am - 8pm Monday to Friday. Between 5pm - 8pm only x-ray facilities were available. On Saturday from 9am - 1pm there were scanning facilities and a radiologist available for clinics.
- Physiotherapy was available on-site, and the department was open from 7:30am- 8pm Monday-Friday, providing an inpatient service 24 hours a day seven days a week. Out of hours physiotherapy was available via on-call.
- Onsite pharmacy service opening hours were Monday to Friday 8:30am to 4:30 pm, and an on-call service was available out of hours.

Access and flow

- The Admissions Policy outlined the criteria for admission acceptance, including where the hospital was not able to safely provide the expected required levels of treatment and care. The policy identified in favour of nationality and culture, with the exceptions justified and validated on legal grounds.
- The executive director (ED) told us almost all referrals came through the GP, the exception to this being cosmetics. ED expressed concern about the appropriateness of some GP referrals because the occurrence rate for cancers was relatively low compared with the number of endoscopies performed.
- On arrival at the hospital, staff showed surgical patients to their rooms on ward two. Patients changed and prepared for surgery in their room. Staff then escorted patients to the theatre suite for their operation. Immediately after surgery, staff cared for patients in the recovery room. Once patients were stable and pain-free, staff took them back to the ward to continue recovering. Patients designated a responsible adult to collect and escort them home from the ward after discharge. Day case patients went home the same day, and inpatients stayed on the ward for one or more nights after surgery.
- Because all inpatients were admitted to the ward and allocated a room prior to theatre, this meant there were no delays in discharging patients from the recovery area back to their room on the ward post-surgery.
- The hospital cancelled only 30 out of 4,221 procedures on the day of planned surgery for non-clinical reasons during the previous 12 month period. Of these cancelled 27 patients were offered another appointment within 28 day of the cancelled date.
- Referral to treatment waiting times (RTTs) for NHS-funded patients having inpatient surgery at the hospital showed that, on average, 98% of patients received treatment within 18 weeks of referral in 2015. This was better than the national target of 90%.
- The hospital met the RTT target for inpatient surgery in every month for the period April 2015 to March 2016. Although NHS England abolished the national target in June 2015, the hospital continued to treat 90% or more of its inpatients within 18 weeks of referral for the rest of the year. The worst months in this period were April and November, where 96% of patients received treatment within 18 weeks of referral. The best month was February, where 100% of patients received treatment within 18 weeks.
- Theatre staff participated in an on-call rota. Consultants were on-call whenever they had a patient in the hospital. Anaesthetists were on-call for the first 24 hours after a patients operation. This system ensured staff were available should a patient need to return to theatre at night or at a weekend.

Meeting people's individual needs

- Staff had access to language line to assist communication with non-English speaking patients. Staff we spoke with were aware of this but reported it was not often used. Information provided to us was the service had only been used on 10 occasions since August 2015. We observed patients' relatives acting as interpreters during our inspection. This is not considered to be best practice.
- We did observe language line being used post operatively for a patient for whom English was not their first language; however this patient had been consented for their operation without language line or another interpreting service being used. There was a risk the patient may not have been given sufficiently detailed information, including the risks associated with the surgery. This aspect of communication is essential for the informed consent process.
- An external contractor provided pre-cooked food for the hospital. We reviewed patient menus and saw a balanced variety of choices. This included options for

vegetarians. The hospital also catered for other cultural needs, such as Halal and Kosher, on request. There were no patients staying over night during our visit. There were three surgical day case patients.

- Information on special cultural, religious or dietary needs was gathered at the pre-assessment stage and this information was passed onto the ward and theatre teams. Patients we spoke with at pre assessment confirmed this information had been taken from them.
- Patient-Led Assessments of the Care Environment (PLACE) scores for the period February to June 2015 showed the same or above the England average with respect to food.
- In the patient satisfaction dashboard April 2016, the hospital scored 86.3% for the quality of food which was a 6.8% decrease in score since April 2015.
- There was a general lack of information in the ward area, such as information on how to make a complaint or how to access external organisation for additional support. The few leaflets we found on the ward were in English and staff we spoke with said they were not available in other languages.
- All patients apart from one, we spoke with 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.
- Staff told us they had training in caring for patients living with dementia. We saw dementia awareness training was one of mandatory sessions for all clinical staff.
- Staff told us they would help this patient group by asking their carer to attend appointments with them.

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.
- It was not immediately clear how patients could raise a concern or complaint, unless they had access to the website. There were no leaflets on display to guide patients.
- We reviewed in full five complaints, as selected by the inspector. From our review we found there was a formal 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.
- Learning from complaints or concerns was communicated to staff through meetings with Heads of Departments (HODs). Minutes reviewed by us confirmed this.
- The hospital's website provided clear information on how to make a formal complaint.
- The hospital received 69 formal complaints in the period April 2015 – March 2016, which was an increase from the previous reporting period.

Are surgery services well-led?

Good

We rated the service as good for well led. This was because:

- Staff understood the hospital's aim to continuously improve quality and enhance patient experience.
- Eight strategic priorities had been identified for the financial year
- Progress on the business plan was shared with us relating to the ambulatory care service, which detailed completion of the building work in November 2016.
- Clinical Governance Meetings (CGM), which were held monthly, were described as the "central pillar of governance".
- Information was communicated to staff via the 'Clinical Governance and Quality & Risk Bulletin'. These bulletins contained details of safety alerts related to medical devices, medicines and patient safety.
- Meetings 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.

- There was a culture of transparency and honesty amongst staff. Staff felt supported and that there was an open door policy.
- There was effective and responsive leadership at the executive level, and staff commented favourably on the director of clinical services and other senior staff.

Vision and strategy for this service

- The local business plan had eight elements, which underpinned the broader organisational vision. This was to provide the best patient experience, best outcomes and the most cost effective. The local vision was; to strive to continuously improve the health of our local community by providing accessible, compassionate, quality healthcare. Staff told us they understood the vision and how to apply it to their role and their interactions with patients.
- Eight strategic priorities for the location had been identified for the financial year and included for example; having an effective governance framework, providing superior patient care, people, performance and culture. In terms of business growth, they were looking to grow the business, with a focus on more complex procedures and services.
- An example of progress made on the business plan was shared with us. This related to ambulatory care, which was progressing through conversion of patient areas. A target was set for completion in November but formally commencing in the New Year.
- Surgical staff understood the hospital's aim to continuously improve quality and enhance patient experience. Staff felt the on-going refurbishment plans would play a greater role in enhancing patient's experience.

Governance, risk management and quality measurement

- We were told clinical departments reported to the director of clinical services. Other departments reported to the executive director (ED).
- The hospital had it's own governance structure, with the ED reporting to the national director of business development. We were told regional meetings provided the opportunity to review comparative data and performance outcomes.
- 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)
- Various committee were established, all of which reported either directly to clinical governance or indirectly through HODs. The frequency of meetings varied, with monthly HODs and the Quality Committee and Complaints Committee met every three months.
- CGM, which were held bi-monthly, were described as the "central pillar of governance". The Quality Committee fed into the CGM, taking responsibility for complaints, staff feedback, and patient satisfaction.
- Clinical governance meeting minutes reviewed indicated representation from the executive team, and HOD's. We were told prior to the meeting a report was sent out to each department, enabling them to complete any relevant information, such as audit, quality and risks. 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, audit, and quality. We noted examples of learning from incidents, including those which happened in other BMI hospitals was shared at this meeting.
- A review of actions identified at previous meetings was supported by a separate action tracker. We reviewed the most current tracker and identified a red, amber and green (RAG) status was attached to each action. Six of the actions were rated as red and 12 as amber. The remaining 20 did not have a RAG rating, and although agreed dates for completion were set as July or August 2016, we could not identify if these had been completed.
- Minutes of CGM held on 26 July 2016 included information on patient feedback in the form of a patient satisfaction dashboard. We saw the performance indicated below the expected target in a number of areas. The resulting ranking was 47 out of 55 BMI hospitals.
- Information was communicated to staff via the 'Clinical Governance and Quality & Risk Bulletin'. Such bulletins contained details of safety alerts related to medical devices, medicines and patient safety. They also included shared learning from events, as well as details of required actions to be taken by staff.
- A Clinical Governance report was completed by the director of clinical services. This was made available for

discussion at the MAC, which met five times per year. We saw the July report and noted information was communicated to the MAC with regard to audits, incidents, referral to treatment times, un-planned re-admissions, and post-operative infections.

- The MAC membership was made up of the executive director, director of clinical services, chair of the MAC, anaesthetist representative, GP representative, consultant surgeons in hand and trauma, orthopaedics, gynaecology, urology, dermatology, gastroenterology and vascular medicine.
- We were told the MAC chair was on-site two days per week. The MAC chair told us they met with the director of clinical services 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.
- We observed the data from quality reports and dashboards provided oversight in relation to safety, effectiveness and performance in general.
- We were told by the ED that an audit timetable was set up, with responsibility assigned to respective HODS. Results from such audits fed into the corporate database. We view audits results for hand hygiene, peripheral line insertion, catheter care, surgical sites, commode and uniform audits which are undertaken on a monthly or quarterly basis.
- There are 187 doctors and dentists employed or practicing under rules and privileges of the provider. 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. However, we noted all the files reviewed had missing information to some degree. For example, proof of indemnity, expired data protection registration, self-declarations, and expired Disclosure and Barring checks. We spoke with the responsible individual for overseeing this and they were able to show us a formal database with evidence of monitoring, together with letters sent out requesting information.
- Appraisals and re-validation was monitored and requested where renewal was required. MAC minutes confirmed discussion of the removal of individuals where they had not provided the required information.
- We discussed risks with the ED and were told the risk register held corporately was based on themes, and the location was required to provide information each quarter as to how they were managing such risks, including any mitigation. Local risks when identified had to be fitted into the most appropriate theme, which was not easy for managing at a location level. A quarterly meeting was held with the Quality and Risk Manager (QRM) and Health and Safety, where the risk register was discussed. New risks had to be fed through the QRM.
- We were told the top risks identified were related to the following; Infrastructure risk – failure of critical plant, recruitment of core staff, repeat of the flood experienced in 2013, the impact on levels of activity of the changing pattern of acuity, and medical equipment requiring replacement.

Leadership of service

- There was effective and responsive leadership at the executive level, and staff commented favourably on the director of clinical services and other senior staff. 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 that they "enjoyed" working at BMI The Shirley Oaks Hospital. Staff told us one of the best things about working at the hospital was their colleagues.
- There were heads of department (HOD), who 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 9.30am 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 patient numbers on the day, admissions expected for the next day ahead, general activity, resources, and cover for holidays.

- The director of clinical services told us they were very proud of the HODs, describing them as very responsive to change, and how they liked having the chance to be involved and their opinions sought.
- We were provided with information which demonstrated a formal process was used to manage behaviours or actions that were not consistent with the values and expected behaviours. 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.
- There was a culture of transparency and honesty amongst staff. Staff told us managers encouraged and supported them to report incidents. We asked two members of staff about duty of candour. Both could describe what this meant and gave examples of when it might be used.
- There were vacancies for one Full Time Equivalent (FTE) nurse in theatre giving a vacancy rate of 8.0% which is comparable to other independent hospitals we hold data for. There were three FTE Operation Department Practitioners (OPDs) and Health care Assistants (HCAs) working in the theatre department, giving a vacancy rate of 30%, which is high compared to other independent acute hospitals we hold data for.
- There were high levels of staff stability within theatre teams, with the low level of 6.21% of staff turnover in theatre nurses during the period April 2015 – March 2016 and less than 1% in ODPs and HCAs.
- Theatre departments reported low rates of staff sickness, with 10% sickness rates across all staff groups in the period April 2015 – March 2016. The lowest sickness rate in theatres was 0% amongst theatre nurses in eight of the months within the period, and the highest was 10% amongst ODPs and HCAs in June and September 2015. In the six month there was no sickness amongst ODPs and HCAs.

Culture within the service

- An equal opportunities approach was applied to recruitment and selection. Information provided to us showed 56.5% of the locations workforce were white British.
- The requirements related to duty of candour were met through the processes for investigating incidents, and reviewing and responding to complaints. The staff we spoke to 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.
- Staff provided positive responses about the culture in the location. Comments included it being a “very nice environment to work in”, “we are a team”, and I would be happy knowing my parents would be treated with respect. “Staff have a lovely approach.”
- 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.

Public and Staff engagement

- We were told by the ED the values of the hospital had been debated with HODs, and these were aligned with the key lines of enquiry used by CQC. HODs then took this information back to departments for discussion with staff.
- Staff told us they felt very much supported by the ED and director of clinical services, both were described as having an “open door”. One staff member told us they would have no hesitation in approaching either if they had a problem.
- Staff felt they had opportunities to develop; an example provided to us included a staff member having the opportunity to participate in a site review with the regional manager.
- Staff told us about the “above and beyond” scheme, where employees were nominated for outstanding practice.

Innovation, improvement and sustainability

- The endoscopy suite is Joint Advisory Group Gastrointestinal Endoscopy (JAG) accredited. JAG accreditation aspires to, set standards for individual endoscopist’s,set standards for training in endoscopy, quality assure endoscopy units, quality assure endoscopy training courses. The Unit is due for reaccreditation in November 2016.
- The hospital was a BMI Healthcare pilot site for ambulatory care. Ambulatory patients did not transfer to the ward after minor procedures and instead spent a short time in recovery before early discharge. The benefits of ambulatory care included helping the patient feel more normal after surgery, reduced costs to patients and commissioners, and ease of scheduling.

Requires improvement

Surgery

- The service was continuing to work with external Clinical Commissioning Groups and GP to ensure best experience for the patients. There were standard and acute care contracts for NHS work, which mainly related to general and ENT surgery, orthopaedics, and gynaecology. A recent initiative was established for gynaecology services, which involved triaging referred patients before either arranging treatment at the hospital or referring on for secondary care externally.
- We were told south London 'cluster group' meetings were held to discuss NHS contracts and quality of services.
- A meeting took place monthly with the main CCG to discuss services and specific needs.
- 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	Not sufficient evidence to rate
Caring	Good
Responsive	Good
Well-led	Good

Information about the service

BMI The Shirley Oaks Hospital Outpatients department (OPD) is in the main hospital building in a separate department. It has 10 consulting rooms, two minor procedure rooms, one audiology screening booth and a cardiology screening room.

From April 2015 to March 2016 there were 31,176 OPD attendances. NHS patients accounted for 33% of these attendances, whilst 67% had private funding or were self-paying. The OPD offers a range of clinics including orthopaedics, urology, gynaecology and cardiology.

There is a standalone physiotherapy department, which provides a range of therapies including hand therapy, men and women's health clinics and Pilate's classes. Patients can be referred by their consultant, GP or self-refer for treatment.

The diagnostic imaging department is located on the first floor of the hospital. It provides a range of imaging facilities including x-rays, computerised tomography (CT), and ultrasound scanning. Radiographers provide a 24-hour service for inpatients. MRI scanning is provided by a separate private company, which we did not inspect on this occasion. There are interventional procedure clinics on a weekly basis.

BMI The Shirley Oaks Hospital provides outpatient clinics for children aged three to17 years of age. From April 2015 to March 2016, there were 715 attendances of children and young people. They have a service level agreement with a paediatric nurse from another BMI hospital to attend during the paediatric clinics. The Resident Medical Officer (RMO) is trained in advanced paediatric life support.

We visited the BMI The Shirley Oaks Hospital during an announced inspection on 17 and 18 August. We spoke to 13 members of staff including managers, consultants, physiotherapists, and healthcare assistants. We spoke with eight patients and two relatives. We looked at 21 sets of medical notes, made observations of the environment and staff interactions with patients and other people using the services.

Good

Outpatients and diagnostic imaging

Summary of findings

Overall, we rated the outpatients department and diagnostic imaging as Good. We rated safe and responsive as requires improvement and caring and well led as good. We do not currently provide a rating for the effective domain in the OPD.

- We observed good infection prevention and control (IPC) practices but some chairs in consulting rooms did not meet IPC standards. Clinical equipment was serviced, appeared clean and functioning. Daily monitoring of resuscitation equipment had taken place.
- The training information provided showed between 85% and 100% of staff had attended mandatory safety training. The resident medical officer (RMO) had training via their employment agency.
- All staff had a minimum of basic life support training and there were paediatric-trained staff to care for children under the age of 18 when children's clinics were running. Staff told us they could ask for additional courses and managers would support them.
- We saw use of evidence based practice and national guidelines, including those related to patient and staff safety in all outpatient areas.
- There was an admitting criterion for patients whose conditions were complex.
- A range of information on the services, including costs was available to patients.
- The radiology service had protocols and guidelines to assess and monitor patient risk such as a new World Health Organisation (WHO) checklist for radiological intervention procedures. The WHO checklist is a simple tool designed to improve the safety of surgical procedures by bringing together the whole operating team to perform key safety checks during vital phases of surgical procedures.
- Diagnostic test results were available in a timely manner for all consultations. Treatment could commence the day the patient saw their consultant if necessary.
- Clinical staff had the required level of skills, knowledge and expertise to support the delivery of treatment and care in the outpatient and diagnostic areas.
- Nurses were preparing for revalidation and they had a resource file to support this. Revalidation for nurses is a new scheme set up by the Nursing and Midwifery Council (NMC) to ensure nurses and midwives are practising safely and effectively.
- Medical revalidation and appraisals were managed to ensure only those consultants with up to date records and fitness to practice had approved admitting practices. The RMO had required training and checks completed through the agency with which they were employed.
- There was a multidisciplinary approach and effective team work within the outpatient services. Specialist nurses were available for breast clinics.
- Staff provided dignified, compassionate and respectful care. Patients and their families were positive about the care they received at BMI The Shirley Oaks Hospital. They told us they felt involved in their care and staff were very helpful.
- The outpatient's friends and family postcard result for May 2016 indicated between 98.2 and 98.5% of patients would recommend the service to others.
- The service was meeting the 92% target for NHS referral to treatment time of 18 weeks most months. Privately funded patients rarely had a wait to see a consultant initially.
- Less than 1.5% of clinics were cancelled in the year to March 2016. These were re-booked promptly.
- Staff were positive about working in the service and felt encouraged to make suggestions for improvement. They showed us examples of new equipment they had received following these suggestions.
- Staff told us there was strong teamwork and managers were visible and easy to talk with.

However;

- Assessment of patient risk was not always completed in the OPD, as observations were rarely done for patients undergoing minor procedures.
- We saw consent was poorly completed in the OPD, with no documentation that risks were explained to the patient.

Good

Outpatients and diagnostic imaging

- Staff in the OPD had little knowledge of the principles of the Mental Capacity Act 2005 and deprivation of liberty safeguards.
- Staff who worked directly with children had not all been trained to the required level of safeguarding, as outlined within the location policy and best practice guidance.
- Although there was evidence of local audits and action plans in the physiotherapy and imaging departments, the OPD did not have a formal audit structure. We were unable to view completed action plans for the OPD audits.
- The location did not currently collect patient outcome data through an accreditation schemes in OPD or imaging.
- Patients told us they had experienced long waiting times for follow up appointments, and long waits once they had arrived at outpatient clinics.
- It was not clear as to the level of safeguarding training the resident medical officer had completed.
- The BMI The Shirley Oaks Hospital was benchmarked against other BMI hospitals and staff told us they were attempting to improve their current low standing of 47 out of 55.

Are outpatients and diagnostic imaging services safe?

Requires improvement

We rated the service as requires improvement for safety. This was because:

- Patients undergoing minor procedures in the OPD did not have observations completed before or after their procedures. This may put patients at risk of becoming unwell without staff being aware. NICE Guidelines CG50 explain the importance of observations for patients at risk of deterioration. Observations both pre and post procedure were part of the minor procedure pathway within the hospital.
- When we viewed the safeguarding policy it stated that staff should be trained in line with the Royal College of Paediatrics and Child Health document "Safeguarding children and young people: roles and competences for health care staff intercollegiate document 2014". This states that paediatric physiotherapists should be level 3 safeguarding trained. However, this staff member was only trained to level 2.
- The RMO had safeguarding children training; however, it was not obvious to what level they were trained and they were unable to tell inspectors.
- Some chairs in the OPD did not meet infection control standards, as they could not be thoroughly cleaned.

However:

- Staffing levels were adequate to meet patient need across all the services.
- There were effective incident reporting systems and staff felt confident in using them.
- The environment was visibly clean and staff adhered to the infection prevention and control (IPC) policy.
- A new World Health Organisation (WHO) checklist was in use

Incidents

- There were 31 incidents in the OPD, and 13 in the diagnostic imaging department from April 2015 to March 2016.

Good

Outpatients and diagnostic imaging

- Staff described the type of incidents they had reported and showed us the paper system used to record incidents. These would then be entered onto a computer system by the quality and risk manager.
- Staff had monthly departmental meetings in OPD and physiotherapy and every two months in the radiology department. We saw the minutes from these which included discussions about incidents and the learning from these. For example, the physiotherapy department had purchased an automated external defibrillator (AED) after a patient had suffered a cardiac arrest in the department.
- 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. Further, a written apology must be provided, a copy of which must be kept in their records.
- Staff described the process of being open and honest with patients if something went wrong. Senior staff gave examples of when this had been used, including a patient receiving another patient's personal detail with an appointment letter. We were told both patients received a written apology from the hospital. The OPD was not able to provide us with evidence of this.
- There had been no incidents reported to the CQC resulting from a patient undergoing a medical exposure to the Ionising Radiation (Medical Exposure) Regulation 2000 (IRMER) in the year prior to inspection.

Cleanliness, infection control and hygiene

- Clinical areas we visited were visibly clean and tidy, and there were arrangements for domestic and clinical staff to ensure safe IPC practices were followed for cleaning areas and equipment.
- There were hand washing facilities in each consulting room and hand gel in all patient areas. Staff in each department told us there were hand hygiene audits; however, they did not know the results of these and we could not view results. We did see staff washing their hands appropriately and all staff observed, were bare below the elbows.
- We saw minutes of an infection control meeting in March 2016 which was attended by members of the OPD, radiology department and physiotherapy. Minutes included details of surgical site infections, meticillin Resistant Staphylococcus Aureus (MRSA) screening and mandatory training levels.
- Personal protective equipment (PPE) including gloves and aprons was available for staff in all clinical areas and we observed these being used during inspection. In one OPD treatment room a sink had been condemned and no minor procedures were allowed to take place in the room until it was fixed.
- Chairs in the waiting room were washable; however, chairs within the consulting rooms were fabric and could not be washed fully. This may have increased the risk of infection spread.
- We saw staff cleaning the OPD and viewed the weekly cleaning rotas, which were completed. Green "I am clean" stickers were in place throughout the radiology department.
- We asked staff in all areas how they would manage a patient with an infection. They told us they would carry out a deep clean following their appointment and try to schedule their appointment for the end of the day if possible.
- Diagnostic imaging completed a deep clean of the department every Monday and each staff member was responsible for assisting with this. We saw the cleaning logs to indicate this had been completed.
- Waste was split into clinical waste and non-clinical waste and each went into different bags. Hospital porters collected and disposed of this daily which we observed whilst on inspection. All sharps bin we saw were signed, dated and appropriately stored.

Environment and equipment

- There were resuscitation trolleys in the OPD and imaging department. Adult resuscitation trolleys were checked daily with no equipment noted as missing. The physiotherapy department had an Automated External Defibrillator (AED), which we observed had been checked daily.
- We observed there was a dedicated children's grab bag in the OPD, which would be used in case of a child cardiac or respiratory arrest. This was checked daily and labels were used for easy access to the correct size of equipment appropriate to the size and age of children.

Good

Outpatients and diagnostic imaging

- The reception for OPD was open and patients and staff could communicate easily with patients. The booking team were based within the reception making it easy for patients to book follow up appointments.
- Radiology staff had access to the appropriate protective equipment to carry out x-rays and scans. We saw testing results for all the radiology equipment were in date and safe. Testing was carried out by an outside radiation protection advisor from a local NHS trust. One machine was emitting a higher dose of radiation than recommended, and this was fixed and deemed safe by the maintenance team. We saw evidence this had been completed prior to our inspection.
- Lights alerting staff and patients to the use of radiology rooms were all in working order during our inspection.
- All equipment we checked was clean and stored appropriately. There was evidence of safety checks having been undertaken on equipment used for patient treatment and care.
- There was a laser machine in the OPD, which had a full audit trail and record of regular checks, which we saw on inspection. The laser protection advisor was from a local NHS trust. We saw evidence of the protective personal equipment policy, the optical radiation safety corporate policy and the local rules for the OPD laser protection.

Medicines

- Prescription pads were kept locked away in the OPD and diagnostic imaging. The keys to obtain the pads had to be signed out and back in again at the beginning and end of each shift. Reception held the keys overnight, and these had to be signed in and out each shift. We saw evidence of the completed sign in and sign out checks and checks to ensure no pads had been used inappropriately or stolen.
- The OPD kept some pre-packed medications for patients to take home if required. Two staff checked the drug out and recorded it so pharmacy could re-order drugs and ensure protocols were followed correctly.
- All medications we saw were kept in locked cupboards and the keys were kept by the nurse and radiographer in charge. There were no controlled drugs kept in the department.
- Fridges and warmers in the departments were checked daily, and temperatures recorded were within the correct range.
- The imaging department used patient group directives (PGDs) for certain intravenous scan contrast and saline flushes for cannulas. PGDs provide a legal framework, which allows some registered health professionals to supply and administer specified medicine to a pre-defined group of patients, without them having to see a doctor. An audit of saline flushes showed batch numbers were not always recorded, and we saw evidence that staff had been reminded to do this in the staff meetings. The next audit was due later in 2016.
- We saw in the OPD reception there was poster advertising a medications advice line. This was open from 2pm-3pm from Monday to Friday. People could ring to get information about the medications they had taken home if they had any questions.

Records

- During inspection, we looked at 18 sets of patient notes including minor operation checklists, and imaging notes for patient undergoing interventional procedures. These were generally incomplete in the OPD but well completed in the physiotherapy and imaging departments.
- Medical records were held on site in a secure department on the ground floor of the hospital. When they were sent to the OPD they were kept in a locked cupboard when not in use.
- Notes had a paper based tracking system to ensure traceability. We saw examples of this in action whilst on inspection in the medical records department.
- Both private and NHS notes were kept in the hospital and all staff we spoke to said there was no issue with obtaining notes when required. We were told there were rarely times when notes were not available.
- Reception staff told us psychiatrists who ran clinics kept their notes and made their own appointments then gave the clinic lists to the receptionists.
- Diagnostic imaging had an online system called CRIS where notes were scanned on and could then be accessed from a password protected online system.

- The physiotherapy department would photocopy patient's notes on discharge so they could have a copy of their physiotherapy requirements when they came for their outpatient appointment. They told us it was easy to access notes for those patients referred from a GP or who had self-referred.
- We saw when medical notes were not available an incident report was recorded and an action plan to prevent this happening again was completed.

Safeguarding

- The hospital had up-to-date safeguarding policies and procedures for both children and adults. Staff knew the safeguarding leads in their hospital and how to contact them.
- Staff we spoke to understood how to raise a safeguarding concern. We were told the OPD and diagnostic imaging departments had not had any safeguarding concerns in the last 12 months.
- Safeguarding training was mandatory for all staff and all registered nurses were required to complete level two as a minimum. Non-clinical staff completed level one safeguarding.
- Information provided pre-inspection showed 96% of staff were trained to level two. Of the 23 staff involved in caring for children two of these were level three trained. Staff told us they were the director of clinical services and the ward manager.
- One of the physiotherapists was paediatric trained and had been trained in level two safeguarding. However, in the BMI safeguarding children policy, which contained guidance from "Safeguarding Children and Young people: roles and competences for health care staff, 2014" in which it is indicated that paediatric physiotherapists should be level three trained.
- The RMO had safeguarding training but could not tell us what level this was. When we looked at training certificates from the agency this did not state the level of training.
- When children's appointments were booked for clinic there was a service level agreement with another BMI hospital that their paediatric nurse would attend to assist with the clinic. We saw this service level agreement was dated and signed this year.
- The hospital had a chaperone policy, which was visible in all patient care areas. We saw documentation of a chaperone being present during a consultation in several patients' notes.
- All staff we asked told us they would feel confident to challenge any concerning practices or behaviours.

Mandatory training

- Mandatory safety related training for staff was a mixture of online e-learning and face to face sessions. It included topics such as equality and diversity, moving and handling and infection prevention and control.
- Information we received pre-inspection showed that between 85% and 100% of staff in the departments we inspected had completed their mandatory training up to May 2016. The target for this training was 90% and managers told us they would give staff protected time for learning to ensure they reached their targets.
- Training was monitored online and each staff member had a password protected training account. This meant the staff could be alerted when a module was due to be completed. Managers had access to this, and would remind staff if they had not completed their training. We were told completion of training was linked to the annual pay increment.
- The resident medical officer (RMO) completed all mandatory training through their agency including advanced life support for both adults and children. We saw certificates for these courses during our inspection.
- Consultants complete their mandatory training at the NHS trust within which they work. The BMI practising privileges policy requires that each doctor must provide annual evidence that this has been completed to continue practising at the Shirley Oaks hospital.

Assessing and responding to patient risk

- The 11 sets of notes we looked at for patients undergoing minor procedures in the OPD were poorly completed. Only one person had a set of pre procedure observations and no patients had post procedure observations completed. This may put patients at risk, as deterioration would not be identified at an early stage.
- We reviewed the policy around caring for patients having minor surgical procedures performed in the OPD.

This states the assisting nurse is responsible for completion of the pre and post procedure patient notes. Staff were not adhering to this policy and this may have be putting patients at risk of harm.

- Receptionists told us they had not had specific training on recognising unwell patients; however, they would inform the nurse in charge immediately if the suspected someone was not well. All staff had basic life support for use in case of an emergency.
- OPD had admitting criteria for patients who were not appropriate to be seen in the department. NHS choose and book patients would be screened for admission suitability when making an appointment ensuring patients could be cared for safely by staff; however, staff could not tell us what these were as all calls were dealt with by a central call centre.
- If a patient became unwell during their time in the department staff told us they would complete a set of observations, ring the RMO to assess the patient and if required ring an ambulance to transport the patient to an NHS hospital. We saw a policy dated July 2016 with instructions on how to deal with a patient who needed admission or transfer.
- There was an emergency button system in the OPD in case of a cardiac arrest and all staff knew how to contact the crash team. There were designated bleep holders acting as responders to emergency calls, and these were identified at the morning 'huddle' meeting.
- Radiology had a specific safety checklist for CT and MRI scans to ensure patients were not given contrast if they had certain health problems. There were protocols to follow if patients did have medical problems and needed blood tests prior to their scan.
- Radiology had evidence that women of child bearing age were tested for pregnancy prior to x-rays or scans. This was audited regularly and showed 100% compliance.
- A WHO checklist for radiological interventions had been introduced in the imaging department. We viewed three of these and all had been fully completed. The manager of the imaging department was auditing these at the time of our inspection. There was no use of a WHO checklist being used in the OPD for patients undergoing minor procedures.
- The audit results with respect to completion of WHO checks indicated 100% compliance for the months January to June 2016. We were not able to identify if the audit included OPD or diagnostic imaging.

Nursing staffing

- The outpatients department was staffed with a minimum of one trained nurse on alongside a nursing sister. Healthcare assistants (HCAs) were used to assist in clinics. The OPD manager told us staffing should be one nurse to one HCA.
- There were no full time vacancies available for staff in the department at the time of inspection and there was a part time post available for a senior nurse.
- There was a high usage of bank staff within the OPD but there were no agency staff used. Bank staff completed an induction in all the departments we inspected. This included a corporate induction checklist, and we viewed completed checklists whilst on inspection. The OPD manager told us there was no need for use of staff acuity tools in the department.
- A paediatric nurse from another BMI hospital would attend children's clinics to ensure paediatric patients were cared for by a specially trained individual.

Medical staffing

- Each consultant worked in set clinics and saw each patient on their specific list. Staff had access to the daily clinic rotas.
- Revalidation and appraisal was part of consultant fitness to practice and agreeing practicing 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.
- The OPD administration manger told us if a certain consultant was on holiday they could offer the slot to a different consultant to allow patients to be seen in a timely manner.
- Radiologists had set slots each week and could perform interventional clinics during the week.
- The RMO worked a two-week rotation, and slept on the premises. They were available by bleep to attend nurse led wound clinics to review any concerning wounds and prescribe medications if required.

Good

Outpatients and diagnostic imaging

Major incident awareness and training

- Staff in the outpatients department told us the major incident policy was available on the intranet and in paper form. We saw this policy on line before inspection.
- A business continuity plan was available for staff to ensure the running of the hospital would continue in the event of a major incident.

Are outpatients and diagnostic imaging services effective?

Not sufficient evidence to rate

We report on effectiveness for outpatients below. However, we are not currently confident that, overall, CQC is able to collect sufficient evidence to give a rating for effective in outpatients department. Therefore, we have not rated this section of the service.

- Consent was not completed in line with BMI policy. Of the 18 consent forms we viewed in the OPD only one set had a fully completed consent form. There were no documented risks discussed with patients in any of the other consent forms we looked at. This means consent was not valid as patients were not appropriately informed.
- Staff in the OPD had little knowledge of the principles of the Mental Capacity Act 2005 and deprivation of liberty safeguards.
- In OPD there was no robust audit process even though audits were completed we could not see detailed completion of these, and action plans were not completed to drive change. When we asked senior management how they would rectify this they were unable to give us a clear answer.

However:

- We saw evidence based care was informed by national guidelines, policies and protocols.
- Diagnostic imaging provided a wide range of services with prompt reporting of images.
- In physiotherapy and radiology, local audits were completed and staff showed us ways in which they had driven improvement.
- Physiotherapy and imaging staff were able to explain and show documentation to assess patients with a lack of capacity.
- Staff were offered courses to improve their clinical knowledge and skills. Revalidation for nurses was on-going and staff felt well supported in completing this. Revalidation for nurses is a new scheme set up by the Nursing and Midwifery Council (NMC) to ensure nurses and midwives are practising safely and effectively.

Evidence-based care and treatment

- Clinical staff we spoke to were aware of relevant clinical guidelines in their areas including the National Institute for Health and Care Excellence (NICE) and Royal College of Charter Physiotherapists. Radiologists followed guidelines from the Royal College of Radiologists.
- Standard operating procedures were referenced with evidence of best practice and national guidelines. These included the "Surgical safety for imaging-guided procedures" which discussed use of the World Health Organisation (WHO) checklist and Ionising Radiation (Medical Exposure) Regulations (IRMER) principles.
- Ionising regulations and diagnostic reference levels (DRLs) for different scanners were available in each imaging room for staff to refer to if required. Staff told us there were new DRLs coming out in the near future. Reference levels give radiographers a guideline of how much radiation should be used for different parts of the body to achieve an adequate scan picture.
- Guidelines were easily accessible on the hospital intranet or as a hard copy, although staff were aware this may not be the most up to date version. Staff in the OPD showed us a printed pictorial guide to finding policies online for those who were not confident in using the IT systems.
- The OPD carried out audits; however, we were unable to see evidence of many of these. We saw evidence of a documentation audit carried out on nursing records in April and May 2016. When we reviewed the action plan, we saw there were no completion of action dates and no assurance that improvement was on-going. When we asked the quality and risk lead what was being done to rectify this they were unable to provide us with an answer.
- There was evidence of a wide range of local clinical audits within the radiology and physiotherapy department. In the first half of 2016 there was only 60% recording of the use of radiology equipment in theatre. Radiology was due to communicate the need for

recording this via the next Medical Advisory Committee (MAC) meeting. There was a 100% compliance rate of radiographers asking female patients about their pregnancy status.
- Physiotherapy carried out an audit on notes in January 2016, which showed completion scores of between 83% and 99%. An action plan was completed and discussed within the department. Another audit was done in May 2016, which showed improvement in these numbers and a new type of note writing template was being developed to further improve scores.

Pain relief

- Chronic pain clinics were held three times a week and these were consultant led. Spinal surgeons also held pain clinics three times weekly.
- If a patient was in pain staff told us the RMO could be contacted to prescribe and review the patient's pain relief while they were in the OPD. The RMO confirmed this was part of their role.

Nutrition and hydration

- Nutrition and hydration needs were met with a coffee and tea machine in the main waiting room. Fresh water was also readily available.

Patient outcomes

- Staff told us diagnostic test results were available in a timely manner for all consultations. This meant treatment could commence the day the patient saw their consultant if necessary.
- The hospital staff told us that they did not currently have accreditation schemes in place for OPD or imaging but were trying to enrol in the imaging accreditation scheme in the near future.

Competent staff

- Nurses we spoke to were preparing for revalidation. They had begun to prepare their portfolios and a resource file was available to help nurses with this. Revalidation for nurses is a new scheme set up by the Nursing and Midwifery Council (NMC) to ensure nurses and midwives are practising safely and effectively.
- Medical revalidation and appraisals for the RMO were completed through the agency with which they were employed. We did not see any revalidation or appraisals in the RMO paperwork whilst on inspection. The hospital senior team told us this was done by the agency and was kept by them.
- Consultants had to complete revalidation as part of their practising privileges. There was a staff member responsible for overseeing this. We reviewed the database of consultants with practising privileges whilst on inspection which was up to date.
- Appraisal rates for the OPD from April 2015 to Mar 2016 were 100% for both nurses and HCAs. From April 2016 to the time of inspection, 50% of nurses and health care assistants had received an appraisal. Staff told us they felt these were helpful and allowed them to ask for further development.
- Staff looking after children in the OPD had paediatric life support training, and some had advanced training in this area. We saw two HCAs had been specially trained in paediatric phlebotomy, and their competency booklets had been completed.
- Staff in radiology could specialise in certain areas such as mammography or CT scanning. We viewed completed competency frameworks for these.
- Physiotherapists had competency booklets for areas such as specialist equipment and being on call outside normal working hours. We saw these were signed and in date.
- The physiotherapy department used peer review to improve their practice. This is a system or process in which employee's receive feedback from the people who work with them. Strengths and weaknesses are identified and can be worked upon.
- All the departments had nominated staff who had been trained to take responsibility for teaching other team members best practice and helped to complete audits. These roles included for example, infection prevention and control leads, and quality and safety.
- The image intensifier in theatre was only ever used by qualified radiologist and not theatre staff.

Multidisciplinary working

- The physiotherapy department worked closely with consultants and gave talks to GPs on certain procedures and their aftercare.
- We saw a service level agreement with a paediatric nurse from another BMI hospital, which ensured staff had a paediatric nurse for children's clinics. We also viewed service level agreements with the pathology collection company and a dietitian.

- Breast clinic patients were discussed at the multidisciplinary team meeting at the local NHS hospital to ensure the best care was given. We did not see any evidence to corroborate this.
- Staff gave examples of when the RMO has assisted OPD staff during nurse led wound clinics and when patients had required pain relief.
- The imaging department could access scans from other hospitals on an online system. Staff told us that GPs were able to access results of scan 48 hours after the test had been completed.

Access to information

- Physiotherapists would photocopy the notes of patients discharged from the wards including their operation notes to ensure the consultant's post-operative rehabilitation instructions were accessible for their OPD appointment.
- Radiographers could access scans and x-rays for patients on an online system. Radiologists could access the picture archiving and communication system (PACS) system anywhere there was a computer allowing fast reporting of imaging. The CRIS system allowed all notes to be scanned onto the system for easy access. There was an image exchange portal to access scans from other hospitals if necessary.
- The imaging department told us there was a 48 hour reporting time for most scans. It was only in exceptional circumstances where a scan needed a second opinion that reporting and sending of results would take longer. GPs would then have the report faxed to them. We saw evidence that in August 2016 the maximum time a report took to be reported and sent to the GP was two days.
- Policies and procedures were accessible to all staff via the intranet and staff showed us how they would access these.
- There were leaflets available in the OPD specific to cardiology and medicines management.
- In the OPD there was no information on the clinic board for patients to see if clinics were running late. The OPD manager told us they were trying to get a new board to display this information more easily.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Whilst on inspection we viewed 18 consent forms in the OPD and three consent forms within the radiology department. Of these 17 were consent form three, which were used for procedures under local anaesthetic, and four were consent form one, used for general anaesthesia or sedation.
- In the OPD there was incorrect use of consent form one. The OPD manager told us they were auditing the use of these and trying to get them out of the department.
- The consent form three was not completed correctly in 13 of the 14 notes we reviewed. Only one form had the risks of the procedure documented and signed. This indicates that the risks of the procedure may not have been discussed with the patient, meaning informed consent may not have been given.
- We reviewed audit information provided pre-inspection. This indicated compliance with consent was 94% in March 2016 and 98% in June 2016. We could not tell from the information, if the audit included OPD or diagnostic records.
- We spoke to one patient who told us they had been given a full cooling off period once being given all the information about their procedure. This meant they could give fully informed consent.
- The three forms we viewed in radiology were completed in full with risks and benefits discussed and signed, and dated by both the radiologist and patient.
- The OPD staff were able to discuss Gillick competencies in relation to how children could give consent. Gillick competence is used in medical law to decide whether a child 16 years or younger is able to consent to his or her own medical treatment, without the need for parental permission or knowledge.
- Most of the staff we spoke to in the OPD were unable to tell us the principles of the Mental Capacity Act 2005. This was despite the fact they had signed to say they had read and understood the policy on safeguarding adults, which incorporated mental capacity and deprivation of liberties. Staff told us they did not often get patients who suffered with lack of capacity but did tell us they would look at the policy if required.
- Both the physiotherapy and imaging department staff were aware of the principles of the Mental Capacity Act 2005 and deprivation of liberty safeguards. They showed us an assessment of capacity form, which they would use if a person's capacity was in doubt. It had to be signed by two members of staff and included outcomes of a best interest assessment if necessary.

Good

Outpatients and diagnostic imaging

Are outpatients and diagnostic imaging services caring?

Good

We rated the service as good for caring. This was because:

- Patients and their families were positive about the way staff treated people. Patients said the care they received was person centred and staff were helpful.
- Patients told us they were active partners in their care and felt fully involved in decisions around treatment.
- People's emotional needs were valued by staff and were embedded in their care and treatment.

Compassionate care

- Patient feedback was generally positive across the areas we visited.
- Patients we spoke to described the service as "super" and described the staff as "helpful and caring".
- The outpatient's friends and family postcard result for May 2016 indicated between 98.2 and 98.5% of patients would recommend the service to others.
- We looked at patient feedback from the postcards in the OPD, which included "everyone was kind, helpful and professional" and "lovely staff, looked after me and explained what was going on at every stage, no waiting around".
- For NHS patients the hospital scored much higher than the England average in the Friend and Family Test (FFT) from October 2015 – March 2016. Between 97% - 100% of NHS patients would recommend the hospital to others.
- We observed receptionists and appointment booking staff being king and courteous to patients. Nurses and consultants were polite and engaging with patients and their families.
- There was a Chaperone policy for the hospital, which was visible in all clinical rooms.

Understanding and involvement of patients and those close to them

- Patients and families told us they felt involved at every stage of their appointment. They were able to ask questions and understood the information they were given.
- Patients and families told us they felt they had enough time to talk to doctors and nurses about their treatment, making them feel at ease.
- We spoke to two patients who had bought family members with them and they told us staff were very accommodating of their loved ones. This helped them feel more at ease during their time in the department.
- Two patients we spoke to said at times clinics would run late leaving them sitting for a long time, which could be frustrating.
- There were posters to advise patients of basic fees and that Consultants may have their own fees. Further information about costs and fees and ways of paying, including spreading the cost was available on the hospital web page.
- Radiographers discussed in their departmental meeting that staff should ensure that patients are aware that fees can range from simple to complex and this can only be determined once the scan had been completed.

Emotional support

- For patients attending the breast care clinic a specialist breast care nurse was available. They were trained in breaking bad news and assisting those patients experiencing emotional distress.
- We observed staff giving emotional support to patients and their families. They were encouraged and supported through treatment by ensuring both patients and relatives were given up to date information.

Are outpatients and diagnostic imaging services responsive?

Good

We rated the service as good for responsive. This was because:

- Staff planned and delivered services in a way that met the needs of the local population. OPD, imaging and physiotherapy clinic times had been extended to allow people to access the service more easily.
- NHS patients were seen within the 92% target for 18 weeks referral to treatment time.
- Less than 1.5% of appointments were cancelled at relative short notice, and appointments were promptly re-booked.

Good

Outpatients and diagnostic imaging

- Care and treatment was co-ordinated with other providers, including the use of a paediatric nurse from another BMI hospital.
- There were low numbers of complaints throughout the service. Patients could complain or raise concerns and were treated compassionately if they did. Staff dealt with complaints in an open and transparent manner.

However:

- Some patients told us they had to wait weeks to get a follow up appointment with their consultant and had long waiting times when arriving to clinics.

Service planning and delivery to meet the needs of local people

- Staff we spoke to told us the maximum time a privately funded patient would have to wait for an appointment would be a week from GP referral if they did not request a specific consultant. If they named a specific consultant this wait could be longer, up to two weeks.
- Three patients we spoke to said some follow up clinics had long waiting times. The hospital staff told us patients were marked on arrival so the consultants could see waiting times on their screens. They told us reception staff monitored anyone waiting over 20 minutes to be seen but there was no written evidence of this.
- NHS patients would book an appointment on line and patients generally waited seven days to six weeks to be seen. The hospital sent us evidence of this.
- Services were available to meet the needs of people. For example, the OPD was open from 8.30am – 8.30pm Monday – Friday and from 8am-1pm on a Saturday.
- The radiology department was open from 9am-8pm Monday to Friday. Between 5pm-8pm only x-ray facilities were available. On Saturday from 9am-1pm there were scanning facilities and a radiologist available for clinics.
- Radiology did not provide CT scans out of hours. Instead if a patient needed a CT scan during this time they were transferred to the local NHS hospital. Staff told us this was due to the low number of out of hour's call outs. They audited this and showed us that from January 2016 to July 2016, only nine patients required an out of hours x-ray.
- The physiotherapy department was open from 7.30am-8pm Monday-Friday and provided an inpatient service 24 hours a day seven days a week. They did not have to be on the hospital site out of hours but available to come in to the hospital at short notice.
- All waiting rooms had chairs at several heights for patients with mobility problems. The car park had adequate parking for those with wheelchairs or requiring assistance with mobility.

Access and flow

- OPD patients were able to book in at reception and make follow up appointments within the department. Waiting times for patients once they had arrived in the clinic were not recorded by OPD staff. Two patients we spoke to said their appointments had previously run over an hour late and this was frustrating. Staff told us they would ask the receptionist to alert patients if clinics were running late and allow patients to rebook if they could not wait. Although there was a board to advise if clinics were running late, this was not in use.
- If a patient required admission from a clinic to the ward staff would complete a set of observations and a reservations form. If they needed transfer to an NHS hospital there was a policy with a step by step chart for staff to follow to ensure patient safety throughout.
- OPD did record the number of "did not attend" (DNA) for patients. In the three months before inspection, 399 people DNA their appointments, which was 3.7% of all attendances. Consultants told us if patients did not attend they would normally telephone them. NHS patients who DNA would be referred back to their GP after two missed appointments.
- NHS patients met the 92% target for referral to treatment (RTT) within 18-weeks each month from April 2015-March 2016.
- There was an admission criterion for patients wishing to have treatment in the main hospital. Patients with certain complex problems or high body mass index (BMI) were not admitted. The criteria ensured patients were not given treatment or care where the hospital could not provide the required level of support. However, medical staff told us at times they were unsure if some of the patients were admitted were appropriate but it was the consultant's decision. They gave us an example of this.

Good

Outpatients and diagnostic imaging

- There were 70 clinics cancelled with less than 72-hours' notice in the last year, this was less than 1.5% of all clinics. Administration staff said when this was the case they would ring the patient and organise a new clinic appointment at the earliest time possible. The OPD manager said she would speak with consultants if they cancelled clinics at late notice and refer them to MAC if it continued to be a problem; however, there was no evidence of this in MAC minute meetings that we reviewed.
- Pathology services were provided by another BMI hospital, and transported from the department on a daily basis. Staff said results were easily accessible online.
- The hospital provided a range of scans and x-rays including mammography (breast screening), fluoroscopy and CT scans and physiotherapy. Patients told us the choice of treatment was adequate and they could complete all treatments in one day, meaning they did not have to travel to the hospital multiple times.
- Physiotherapy patients could self-refer or be referred by their consultant or GP. They offered specialist hand therapy and men's and women's health clinics. They also offered Pilates as part of rehabilitation.

Meeting people's individual needs

- Staff told us they had training in caring for patients living with dementia. We saw dementia awareness training was a one of mandatory session for all clinical staff.
- Staff told us they would help this patient group by asking their carer to come with them to appointments and by seeing them first on the list in clinic. One nurse told us they would ask the nurse in charge what to do if someone with dementia or a learning disability was booked into a clinic.
- We were told there was no way of identifying this patient group at the time of booking appointments. If a person living with dementia or a learning disability was identified when booking an appointment, booking staff would inform reception and the nurse in charge.
- There would be a flag on the booking system for those patients with hearing or sight difficulties to make staff aware these patients may need more assistance.
- Translation services were provided through a telephone language line service. Staff told us they would use this if necessary, but it was rarely required. Leaflets in patient care areas were not translated into other languages.
- The chaperone policy was visible in all waiting and treatment rooms and staff told us this could be accessed on the intranet. The OPD manager had employed three extra staff to ensure chaperones were available for consultants as required.
- There were parking spaces for those with mobility issues and for patients in a wheelchair. Chairs at different heights were available in the waiting rooms.
- The radiology department had appropriate changing facilities and gowns for patients.
- In OPD there were two HCAs trained in paediatric phlebotomy to take blood tests for children. Children were then given stickers and a bravery certificate to make it a positive experience.
- Physiotherapy patients were sent information via an online system, which provided exercise videos and patient leaflets. This could be printed for those without internet access.

Learning from complaints and concerns

- Information on how to complain was visible in the waiting areas. Staff understood what to do it a patient wanted to make a complaint.
- There were 30 complaints received about the OPD and two about diagnostic imaging from April 2015 to March 2016. Trends included complaints about consultant's communication and billing issues.
- Staff told us complaints were dealt with by senior managers. There was a paper form to complete for all complaints including informal complaints. We saw these during our inspection.
- If the complaint could not be resolved informally a full investigation would take place. This would involve the patient's consultant and the quality and risk manager when required. We saw details of complaints and how they were dealt with pre-inspection.

Are outpatients and diagnostic imaging services well-led?

Good

Outpatients and diagnostic imaging

Good

We rated well–led as good for the service. This was because:

- Staff were focused on providing patient centred care and ensuring a good patient experience. Staff told us managers were visible and they felt well supported.
- The leadership and governance within the physiotherapy and imaging department aimed to improve practice and regular governance meetings took place. Action plans were completed following these meetings and followed up by heads of department. Staff told us they had regular learning opportunities from incidents.
- Staff told us their practice was benchmarked against other BMI hospitals and they would receive feedback on patient comment cards.
- Staff enjoyed working at the BMI The Shirley Oaks and felt there was a strong ethos of teamwork and patient centred care.

However;

- Audits in the OPD were not well completed and action plans were not fully in place to lead improvement. Senior members of staff dealing with risk management could not locate these or show action upon areas of poor practice. There was little support for staff in the OPD to improve on audit practise.
- There were no local risk registers available and staff did not always understand the top risks in their departments.

Vision and strategy

- The hospital had a local business plan which was explained by the executive team. This had eight elements, which underpinned the broader organisational vision. It included providing the best patient experience, best outcomes and the most cost effective care.
- Eight strategic priorities had been identified for the financial year and included having an effective governance framework and providing superior patient care, people, performance and culture. In terms of business growth, they were looking to grow the business, with a focus on more complex procedures and services.
- Senior staff discussed their visions for each of the departments we visited. Areas included new scanners, more Pilate's classes, and increasing the amount of business they could accommodate.
- Staff knew the mission statement of the hospital which was "to strive to continuously improve the health of our local community by providing accessible, compassionate, quality healthcare." It was visible at reception and in the OPD waiting room. Staff were able to tell us the values they adhered to in their day to day work.

Governance, risk management and quality measurement for this core service

- The OPD and physiotherapy departments had monthly meetings to discuss incidents, policy changes and improvements in the department. Staff were expected to attend or read minutes of the meetings and sign to say they had understood any actions that needed to be carried out. We saw that in the OPD staff had signed the minutes of these meetings for the last three months.
- Although staff said in the ODP said they gained learning from incidents they could not show any learning or improvements from audit practices in the department. We were not assured that staff understood the audit process or its importance in driving improvement and change.
- The radiology department had a meeting every two months to discuss departmental issues, audit results and changes to policies and practice. We saw minutes of these. Staff told us if there were any issues in the interim they could call a meeting to discuss these.
- Staff told us there was a hospital wide huddle which took place at 09.30am every morning. This was to discuss health and safety, any serious department issues, and who would carry the cardiac bleeps.
- Medical staff we spoke with sat on the Medical Advisory Committee (MAC). They told us they met every two months and discussed issues such as consultant applications for practising privileges, feedback from the clinical governance meetings and the top five hospital risks. This allowed consultants to understand the wider issues in the BMI group and learn from incidents and complaints. We saw minutes of these meetings
- There were monthly governance meetings within the hospital. These were attended by the OPD, imaging, physiotherapy managers, and the executive team

including the director of clinical services. We saw recent meeting minutes, which included discussion of all incidents across the month, complaints and new clinical developments. They were well attended by senior staff.

- A review of actions identified at previous meetings was supported by a separate action tracker. We reviewed the most current tracker and identified a red, amber and green (RAG) status was attached to each action. Six of the actions were rated as red and 12 as amber. The remaining 20 did not have a RAG rating, and although agreed dates for completion were set as July or August 2016, we could not identify if these had been completed.
- Physiotherapy attended regional meetings with other BMI hospitals to ensure practice was consistent and up to date and to see what other hospitals were offering that they may be able to implement within the Shirley Oaks.
- The OPD staff told us their practice was benchmarked against other BMI hospitals. This included staffing levels, billing rates and number of procedures carried out. A patient satisfaction dashboard was available in the clinical governance meeting minutes for July 2016. We saw the Shirley Oaks was dropping in the ranking of other hospitals from 35 out of 55 in February 2016 to 47 in May 2016. The manager told us areas of improvement included billing practises and communication with patients.
- Staff told us a new online system was due to be implemented allowing incidents and risks to be electronically recorded. This would allow easier information sharing of risks and ensure improved patient safety.
- The risk register within the hospital was a corporate register and was based on themes. Each healthcare centre was required to provide quarterly information on their risk management strategies and action plans for this. When a local risk was identified into an appropriate theme which staff told us could be difficult. A quarterly meeting was held with the Quality and Risk Manager (QRM) and Health and Safety, where the risk register was discussed. New risks had to be fed through the QRM.
- Staff in each area told us there was no specific risk register and risks included late running clinics, the décor in the hospital and financial competition from other local health providers.
- The imaging department meetings minutes from June 2016 indicated the risk register had been recently updated to include several incidents of patient cancellation in a certain screening room which may affect the business. Staff showed evidence of good risk management and change from audit practice such as the new WHO checklist.

Leadership / culture of service

- Staff we spoke to told us they felt valued and appreciated as team members. Managers were visible during our visit and staff felt able to discuss issues and concerns openly.
- Staff were very complimentary of their working environment saying it was “the nicest place they had every worked” and they felt team work was the highest quality.
- Staff were able to tell us who their managers were, and also who the senior hospital managers were. They told us they were supportive and felt there was a culture of openness.
- Senior staff were offered the chance to complete a leadership and management course. This was competency based and helped them improve their management skills. Several staff had completed the course across the departments and found it helped them gain new leadership skills.
- Although the ODP was attempting to provide audits there was little support from the greater risk management team. When we asked the quality and risk management team how they would support audit practice in the department they were not able to provide us with an answer.
- An equal opportunities approach was applied to recruitment and selection. Information provided to us showed 56.5% of the locations workforce were white British.

Public and staff engagement

- Physiotherapy had recently attended a church group to talk about staying active in older age and had completed teaching on knee surgery to some local GPs.
- Staff told us about the “above and beyond” scheme, where employees were nominated for outstanding practice. One staff member told us they had been nominated for being caring and had received a prize.
- Staff felt supported in their roles and several staff members had further study paid for to improve their knowledge and skills in caring for patients.

Good

Outpatients and diagnostic imaging

Innovation, improvement and sustainability

- A new service had been set up In April 2016 in the form of an intermediate gynaecological contract. This was a consultant led service, which included triaging patients before deciding if they could be treated at the hospital through choose and book or if they needed to be referred onto secondary care via an urgent care pathway.
- The OPD manager carried out a consultant satisfaction questionnaire in 2015. This showed there were issues around chaperones and staff ensuring they were setting up equipment trolleys correctly. An action plan was completed and to improve on these issues a clinic information folder was developed to show staff how to set up trolleys for certain procedures. Chaperone training was completed and we saw completed competencies.
- The OPD manager had introduced new trolleys into each of the consulting rooms to ensure patients and staff had a smooth appointment. It allowed staff to see what consumables had been used and charge patients appropriately.
- Staff told us if they did want to implement something new they would feel confident to raise this with their managers and felt they would be listened to.
- The OPD had developed a new child friendly satisfaction questionnaire for children who had had their bloods taken. This included questions with smiley and sad faces so staff could see how the service was running. The first results were due at the end of August 2016.

Outstanding practice and areas for improvement

Outstanding practice

- The regular morning engagement meeting was well established. This provided representative staff from each area the full opportunity to share and discuss information.

Areas for improvement

Action the provider MUST take to improve

- Start here..Ensure the consent processes take into account best practice. The use of an interpreter must be arranged for all patients who do not speak English. Family members should not be used to translate for patients.
- The OPD must ensure consent is being completed in line with policy and legislation. Patients must have risks and benefits of procedures discussed with them and documented.

Action the provider SHOULD take to improve

- Assess the content and provision of training, along with staffs understanding of the Mental Capacity Act and Deprivation of Liberty Safeguards.
- Store all patient identifiable records securely.
- Provide information leaflets in other languages when required.
- Review the screening rates for the risk of developing a VTE and improve this to the 95% target.
- Include patient physiological assessments when they are having minor procedures.
- Increase staff adhere to hospital policies with regard to protecting patients from the risk of acquiring a hospital related infection.
- Review surgical site infection rates for primary hip arthroplasty and breast surgery rates to identify and act on possible improvements.
- Review access to the operating theatre to make secure.
- Consider how data on the servicing of equipment can be kept up to date and made available.
- Improve the consistency of labelling on fluids kept in the warming cabinets in theatre.
- Gain assurance of the RMO's level of safeguarding training to the required level.
- Provide level 3 safeguarding training to relevant staff in line with the local policy and Royal College of Paediatrics and Child Health document "Safeguarding children and young people: roles and competences for health care staff intercollegiate document 2014".
- The OPD lead, along with the risk manager, should develop a robust audit structure and a risk register.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

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

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures	Regulation 11 HSCA (RA) Regulations 2014 Need for consent Consent forms were not completed in line with hospital policy. The procedures around gaining patient consent, were not always in line with hospital policy. Discussion of the risks of surgery using both general and local anaesthetic were not clearly recorded. A patient whose first language was English was not provided with a translator during the process of discussing a surgical procedure, the benefits of the surgery and the possible risks. Previous documentary audits showed an on going issue with incorrect completion of consent forms.