BMI The Saxon Clinic

Quality Report

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

Ratings

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

Summary of findings

Letter from the Chief Inspector of Hospitals

We carried out an announced inspection visit of BMI The Saxon Clinic on 26 and 27 January 2016 and an unannounced inspection on 9 February 2016.

Our key findings were as follows:

Overall the hospital required improvement. However, caring was rated good in all the four core services we inspected, medical care (chemotherapy), surgery, children and young people and outpatients, as was effective and responsive in surgery.

Are services safe at this hospital?

- Systems and processes were not always reliable and appropriate to keep people safe. There was an infection prevention and control programme in place, led by an infection prevention and control nurse and supported by a consultant microbiologist. National guidance and specifications on cleanliness, hygiene and infection prevention and control was not always complied with.
- There was no audit tool or audits of patients who developed neutropenic sepsis; however the hospital reported to us that no patients had developed neutropenic sepsis during the previous 12 months.
- The rooms used for chemotherapy, were often used for other services if needed. This meant those patients who may have been immuno- compromised were put at risk of getting a hospital acquired infection.
- There was a policy in place and staff were aware of the impact of duty of candour legislation. We saw that this had been applied where appropriate.
- The director of nursing and the lead nurse for children and young people's services were trained to the appropriate level with regards to safeguarding. Staff were aware of their responsibilities to ensure patients, both adults and children, were protected from abuse and avoidable harm.
- Incidents were reported appropriately. There was some learning, particularly amongst the more senior staff.
- There was a system in place to recognise the deteriorating patient. Appropriate triggers were in place to ensure patients, who had deteriorated were treated according to their clinical needs.
- There was transfer agreement in place with the local trust to ensure that both adults and children could be transferred swiftly to a higher level of care, should this be required.
- There was an RMO on site 24 hours a day and although they had good general skills, and said they were confident, not all of them had specific qualifications to care for both patients undergoing chemotherapy or children and young people.
- Handovers between consultants, RMOs and nursing staff were effective.

Are services effective at this hospital?

- There was limited evidence of how practice was audited against current evidence-based guidance, standards and best practice. The quality and risk manager post had been vacant for eight months prior to the inspection. This had affected the hospital's audit programme.
- There was also limited evidence of patient reported outcome measures in the medical (chemotherapy) and children and young people's services service at the time of our inspection. This meant that staff were unable to confirm how this information was used to improve patient services. There was, however, participation in national audits in surgery, which showed outcomes within an expected range.
- Patients' treatment, with regards to chemotherapy, was discussed within the local NHS multidisciplinary (MDT). None of the Saxon Clinic staff were involved in these MDT meetings.
- The Medical Advisory Committee (MAC) worked closely with the senior hospital managers and the clinical governance committee to ensure that the hospital was supported by the medical society

Summary of findings

- The MAC reviewed all new consultants before practising privileges were approved; this included their scope of practice. The hospital had an effective system in place to ensure that practising privileges were updated with the relevant information, for example appraisal, GMC and MDU membership.
- All staff were aware of their responsibilities with regard to gaining valid consent from adults, children and those who lacked capacity.

Are services caring at this hospital?

- Patients were overwhelmingly complementary about the service they received at the hospital.
- The service provided emotional support to both patients who attended the hospital, and their families. This service extended to counselling and one to one consultations.
- The Friends and Family survey results, for the period April to September 2015 which had a response rate of 60% showed almost 100 % satisfaction with the quality of care. Over 80% of respondents to the inpatient survey rated the quality of care provided as excellent. The BMI patient satisfaction survey, showed a similar high satisfaction, however the response rates were low at 17%. Another shorter survey undertaken of patients had a response rate of 69%.

Are services responsive at this hospital?

- There were some shortfalls in how the needs of different people were taken into account. For example there were no formal mechanisms in place to ensure the service was able to meet the individual needs of people living with dementia, or a learning disability.
- A risk assessment to ascertain patients' mental capacity was carried out at pre-admission clinics or on admission. However, staff had not completed any training in these areas and were unable to describe any formal links to obtain specialist advice in such circumstances. However staff could not recall caring for people with these needs in this specialist service and therefore the perceived impact was low.
- The services provided reflected the needs of the local population. Services were flexible, offered choice and continuity of care.
- The booking system was conducive to patient needs, as where possible patients could select times and dates to suit their family and work commitments.
- Operating theatre lists for elective surgery were planned with the operating theatre manager and bookings team. This was to ensure all aspects were checked and considered before booking patient on to the list to ensure patients safety and needs were met. In addition it ensured available operating time was used effectively.
- Children were cared for in an area of the adult ward. The physical environment had not been sufficiently adapted to ensure it was suitable for children and young people's needs.
- All surgical patients were risk assessed using American Society of Anesthesiology (ASA) guidelines. If they were unsuitable for surgery, for example they had multiple comorbidities and may require high dependency care post operatively; their surgery was not undertaken at The Saxon Clinic.
- There was a culture of learning from complaints and concerns, particularly at senior level. However, not all verbal complaints were recorded or processed in a systematic manner.

Are services well led at this hospital?

- Key risks were not always recognised. It was not clear how often the risk register was updated. Some risks had been on the register for several years and no further action to mitigate the risks had been taken. The service reviewed and acted on feedback about the quality of care received. There were some arrangements for monitoring the quality of the service provided.
- There was good local leadership and an open culture where staff felt valued.
- The quality and risk manager post had been vacant for eight months prior to our inspection. A senior member of staff was covering for this post as well as their own role. It was clear that this had directly impacted on the pace at which risk management had been managed.

Summary of findings

- The vision and values of the hospital were incorporated into the appraisal system. However not all staff had undergone an appraisal which meant there was mixed awareness and understanding of the vision's principles.
- Staff we spoke with could not describe any defined cancer strategy in place other than a proposed move to new facilities. We noted these plans, but saw no evidence of when they would be implemented.
- Each department had a business plan which was incorporated into the hospital plan.

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

Action the hospital MUST take to improve

- The hospital must ensure compliant sinks and taps are available in the clinical areas and patient rooms which conform to Health Building Note 00-10 Part C Sanitary Assemblies to allow correct hand hygiene practice.
- Improve handwashing facilities in the physiotherapy and outpatients department.
- The hospital must ensure carpets in clinical areas are replaced with flooring that meets the requirements of Health Building Notice (HBN) 00-09: Infection control in the built environment.
- The hospital must ensure compliance with national guidance for monitoring and reporting neutropenic sepsis, although the hospital reported that they had not admitted any patients with neutropenic sepsis.
- The hospital must ensure that when risks are identified that they are recorded, reviewed regularly and timely action is taken to mitigate them.

Action the hospital SHOULD take to improve

- An audit programme should be in place to ensure compliance with national guidance and to measure patients' outcomes.
- Review the MDT arrangements, for patients undergoing treatment for cancer with the local trust.
- Improve staff attendance at some aspects of mandatory training, for example basic life support, paediatric basic life support and acute illness management.
- Ensure all staff have an annual appraisal.
- Ensure that complaints are dealt with consistently.
- Implement specific children's and young people's audits, according to BMI policy, in order to measure patients' outcomes.
- Carry out a risk assessment on the children and young people's service and the areas in which children are cared for.
- Review the requirement to make child friendly information available.
- Consider the risks and sustainability surrounding the paediatric service, when there is only one person in a substantive post, supported by temporary staff only, carrying sole responsibility for delivering it.

Professor Sir Mike Richards
Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Medical care	Requires improvement	Overall we rated that medical care required improvement with regards to safety, effectiveness, and leadership of the service. We rated caring and responsiveness as good. Risks associated with cleanliness, hygiene and infection prevention and control were not fully recognised, assessed or managed. Rooms used for chemotherapy were used for other patients, increasing the risk of immuno-compromised patients getting an infection. There was no principal cancer strategy or clinical director with sole responsibility for chemotherapy services. The arrangements for governance and risk management were not always dealt with in a timely way. Information about patients' care and treatment, and their outcomes was not routinely collected and monitored. However, patients' care and treatment was generally planned and delivered in line with current evidence based guidance, best practice and legislation. Feedback from patients and those close to them was positive. Patients were treated with respect and dignity at all times and were kept informed of their treatment plan and progress. Staff spent time speaking with patients, and responded compassionately when people needed help and support. Infection rates were low. Clinical waste, including chemotherapy waste and sharp objects, were disposed of safely. There were arrangements in place to ensure medicines, including cytotoxic substances, were ordered, stored, dispensed and administered safely. There was sufficient equipment to maintain safe and effective care. There were clearly defined systems and processes to keep patients safeguarded from abuse. There was an extravasation policy and staff were clear with regards to the process to be followed if there should be extravasation.

Summary of findings

There was a policy and procedure in place, with regards to handling cytotoxic substances, which staff were clear about. Staff were also aware of the process to follow, according to the policy, and for dealing with cytotoxic spillages.
Staff were adequately trained and supported in their individual learning and development.
Patients' care and treatment was generally planned delivered in line with current evidence based guidance, best practice and legislation.
Patients had choice, flexibility and continuity of care. There was no evidence of any long waiting times, delays or cancelled appointments. All the consultants specialised in treating particular tumour sites. Consultants had their own patient records and were able to access diagnostic test results without delay. There was effective multidisciplinary working between nurses, specialist nurses, doctors, and allied health professionals.

Surgery

Requires improvement

Surgical services required improvement to be considered safe and well led.
We rated responsive, effectiveness and caring as good.
Systems and processes were not always reliable and appropriate to keep people safe. Infection prevention and control measures did not ensure patient safety. National guidance on cleanliness, hygiene and infection prevention and control was not always complied with. In particular sinks and taps in patient rooms did not allow effective hand hygiene practice. These identified risk issues were not always dealt with in a timely way and had remained on the risk register since 2013 with no deadline set for their closure.
There was sufficient competent staff to meet the needs of patients however there were gaps in the management and support arrangements for some ward staff, such as completion of staff appraisals.
Incidents were reported and dealt with appropriately and trends and actions to minimise risks were communicated to staff.
Patient areas were visibly clean, tidy and appropriately equipped. Patients were assessed, treated and cared for in line with national guidance.

Summary of findings

There were effective arrangements in place to monitor and manage pain. Patient surgical outcomes were monitored and reviewed through formal national and local audit.

The service reviewed and acted on feedback about the quality of care received. There was good local leadership and an open culture where staff felt valued.

Services for children and young people

Requires improvement

Overall, we found the children and young people's service was good in regards to caring and required improvement in safety, effectiveness, responsiveness and to be considered well led.

We found that the hospital did not ensure that recovery nurses had specific recovery competencies in children and young people's care. However, the two members of staff on duty at the time of our inspection were trained in paediatric immediate life support (PILS) which is the minimum standard required under 'Royal College of Anaesthetics 2015' Guidance.

There were no specific audits for children's and young people's services.

We did not see any child friendly easy to read information available at the hospital. However, there were some health education information leaflets for young people available at the nurses' work station.

A passionate and motivated lead nurse led the children's and young people's service, however we expressed concerns with regards to the sustainability surrounding the paediatric service, when there was only one person in a substantive post, supported by temporary staff only, carrying sole responsibility for delivering it.

The service demonstrated that care was provided in accordance with evidence-based guidelines; however, care was not being monitored via audit to demonstrate compliance.

Children were nursed in the rooms nearest to the nurses' work station. The rooms were not for the sole use of children and were not adapted to ensure they were suitable for the children and young people's needs.

Summary of findings

The hospital had cover from a resident medical officer (RMO) 24 hours a day. One RMO that was used, had experience and a qualification caring for children however, not all RMOs had this level of training or experience.

The service was small and intermittent however; the hospital did not have allied staff, for example a play specialist to support children and young people during their visit to hospital.

Safeguarding systems were in place and staff knew how to respond to safeguarding concerns. All staff that came into contact with children and young people had the appropriate level of safeguarding training. There was a paediatric lead nurse for safeguarding who had also received training in female genital mutilation (FGM).

All areas we visited were visibly clean and equipment checks were in place and up to date.

Children who attended the hospital for day surgery were cared for by registered nurses, (child branch). When children zero to three years were attending outpatient's clinic for consultation a registered nurse, (child branch) attended to the clinic.

Surgeons and anaesthetists that had practicing privileges at the hospital also cared for children in their NHS practice.

There was a process in place for transferring children who were not well enough to go home after their surgery to the local NHS acute trust for continuing care.

Pain assessments were embedded in the paediatric pathway and we saw evidence that assessments were being completed. Parents told us that their children's pain had been well managed.

The hospital did not have a consent form specific to children and young people however there was a section pertaining to gaining consent for children, in the generic consent policy. Registered nurses (child branch) were aware of Gillick competence.

Comprehensive information was sent to children and young people and their parents/ carers prior to surgery; however, this information was not in a child friendly format.

There was a child friendly menu offered to children and young people. However, they could also order from the adult menu should they wish to.

Summary of findings

All children and young people were pre-assessed before admission for day surgery.
Children were treated with dignity and respect.
Parents we spoke to were positive about the care their children received.
We observed calm relaxed and compassionate interactions between staff and children. Nurses communicated with children using language appropriate to the child's age.
Nurses were encouraging and supportive to both the children and their parents and recognised their emotional needs.
Operating dates for children and young people's services were published in advance to allow the hospital to plan to have two registered nurses (child branch) on duty for children's day case lists.
Children were routinely scheduled first on the operating lists ensuring that they were recovered and discharged at an appropriate hour of the day.
Parents were given access to accompany their children to the anaesthetic and recovery rooms.
We found that the hospital had a policy on caring for children and a strategy and vision that was displayed in the bedrooms.
There were no specific audits for children's and young people's services.

Outpatients and diagnostic imaging

Requires improvement

We identified the safety, responsiveness and leadership of the service required improvement.
We rated caring and responsive as good.
The CQC does not rate the effective domain in outpatients and diagnostic imaging.
We inspected the effectiveness of the outpatients and diagnostic imaging services but did not provide a rating because we are not currently confident that, overall, CQC is able to collect sufficient evidence to give a rating for effective in outpatients department.
National guidance on cleanliness, hygiene and infection prevention and control was not always complied with. In particular: carpeting, furniture and surfaces could not be adequately cleaned in outpatients; there were insufficient hand washing facilities in physiotherapy, and a lack of dirty utility facilities in the imaging department.
Reporting of safety incidents was not consistent.

Summary of findings

There were limited available appointments for some imaging services.

The needs of different people were generally taken into account; however there were no formal arrangements in place to ensure services were able to meet the individual needs of people living with dementia, or a learning disability.

The arrangements for governance and performance management did not always operate effectively.

Feedback from patients and those close to them was positive. People were treated with respect and dignity at all times and were kept informed of their treatment plan and progress.

Patients using the service were protected from the harmful effects of ionizing radiation.

The service was adequately staffed and staff were suitably trained and supported in their learning and development.

Staff satisfaction was good and staff felt motivated and valued.

Summary of findings

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Requires improvement

BMI The Saxon Clinic

Services we looked at
Medical care; Surgery; Services for children and young people; Outpatients and diagnostic imaging.

Summary of this inspection

Background to BMI The Saxon Clinic

BMI The Saxon Clinic is a private hospital in Milton Keynes. It has 37 registered beds. The hospital was opened in 1985 and is purpose built.

The original build has been extended and now has two operating theatres (one with laminar flow) and an endoscopy theatre. The hospital undertakes a range of surgical procedures and treats adults and children from aged three years. The Saxon Clinic provides cancer care services including chemotherapy to adults.

The hospital provides outpatient consultations to both adults and children. The outpatient department comprises 12 consulting rooms together with a minor treatment room. The hospital offers imaging and physiotherapy services in addition to a pharmacy department providing services for both inpatients and outpatients. All patient services are situated on the ground floor of the building.

The hospital is managed by BMI Healthcare and is part of a network of 59 hospitals across England, Scotland and Wales.

The hospital provides care for private patients who are ether paid for by their insurance companies or are self-funding. Patients funded by the NHS, mostly through the NHS referral system can also be treated at BMI The Saxon Clinic.

Our inspection team

Our inspection team was led by:

Inspection Lead: Kim Handel, Inspection Manager, Care Quality Commission.

The team of nine included CQC inspectors and a variety of specialists: theatre nurse, consultant surgeon, governance specialist, chemotherapy nurse specialist and an infection prevention and control nurse.

How we carried out this inspection

Before visiting, we reviewed a range of information we held about the hospital and each core service.

We carried out an announced inspection visit on 26 and 27 January 2016 and an unannounced inspection on 9 February 2016. We spoke with a range of staff in the hospital, including nurses, allied health professionals, support staff and consultants. During our inspection we reviewed services provided by BMI The Saxon Clinic in the ward, operating theatre, outpatients and imaging departments.

During our inspection we spoke with 15 patients and 47 staff, including consultants, who are not directly employed by the hospital. In addition, we spoke with six family members/carers from all areas of the hospital, including the wards, operating theatre and the outpatient department. We observed how people were being cared for and reviewed personal care or treatment records of patients.

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

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

Summary of this inspection

Information about BMI The Saxon Clinic

The hospital has 37 inpatient rooms on the ground floor, all with en-suite facilities. However, 30 of these are used for in and day patient care currently. There are two operating theatres, one with laminar flow, 12 consultation rooms and an endoscopy room.

BMI The Saxon Clinic provides an outpatient service for various specialties to both private and NHS patients. This includes, but is not limited to, orthopaedics, gynaecology, general surgery and urology. There were 4,548 surgical procedures carried out between October 2014 and September 2015. 1017 of these were patients who stayed one or more nights and the remainder, 3425, were day cases.

Between October 2014 and September 2015, 32,359 people were seen in outpatients. The outpatient department provides a local anaesthetic minor operation service.

Between October 2014 and September 2015 around 31% of the patients having day or inpatient treatment were funded by the NHS, the remaining patients were self-funding or paid for by their insurance companies. The hospital is accredited by all the major private medical insurers.

In outpatients there was a similar proportion of NHS and patients funded by other means.

112 doctors have practicing privileges and their individual activity is monitored. There are 76.2 whole time equivalent employed staff.

BMI The Saxon Clinic has no external accreditations.

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

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

The hospital has a contract with Milton Keynes NHS Trust Hospital, which is nearby, to provide pathology, histology and microbiology services. Endoscopes are also decontaminated by this trust. In addition MRI services, further histopathology and pathology services are provided from a number of independent sources. Decontamination in relation to theatre instrumentation is provided by BMI's decontamination centre, 35 miles away.

BMI The Saxon Clinic has been inspected three times by the Care Quality Commission, between December 2012 and October 2013 with 10 of the core standards being assessed during these inspections. Some standards assessed, including, infection prevention and control, records, notifications, supporting workers and medicines management were found to be non-compliant. However, by October 2013, there was only one outstanding non-compliance which was around medicines management.

Detailed findings from this inspection

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Medical care	Requires improvement	Requires improvement	Good	Good	Requires improvement	Requires improvement
Surgery	Requires improvement	Good	Good	Good	Requires improvement	Requires improvement
Services for children and young people	Requires improvement	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement
Outpatients and diagnostic imaging	Requires improvement	Not rated	Good	Good	Requires improvement	Requires improvement
Overall	Requires improvement	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement

Notes

We are currently not confident that we are collecting sufficient evidence to rate effectiveness for Outpatients and Diagnostic Imaging.

Requires improvement

Medical care

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

Information about the service

Medical care, which comprises of a chemotherapy service at BMI The Saxon Clinic cares for adults with any cancer, where it is safe to deliver chemotherapy and supportive treatments outside a dedicated cancer centre. Treatments include simple and complex cytotoxic drug treatments and targeted therapies. Between October 2014 and September 2015 there were 394 attendances.

The service is situated in one location in three designated single accommodation rooms, where patients are provided with a reclining chair or bed and ensuite bathroom facilities. It is an evolving service that is due to move to another area within the hospital as part of an improvement plan.

Treatment and care is provided by five oncology consultants and a specialist team of nurses, pharmacists and therapists, to support patients and those close to them. The service is open between 08.00 and 20.00 hours Monday to Friday, by appointment. Chemotherapy is generally administered between Tuesday and Friday, and appointments for pre-treatment diagnostic tests arranged on Mondays. There are arrangements to care for, or transfer people to either the inpatient ward in the hospital or other facilities, if they become unwell as a result of their treatment.

During our inspection we spoke with the nurse manager with the lead responsibility for nursing within the service (head of service), four patients, six members of staff, three nurses including a specialist breast care nurse, and two pharmacists. We observed interactions between patients and staff. In addition, we considered the environment and looked at records, including four patient records. Before and during our inspection we also reviewed performance information about the service.

Requires improvement

Medical care

Summary of findings

Overall we rated that medical care required improvement with regards to safety, effectiveness and leadership of the service. We rated caring and responsiveness as good.

We found:

- Risks associated with cleanliness, hygiene and infection prevention and control were not fully recognised, assessed or managed. Rooms used for chemotherapy were used for other patients, increasing the risk of immuno-compromised patients getting an infection.
- The rooms used to administer chemotherapy were carpeted. There was no defined process for cleaning chemotherapy spillages on carpets.
- There was no principal cancer strategy or clinical director with sole responsibility for chemotherapy services.
- The arrangements for governance and risk management were not always dealt with in a timely way.
- Information about patients' care and treatment, and their outcomes was not routinely collected and monitored. However, patients' care and treatment was generally planned and delivered in line with current evidence based guidance, best practice and legislation.
- Although the needs of different patients were taken into account, there were no formal arrangements in place to ensure the service was able to meet the individual needs of patients living with dementia, or a learning disability. This included admission criteria. However; staff we spoke with could not recall people with such needs using the service and therefore, the impact of this was minimal.
- There was a limited approach to obtaining the views of people who used the service, staff and other stakeholders. There was little innovation or service development; however we noted the evolving nature of the service.
- Patients highlighted to us and we noted that, that the environment required updating and refurbishment. This was acknowledged by staff, including the senior managers. Both patients and staff told us that transfer of the service to a dedicated part of the hospital was planned. There was no specific time scale for this, or any evidence of interim solutions to mitigate the identified risks in the meantime.

We also so identified some good practice:

- Feedback from patients and those close to them was positive. Patients were treated with respect and dignity at all times and were kept informed of their treatment plan and progress. Staff spent time speaking with patients, and responded compassionately when people needed help and support.
- Infection rates were low. There had been no reported incidents of health acquired Methicillin Resistant Staphylococcus Aureus (MRSA) or Clostridium Difficile (C. difficile) in the six months prior to our inspection. Clinical waste, including chemotherapy waste and sharp objects, were disposed of safely.
- There were arrangements in place to ensure medicines, including cytotoxic substances, were ordered, stored, dispensed and administered safely. There was sufficient equipment to maintain safe and effective care. There were clearly defined systems and processes to keep patients safeguarded from abuse.
- There was an extravasation policy and staff were clear with regards to the process to be followed if there should be extravasation.
- There was a policy and procedure in place, with regards to handling cytotoxic substances, which staff were clear about. Staff were also aware of the process to follow, according to the policy, and for dealing with cytotoxic spillages.
- Staff were adequately trained and supported in their individual learning and development.
- Patients' care and treatment was generally planned delivered in line with current evidence based guidance, best practice and legislation.
- Patients had choice, flexibility and continuity of care. There was no evidence of any long waiting times, delays or cancelled appointments. All the consultants specialised in treating particular tumour sites. Consultants had their own patient records and

Requires improvement

Medical care

were able to access diagnostic test results without delay. There was effective multidisciplinary working between nurses, specialist nurses, doctors, and allied health professionals.

Are medical care services safe?

Requires improvement

We have rated the medical care (chemotherapy) service as requires improvement for safety.

We found :

- There was an infection prevention and control programme in place, led by an infection prevention and control nurse and supported by a consultant microbiologist. National specifications for cleanliness were not fully adhered to which meant that patients were not always kept safe from the risk of infection. Carpet should not be used in treatment areas, or areas where body-fluid spillage is anticipated, including corridors and entrances as there is a high probability of body fluid contamination. Some clinical areas we saw were carpeted. This did not meet the requirements of Health Building Notice (HBN) 00-09: Infection control in the built environment.
- Monitoring whether safety systems were implemented, and whether identified risks were acted upon was not always effectively managed. For example, the risks associated with infection had been identified on the hospital's risk register, however there was no effective action taken to resolve them. This meant that vulnerable patients may not have always been kept safe from the risk of infection.
- There was no preventative maintenance or cleaning programme or specific risk assessment in evidence for carpeted areas as required by (HBN) 00-09 and the National Specifications on Cleanliness (NSC) or The Health and Social Care Act 2008: Code of Practice on the prevention and control of infections and related guidance. In addition, there was no defined process for dealing with chemotherapy spillages on carpets.
- Staff were unable to confirm when the carpets or soft furnishings had last been cleaned.
- There were insufficient hand washing facilities in some treatment areas. Those that were there did not meet the requirements of HBN 00-09 or HBN 00-10 Part C: sanitary assemblies.

We also saw examples of safe practice:

- There had been no reported incidents of MRSA or Clostridium Difficile in the six months prior to our inspection. The hospital gathered patient information such as hospital acquired infections and reviewed these through its clinical governance processes.
- Clinical waste was disposed of safely. This included chemotherapy waste.
- There were arrangements in place for managing medicines, including chemotherapy, to keep people safe. Chemotherapy was manufactured off site, on a named patient basis, aseptically, (in a germ free environment) by an external provider. There was sufficient equipment, for example intravenous pumps and subcutaneous syringe drivers, to maintain safe and effective care.
- There were systems in place to make safeguarding referrals if staff had concerns about a vulnerable adult. There had been no safeguarding concerns reported within the previous year.
- The chemotherapy service was adequately staffed.
- There was a process in place to obtain rapid treatment for patients who were suspected of having neutropenic sepsis. However, the hospital reported that there had been no incidents of neutropenic sepsis during 2015; therefore an audit had not been undertaken. There was no audit tool.

Incidents

- Staff understood their responsibilities to raise concerns, record and report safety incidents, and near misses, and to report them. There was a hospital incident policy in place, which staff knew how to access. Although there was an electronic reporting in place, generally staff did not use this. If they needed to report an incident, they recorded it on a form, one colour for clinical incidents and another for non-clinical. These were then recorded on the electronic system by an administrator after having been scrutinised by the executive director or the director of nursing. Staff told us they did not always receive feedback on incidents they had reported or those reported by colleagues. However, managers were able to demonstrate that incidents were investigated and outcomes shared via heads of department meetings.
- The hospital reported 145 clinical incidents in the reporting period October 2014 to September 2015, of which only four related to the oncology (chemotherapy service). All four were rated as low or no harm and appropriate action had been taken at the time to prevent similar incidents happening again.
- We saw some staff attended a daily ‘huddle’ meeting with colleagues from other departments within the hospital, where they discussed solutions to safety issues relating to the environment, equipment, resources and any incidents.
- The hospital reported one incidence of a never event, in the reporting period October 2014 to September 2015. A never event is a serious incident that is wholly preventable, as guidance or safety recommendations that provide strong systemic protective barriers are available at a national level, and should have been implemented by all healthcare providers. The never event had not occurred within, or had a specific impact upon the chemotherapy service.
- There were procedures in place that required all deaths within the hospital to be recorded, and discussed monthly at the hospital’s clinical governance meeting. However, there had been no deaths within the chemotherapy service, or the hospital, in the reporting period October 2014 to September 2015.
- Safety alerts received from external sources that required action, for example alerts from the National Reporting and Learning System (NRLS) were circulated to relevant heads of departments and were effectively followed up. This meant appropriate action was taken with regards to any national alerts.

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. Staff showed us the BMI policy about being open and honest and understood their responsibilities with regards to the Duty of Candour. Staff told us there were no recent situations when this had been required within the chemotherapy service. Our review of the complaints records, incident reports and patient records relating to chemotherapy, confirmed this to be the case.
- Staff told us there was regular discussion about the principles of Duty of Candour at staff meetings such as the daily ‘huddle’ meeting, which we observed.

Safety thermometer

- The hospital gathered patient information such as hospital acquired infections and reviewed these through its clinical governance processes. This information was displayed on staff notice boards, within clinical areas and on the hospital website. There had been no reported infections, including those related to intravenous catheters, pressure ulcers, falls or blood clots relating to the chemotherapy service.

Cleanliness, infection control and hygiene

- There were some systems in place to prevent and protect people from a healthcare associated infection. However, identified risks were not always effectively managed. For example, the risks associated with infection had been identified on the hospital's risk register, but there was no remedial action taken to resolve them. This meant that patients were not always kept safe from the risk of infection.
- Patients undergoing chemotherapy treatment are very susceptible to infection. Staff told us there were systems in place to reduce the risk and spread of infection such as cleaning check lists and wearing personal protective equipment during clinical procedures. However, the rooms used for chemotherapy were used for other patients, for example those requiring a dressing change. This meant that immuno-compromised patients may be put at risk of getting a hospital acquired infection.
- There was a named nurse for infection control and a system in place for staff to seek expert advice from a named microbiologist. This included an out of hours provision. We saw examples of where this had happened.
- Carpet was used as a floor covering throughout the hospital, including in the rooms where chemotherapy treatment was being carried out. We asked for evidence of specific risk assessment of carpeted areas in respect of Department of Health Building Note 00-09 Infection Control in the built environment, and were told that none had been undertaken. The risk of cross infection had been identified on the hospital's risk register. However no actions had been taken other than a proposed move to new facilities within the hospital, with an unspecified time frame.
- There was no preventative maintenance or deep cleaning programme or specific risk assessment in evidence for carpeted areas as required by (HBN) 00-09 and the National Specifications on Cleanliness or The Health and Social Care Act 2008: Code of Practice on the prevention and control of infections and related guidance. Staff were unable to confirm when the carpets or soft furnishings had last been cleaned.
- Infection rates were low. There had been no reported incidents of hospital acquired Methicillin Resistant Staphylococcus Aureus or Clostridium Difficile in the six months prior to our inspection.
- Personal protective equipment was worn during clinical procedures including administration and disposal of cytotoxic medication and when dealing with a cytotoxic spillage. We saw disposable gloves, aprons, eye protection and masks were available and correctly stored in dispensers.
- There was a policy for cytotoxic spillage and staff demonstrated awareness and understanding of the local policy of what to do and where spillage kits were stored. All the spillage kits we saw were safely stored and within date. In addition there was an awareness of the process to follow should a member of staff become contaminated with cytotoxic material. However, this did not specifically reference spills on carpets and meant that anyone entering a room where this had happened, staff, patients and visitors, could have been exposed to cytotoxic spillage.
- Clinical waste was stored securely in locked compounds outside the building.
- Clinical equipment all appeared clean and was labelled with: "I am clean" notices to show when it had last been cleaned. We noticed some dust on light fittings in a treatment room and there was no evidence of when they had last been cleaned.

- We saw that clinical waste, including chemotherapy waste and sharp objects were disposed of safely. Waste was separated in different coloured bags to signify different categories of waste, for example, cytotoxic waste was disposed of in purple bags. We observed staff washed their hands regularly and adhered to the 'bare below the elbow' dress code. However, in addition to the three treatment rooms there was a large consultation room which was used as both a staff office and a treatment room. Minor procedures, were carried out there, for example, blood tests and dressing changes.

- The nearest hand washing facility to the large consultation room was in the adjacent clinical utility room. There was no segregation of clean and contaminated waste in the consulting room or the clinical utility room.
- Clinical waste awaiting collection was stored in locked containers that were secured safely.

Environment and equipment

- The design, maintenance and use of facilities and premises were not always optimised to keep people safe.
- The three chemotherapy treatment rooms contained both a large, reclining chair and a bed, which restricted space. This meant that it could have been difficult for staff to have enough room to easily access and manage a patient in an emergency situation.
- There was a lack of hand washing facilities in the physiotherapy department.
- Resuscitation equipment for use in an emergency was stored securely in a designated trolley, checked daily and documented as complete and ready for use. All drawers and shelves were fully stocked with consumables and medicines that were in date. Emergency equipment was all clean and ready for use. Staff provided evidence that they were trained in its use as part of the hospital's mandatory training.
- All electrical equipment we saw was marked as having undergone a portable appliance test, giving assurance that it was safe for use. There was a central register of equipment held by the hospital.
- There was 24 hour maintenance support which staff knew how to access.
- There was sufficient equipment, such as intravenous pumps and subcutaneous syringe drivers, to maintain safe and effective care.

Medicines

- There were arrangements in place for safely managing medicines, including chemotherapy. This included systems for obtaining, prescribing, recording, handling, storage and security, dispensing, safe administration and disposal. Allergies were recorded on the medicines charts.
- We looked at a random sample of medicine stock and related records and saw that these had been reconciled correctly.
- All areas used to store medicines were secure, with access restricted by named staff using a keypad. There were specific procedures for staff to gain emergency access to the pharmacy out of hours, with both the resident medical office (RMO) and senior nurse holding separate keys.
- Prescription stationery such as medicine administration records were managed safely.
- Medicines, including those that required refrigeration, were stored safely, in accordance with local and national guidance, and were all within date. Daily checks of the fridge temperature were carried out and recorded, and were all within the required range. There was a process to follow if the temperature should fall out of the safe range. Staff were aware of the action to take should this happen.
- Chemotherapy was manufactured, aseptically, by an external provider. Chemotherapy was supplied on a named patient basis and checked by pharmacists and pharmacy technicians with specific training in this area. There were two pharmacists who had achieved and maintained competencies in oncology through specialist training. The pharmacists ensured that these medicines were stored safely. If chemotherapy was not given, the reason for this was recorded on the patient's medicines administration record.
- If patients were given chemotherapy tablets as a take home medicine, they were given specific advice on how they should be stored and handled.
- Staff received and acted on safety alerts relating to medicine products in a timely manner.

Records

- Patient records contained information of the patient's journey through the service including, investigations, test results and treatment and care provided Patients' records were largely paper based, with the exception of digital images of x-rays and ultrasounds. All the records we saw were accurate, complete, legible, and up to date.
- Patient records were available at each consultation and consultants' records were integrated into the hospital records for each inpatient.
- All computer systems were secure and accessed by staff with individual login details.
- We saw that all paper based patient records were securely stored in an area accessed by staff using a secure keypad system.

Medical care

Safeguarding

- There were arrangements in place and staff understood their responsibilities to safeguard adults from abuse that reflected both relevant legislation and local requirements.
- There were systems in place to make safeguarding referrals if staff had concerns about a vulnerable adult. The staff we spoke with talked confidently about the types of concerns they would look for and what action they would take.
- There were two individual staff members who were the named location leads for adult safeguarding and child safeguarding respectively. Staff we spoke with correctly identified the safeguarding leads by name and correctly described how they would work with them to raise and escalate any safeguarding concerns.
- All staff who worked within the chemotherapy service had completed level two adult and children safeguarding training as part of their mandatory learning and development.

Mandatory training

- There were systems in place that required staff to attend mandatory training. Heads of department were responsible for encouraging staff to attend mandatory training and ensure compliance with attendance. The BMI mandatory training policy specified a target of 85% compliance. For the majority of topics within the mandatory training schedule, the hospital had exceeded this target. However:
  - Acute Illness Management (AIMS) for Registered Nurses was at 43%
  - Immediate Life Support was 81%
- Training attendance was monitored and reviewed at clinical governance meetings.
- We were told that bank nurses currently employed within the service had mandatory training and access to the BMI online training system. In addition, nurses employed at other hospitals were required to evidence the mandatory training they had undertaken so that they did not have to repeat it at The Saxon Clinic.
- Training figures for the chemotherapy service were not specified. All staff we spoke with told us they had completed mandatory training in essential safety systems, including immediate life support training and local records confirmed this happened.

Assessing and responding to patient risk

- There was an admission policy setting out agreed criteria for admission to the service. All patients were admitted under the care of a named consultant.
- The practising privileges agreement for each named consultant ensured there was 24 hour clinical support from the named consultant when they had patients in the hospital. This included making alternative arrangements for a named consultant to attend to patients in an emergency if they were not available. There was a resident medical officer (RMO) in the hospital who was able to provide first line emergency treatment.
- Staff we spoke with were clear of the procedure to follow if a patient deteriorated. The hospital assessed patients by using the national Early Warning Score (NEWS). If patients developed complications they were transferred from the chemotherapy unit to the hospital inpatient facility. If the complications were more serious, patients were moved out of the hospital to a neighbouring NHS facility by emergency ambulance. There was a service level agreement with the local trust to support this. However, transferring patients out of the hospital because they were unwell, was unusual. There had only been one transfer, of a patient undergoing chemotherapy, to the inpatient facility of the hospital and no transfers to the NHS in the reporting period, October 2014 to September 2015. Any such transfers of care would have been recorded as an incident.
- There was a daily multidisciplinary meeting within the hospital known as “the huddle” designed to discuss and review safety issues. For example, equipment, staffing levels and any newly identified risks.
- Patients were advised of the risk of neutropenic sepsis whilst they were undergoing chemotherapy. Neutropenic sepsis is a life threatening condition where the chemotherapy adversely affects the body’s ability to resist infection by affecting the bone marrow and decreasing white blood cell production. We asked to see the most recent audit of patients who displayed signs and symptoms of this infection and were told that no data was available for the reporting period, October 2014 to September 2015, because there had been no patients with neutropenic sepsis. However, there was no audit tool in place. This meant that the service could not be assured that patients who had displayed symptoms of a possible infection received antibiotic treatment and blood tests within an hour of arrival, which is best practice.

- Extravasation is a recognised complication of chemotherapy, where toxic medicines escape into the tissues rather than being confined to the vein. This can cause anything from a minor skin reaction to severe tissue injuries. The more serious reactions require rapid assessment by a plastic surgeon, which is best practice. Staff were aware of the policy to follow should extravasation occur. Patients who had a mild reaction would be treated locally according to the hospital's extravasation policy. There were kits available, which staff were aware of, to deal with any extravasation. However, if further treatment was required, the patients would be transferred to an NHS facility.
- Named nursing staff who had completed specialist training were on call to provide a 24 hour telephone triage service for patients following transfer to their home, using the United Kingdom Oncology Nurses Society (UKONS) triage rapid assessment and decision tool kit. This is designed to promote quality and consistency for patients seeking telephone advice. We looked at records and saw that this happened. Patients we spoke with who had used the telephone advice line told us they felt supported and reassured by the nurse's response on each occasion they had called.
- We saw all telephone advice was recorded in accordance with the hospital standard operating procedure.

Nursing staffing

- Staffing levels, skill mix and caseloads were planned and reviewed so that people received safe care and treatment at all times. Although Guidance on Safer Staffing Levels (RCN 2013) does not specify levels of staffing for patients undergoing chemotherapy and there are no specific, national current guidelines on nursing staffing levels.
- Staff told us, and we saw from the staffing rotas, that no agency staff were used within this specialist service, and that the permanent staff mostly covered vacant shifts by working extra hours. Staff did tell us; however, that they needed to utilise bank staff to ensure that holidays were adequately covered. Patients we spoke with confirmed they always saw the same team of nursing staff at each consultation, and felt that communication between the nurses and consultant was clear and timely.
- The two chemotherapy trained nurses provided cover for each other. However, one worked part time, which meant the head of the service was on call for several days in a row. We saw two weeks of forthcoming on-call days which confirmed the head of service was on call for six days in a row, had one day off, then a further 12 days on call in a row. In practice, out of hours calls were infrequent.
- There was a local induction process in place for permanent, and temporary (bank) nursing staff. The induction consisted of a checklist used to ensure temporary staff were familiar with the environment they worked in.
- Staff told us they did not have dedicated administrative staff to support the service which meant that nurses were responsible for all administrative duties. There were no plans to recruit an administrator.

Medical staffing

- Services were provided by consultants who had been granted practising privileges by the hospital. The medical advisory committee (MAC) carried out checks before granting new consultants practising privileges. This included checks on their scope of practice, with regards to management of patients undergoing treatment for cancer, to ensure they were only managing patients' treatments where they were competent to do so.
- All of the patients were admitted under the care of a named consultant. The consultants reviewed their patients prior to treatment commencement of each treatment and provided a 24 hour on call service as and when required. The day to day medical service was provided by the RMO who dealt with any routine and also emergency situations in consultation with the relevant consultant. Out of hours, consultants provided either telephone advice or attended in person. Part of the consultant's practising privileges agreement was that they should be within 30 minutes travel time of the hospital The RMO was up to date with mandatory training for advanced life support, however, they were not specialist chemotherapy doctors.
- Nursing staff told us they felt well supported by the consultants, both whilst they were on site and if they needed to be telephoned out of hours.
- Patients told us they saw their consultant at each appointment and felt confident that there was clear communication between the medical staff, nursing staff and other therapists.

Major incident awareness and training

Requires improvement

Medical care

- The hospital had a service contingency plan in place for staff to use in the event of interruption to essential services. Staff were aware of the escalation process if there was an incident requiring a major response.
- Emergency bleep holders were designated each morning at the daily morning hospital meeting to ensure that there were clear lines of accountability and responsibility in managing emergencies.
- The hospital had a service level agreement with the nearby trust for The Saxon Clinic to accept patients if they had the capacity, in the event of an emergency situation in the locality. The trust were notified daily of the anticipated capacity.

Are medical care services effective?

Requires improvement

We rated the effectiveness of the chemotherapy services as requires improvement because:

- There was limited evidence of how practice was audited against current evidence-based guidance, standards and best practice.
- There was also limited evidence of patient reported outcome measures in the chemotherapy service at the time of our inspection. This meant that staff were unable to confirm how this information was used to improve patient services.
- Patients' treatment was discussed within the local NHS multidisciplinary (MDT). None of the Saxon Clinic staff were involved in these MDT meetings.

- We also saw some areas of good practice :

- Patients had their needs assessed, their care goals identified and their care planned and delivered in line with evidence-based, guidance, standards and best practice.
- Patient's nutrition and hydration needs were assessed and met.
- Staff had the right qualifications, skills, knowledge and experience to do their job, and completion of mandatory training generally met the hospital's targets.
- Staff were encouraged to take on new responsibilities; however there had been some delay in nurses accessing the non-medical prescriber programme, which remained unresolved at the time of our inspection.
- Staff were aware of their responsibilities surrounding consent. The hospital consent forms complied with Department of Health guidance and staff had an understanding of their responsibilities under the Mental Capacity Act 2005 (MCA).

Evidence-based care and treatment

- Patients had their needs assessed, their care goals identified and their care planned and delivered in line with evidence-based, guidance, standards and best practice.
- Policies were available on the hospital intranet and were based on professional guidance such as that published by the National Institute for Care and Health Excellence (NICE) and the Royal Colleges. Staff demonstrated they were able to access them.
- Staff in the chemotherapy service had a good awareness of local policies.
- Staff were active members of the BMI cancer network group and the Thames Valley Cancer Network. This meant they shared information and learning about best practice.
- There were no cancer related audits in place, for example neutropenic patients receiving antibiotics in line with national guidelines, peripherally inserted intravenous catheter (PICC) lines, to ensure the correct patients were being selected for PICC line and their outcomes. In addition there were no audits of patients outcomes with regards to the efficacy of their treatment.

Pain relief

- The resident medical officer or consultant was available to prescribe medicines if necessary. Staff were able to demonstrate the use of assessment frameworks, for example analgesic ladder, to assist in detecting, assessing and managing pain.
- Patients perception of pain was measured using a recognised tool.
- Patients who were on regular analgesia to relieve their pain, were permitted to self-medicate according to the hospital policy.

Nutrition and hydration

- We saw that the patient's nutrition and hydration needs were assessed and met. Patients could be referred to a dietician who provided a service to the hospital on a practising privileges basis.

Patient outcomes

- There was little evidence of participation in relevant local and national audits, benchmarking, accreditation, peer review, research and trials. There was no information about outcomes of people's care and treatment as it was not routinely collected and monitored, which meant that it was not clear that the intended outcomes for people were being achieved.
- There was limited evidence of audits of chemotherapy regimes or patient reported outcome measures at the time of our inspection.
- There were no cancer related audits in place, for example neutropenic patients receiving antibiotics in line with national guidelines, peripherally inserted intravenous catheter (PICC) lines, to ensure the correct patients were being selected for PICC line and their outcomes. In addition there were no audits of patients' outcomes with regards to the efficacy of their treatment.

Competent staff

- Staff had the right qualifications, skills, knowledge and experience to do their job. All staff had completed the BMI corporate and hospital induction programme, and developed and maintained competencies specific to their role, for example administration of chemotherapy. Staff we spoke with told us that the induction and ongoing competency framework was useful and met their needs.
- Nurses we spoke with were aware of the requirements of the Nursing and Midwifery Council's (NMC) new revalidation scheme. The hospital had arranged workshops to support the nursing staff through this.
- Staff had clearly defined job descriptions. No staff member could recall a situation where they had been asked to act outside of their level of competence. Staff told us they felt satisfied with the arrangements in place to raise concerns about their scope of practice, should the need arise.
- The hospital maintained a Medical Advisory Committee (MAC) whose responsibilities included ensuring any new consultant was only granted practising privileges if deemed competent and safe to practice. The MAC was attended by a group of consultants who held practising privileges and represented their colleagues with the hospital. Its terms specified membership, quorum and responsibilities which included regulatory compliance, practising privileges, quality assurance and proposed new clinical services and techniques.
- The MAC carried out checks, according to BMI's practising privileges policy, before granting new consultants practicing privileges, including checks on their scope of practice to ensure they were undertaking procedures that they were not competent to do.
- Consultants were required to produce evidence annually of their professional registration, revalidation, indemnity insurance, appraisal, mandatory training and continuous professional development before their admitting privileges were renewed.
- We saw evidence of anaesthetists and consultant surgeons being reviewed and discussed at the MAC. Consultants had their practising privileges suspended by the Executive Director if they did not provide the relevant information in a timely manner.
- Patients told us that they felt confident in the skills and competence of staff. One patient said: "They are always very gentle with the needles, and give me plenty of useful information." Another patient told us they were confident that the staff communicated openly with each other and asked for and acted upon advice as required.
- Staff we spoke with had not all had undergone an annual appraisal due to some staff changes. The hospital provided evidence that 65% of staff had undergone an appraisal in the previous year. However, this was not broken down to departmental level. Staff told us they found the appraisal system useful to discuss their progress and career aspirations with their line manager.
- There were no formalised systems to ensure one to one meetings with line managers and staff told us these did not happen on a regular basis. This meant that staff may not have always been supported effectively or that appropriate mentoring and coaching was available.
- Staff told us there was a variety of means through which they received vital communication. They described staff meetings and notice boards and we saw records that confirmed these methods took place.
- There was a range of competency assessments in place with regards to use of equipment, for example, intravenous and subcutaneous pumps/syringe drivers.

Multidisciplinary working

- There was a supportive culture of multidisciplinary working between nurses, specialist nurses, doctors, and allied health professionals within the hospital. This included both inter hospital multi-disciplinary working and between the hospital and the community.
- Multidisciplinary team (MDT) meetings were held regularly where patients being treated at BMI The Saxon Clinic were discussed. These meetings took place at the neighbouring NHS Hospital Trust, at the request of the treating consultant. Topics included: symptom control, psychological care and discharge of patients. The consultant informed staff working in the chemotherapy service at BMI The Saxon Clinic when such discussions took place. Following the MDT discussion either the MDT coordinator or the consultant provided relevant staff with a copy of the patient treatment plan. This was in line with NICE guideline CG104 (February 2014).
- Although the doctors regularly attended MDT meetings with the local NHS Hospital Trust, this did not regularly extend to nurses and other therapists at BMI The Saxon Clinic. We were told that work was in progress to establish more formal links, however, we saw no evidence of this at the time of the inspection.

Seven-day services

- The chemotherapy service was provided between 8am to 8pm, Monday to Friday.
- Out of hours services for radiology, pharmacy, and non-clinical support were available via an on call system.
- If prescribed medicines were required outside of the pharmacy opening times there were arrangements in place to ensure emergency access to the pharmacy stock via a dual key system.

Access to information

- Staff were able to show us how to obtain key polices on the hospital's intranet, for example infection prevention and control, medicines management and chemotherapy guidelines. Results of blood tests and x-rays were also readily available electronically.
- Discharge letters were sent to the patient's GP with details of the treatment provided, on the day of each consultation, detailing follow up advice, arrangements and medicines provided. These were copied to the patient for their information.
- Patients told us they felt they were kept well informed of treatment plans, medicines, and exercise regimes.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff understand the relevant consent and decision-making requirements of legislation and guidance, including the Mental Capacity Act 2005.
- The service had an up to date consent policy that staff were familiar with. Compliance with the policy was not audited.
- Staff we spoke with were clear about their responsibilities in relation to gaining consent from patients.
- We looked at four patient's records and saw consent forms were fully completed, signed and dated by the consultant, or specialist nurse and patient. The planned chemotherapy treatment was identified, the associated risks, benefits and intent of treatment was described. In addition, the patients had been assessed as having the capacity to consent to treatment.
- Mandatory e-learning about safeguarding provided for staff included information about the Mental Capacity Act and Deprivation of Liberty Safeguards (DoLS). The training compliance for the whole hospital was 92%. Staff explained they would contact their clinical lead for advice and involve the consultant and other people as appropriate.

Are medical care services caring?

Good

We have rated this service as good for caring because:

- Patients and those close to them were treated with kindness and respect. Those we spoke with were consistently positive of the care and treatment they received. We saw that patients' privacy and dignity were upheld at all times, and that the staff were caring and respectful of each other, as well as patients.
- Patients were given appropriate and timely support and information to cope emotionally with their care, treatment or condition.
- Patients and those close to them were well supported in a variety of ways and given as much or as little information as they wanted. Some patients had been attending the hospital for some time and described the good rapport they had with staff. Staff told us that they provided open evenings for women with cancer to have

their wigs fitted, massages, and manicures. This allowed patients to have appointments with a different focus from their treatment and to meet other people using the service.
- Staff visited patients after they had been transferred to other services, for example if they required hospice care.

However we also found some areas for improvement :

- There was a large consulting room that was also used as an office. It had no privacy curtains or screens and was frequently used by staff performing administrative duties. This may have compromised people's privacy. We did not see any patient consultations in this area on the day of our visit and therefore could not fully assess the impact this had.

Compassionate care

- Staff understood the impact the patient's care, treatment or condition had on their wellbeing and on those close to them. Staff took the time to interact with people who used the services and spoke with them in a respectful and considerate manner. Patients were asked about their preferences for sharing information with family members.
- We saw and heard examples of compassionate care. Every patient we spoke with was extremely complimentary about the care they received. Patients described the continuity of care as good, as they saw the same team of medical and nursing staff at each appointment.

Understanding and involvement of patients and those close to them

- Patients told us they felt well supported and were given appropriate and timely information to participate in their care and treatment.
- Patients and those close to them were given as much or as little information as they wanted. If they needed time to make a decision, this was supported by staff.
- Relatives were actively encouraged to become involved in treatment plans where appropriate.
- All the patients we spoke with were aware of what to do if they felt unwell during admission and upon discharge home.

Emotional support

- The service provided emotional support to both patients who attended the hospital, and their families. This service extended to counselling and one to one consultations. There was information about treatment and side effects, and ongoing support groups.
- There was a support group for patients who had undergone breast surgery at the hospital.

Are medical care services responsive?

Good

We have rated responsiveness as good because:

- There were some shortfalls in how the needs of different people were taken into account. For example there were no formal mechanisms in place to ensure the service was able to meet the individual needs of people living with dementia, or a learning disability. Staff had not completed any training in these areas and were unable to describe any formal links to obtain specialist advice in such circumstances. However staff could not recall caring for people with these needs in this specialist service and therefore the perceived impact was low.
- Staff we spoke with could not recollect any recent complaints management training or where complaints had been used as an opportunity to learn.

There were also some good elements of responsive care :

- Patients were seen promptly for treatment and we saw no evidence of cancelled or delayed appointments. However this was not formally monitored or reported upon.
- Care and treatment was coordinated with other services in a timely manner.
- Snacks were available in the chemotherapy suite and patients had drinks within reach.
- Patients we spoke with were very satisfied with the catering service provided.

Service planning and delivery to meet the needs of local people

- Essential pre-treatment blood tests and treatment could generally be carried out on the same day.

Requires improvement

Medical care

- Most of the patients had their chemotherapy delivered via intravenous lines that were inserted at every treatment and rarely used medical appliance that were installed beneath the skin, or peripherally inserted central catheters (PICC) lines.
- The external supplier of chemotherapy medicines provided a Monday to Friday service. Chemotherapy was manufactured and delivered to the hospital, on a named patient basis, according to a service level agreement.
- Relatives were offered refreshments if they wished to stay with their loved one.

Access and flow

- There was no available data to confirm service specific waiting times; however we were told that no patients experienced any delays or cancellations and that access to consultants was normally immediate. Patients we spoke with consistently reported that this was the case and we observed that this happened.
- There was sufficient parking near the facilities for patients. This included spaces for patients who had a mobility disability.

Meeting people's individual needs

- Arrangements could be made for patients to have their intravenous lines 'flushed' by the community nurses or their local hospital, to minimise inconvenience for patients having to travel long distances.
- Cold caps were offered to patients undergoing chemotherapy, where there was a risk of hair loss.
- A wig service was also available for patients who had lost their hair through treatment. This was provided outside of their treatment appointment to allow time and focus.
- The hospital had no formal links with a specialist learning disability team Staff told us that they had not had the opportunity to complete any relevant learning in this area.
- Staff we spoke with were unsure about any provision or the availability of easy read advice leaflets and we saw no evidence that these were provided.
- None of the staff we spoke with had received training to support people with dementia. However, they said they would ensure any patient who had particular needs would be given extra assistance, and they could seek advice from the specialist consultants within the outpatients department.
- Patients we spoke with were unanimous in their praise about the care and attention they received. They told us their needs were anticipated and met. We observed this happened.
- Written and verbal information was available for a range of conditions, their treatments and associated needs.
- Only four patients using the service had responded to the hospital's patient satisfaction survey which meant impact could not be assessed as the sample size was so small.
- Patient call bells were answered immediately.

Learning from complaints and concerns

- There was an up to date complaints procedure in place which set out the various stages of complaints and the time scales for responses.
- There was varying degrees of knowledge about learning from complaints and concerns. The more senior staff were aware of learning, but generally more junior staff told us they had not had such information shared with them.
- There were no unresolved complaints about the service during the reporting period or at the time of our inspection.
- None of the patients we spoke with knew the correct complaints procedure to follow and told us they would probably speak to their consultant or approach BMI Head Office. We saw no evidence that the complaints procedure was accessible to patients. However, all of the people we spoke with told us they had never had a cause to complain or raise any concerns.

Are medical care services well-led?

Requires improvement

We rated chemotherapy services as requires improvement for well led because;

- The management team had identified risks associated with the inadequate facilities, particularly risk of infection and lack of privacy. There was no specified time scale for the transfer of services, or any evidence of specific solutions to mitigate the identified risks in the interim period.

- The leadership arrangements and culture did not always support the delivery of high quality person centred care. Identified risks were not always dealt with appropriately or in a timely way.
- There was an unfilled vacancy for the quality and risk manager within the hospital. This post had been vacant since May 2015.
- There was no clinical director with sole responsibility for cancer, or any representation on the leadership team for this service of consultant oncologist, haematologist, or pharmacist. There was no principal cancer strategy.
- There was a suitably qualified and experienced nurse with responsibility for leading the nursing services. Nursing staff with managerial responsibilities did not have specified time for management or leadership in their job description, and had limited administrative support.
- The arrangements for governance and performance management did not always operate effectively.
- People who had used the services, and those associated with them were not actively engaged and involved in the hospital. There was a limited approach to obtaining the views of people who used the services and other stakeholders. This meant that there was not always sufficient information on which to base decisions to improve services.

Vision and strategy for this service

- The vision and values of the hospital were incorporated into the appraisal system. However not all staff had undergone an appraisal which meant there was mixed awareness and understanding of the vision's principles.
- Staff we spoke with could not describe any defined cancer strategy in place other than a proposed move to new facilities. We noted these plans but saw no evidence of when they would be implemented.

Governance, risk management and quality measurement

- The majority of staff, including leaders of the service, generally understood the challenges to good quality care and could describe the actions needed to address them. There were arrangements in place to ensure that quality, risk management and quality issues were monitored and acted upon including daily safety 'huddles' and monthly governance meetings to discuss performance and priorities; however not all the actions had specified deadlines, or were assigned to specific individuals.
- We looked at the hospital risk register. There were two risks relating to the chemotherapy service, carpeting in clinical areas and non-compliance with fire regulations in one area. It was not clear how often the register was reviewed. Not all of the risks had reports of actions being taken to mitigate risks. For example, the infection risks were known to the hospital senior management team, but no actions had been taken other than a proposed move to new facilities within the hospital, with an unspecified time line.
- We found limited evidence of quality measurement, for example a lack of regular audits or patient satisfaction surveys. There was a long standing unfilled vacancy for the hospital quality and risk manager which some staff thought may have contributed to this.
- The clinical governance (CG) committee met every other month. Senior department leads attended the governance meetings and were responsible for cascading information back to their departments. The CG committee considered a range of complaints, incidents, health and safety issues and patient satisfaction. In addition, local audits, patient safety and care were included to ensure actions were completed by target dates.
- Most of the governance processes we saw reflected the hospital's clinical governance policy. This included the requirements to use a standard agenda, and ensure sub committees provided reports, such as from the medicines management, resuscitation and infection control committees.
- Audit results and proposed actions were reviewed in a range of topics such as medicines management, infection control and health and safety.
- The Medical Advisory Committee (MAC) met quarterly. It was attended by a group of consultants who held practising privileges and represented colleagues from each speciality service at BMI The Saxon Clinic. Its terms specified membership, quorum and responsibilities; which included regulatory compliance, practising privileges, quality assurance and proposed new clinical services and techniques.

- The MAC carried out checks, according to BMI's practising privileges policy, before granting new consultants practicing privileges, including checks on their scope of practice to ensure they were undertaking procedures that they were not competent to do.
- Consultants were required to produce evidence annually of their professional registration, revalidation, indemnity insurance, appraisal, mandatory training and continuous professional development before their admitting privileges were renewed.

- There was a 100% completion of verification of registration of staff with their respective regulatory bodies such as the Nursing and Midwifery Council.

Leadership of service

- It was clear that staff were supportive of each other. All the staff we spoke with spoke highly of the senior management team and colleagues.
- The nursing leadership team were knowledgeable about quality issues and priorities and described the challenges they faced, however formal engagement with staff, patients and other stakeholders was limited.

Culture within the service

- All the staff we met appeared enthusiastic and motivated towards ensuring that the patients received the very best care.
- Staff felt engaged with the planning of the proposed move to a new environment, and gave an example of how they felt listened to with the successful acquisition of three reclining treatment chairs.
- Staff described how they generally felt respected, that they were able to share ideas and opinions and that their contribution was valued by the senior management team. There was evidence of teamwork and commitment from staff to ensure the patients were treated well. We observed good team interaction.

Public and staff engagement

- At the time of the inspection, there were no formal arrangements to monitor staff satisfaction. However, the hospital has since told us that the staff satisfaction survey was underway. We were not provided with the survey used or the results. We saw retention of staff was good and that there was no reported dissatisfaction amongst team members
- There was a limited approach to obtaining the views of people who used the service and other stakeholders.

Innovation, improvement and sustainability

- We asked for examples of innovation and improvement. Staff told us their main focus was on planning the new facilities within the hospital which meant there were no other proposed developments until that was complete.
- The hospital safety huddles were seen to introduce a greater awareness about safety issues and reporting.

Requires improvement

Surgery

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

Information about the service

BMI The Saxon Clinic is registered for 37 beds of which 30 were occupied at the time of the inspection. The beds were used flexibly for mostly surgical, patients; however, occasionally they were occupied by medical patents, or those undergoing chemotherapy.

The inpatient rooms were contained on one ward. Each single room has en-suite facilities with either a bath or shower. There are two operating theatres (one with laminar flow) and an endoscopy theatre. The majority of the hospital's work is adult elective surgery, predominantly orthopaedic surgery. Cosmetic surgery is also provided. A small number of children (92) were treated in the hospital, mostly for minor surgery on a day case basis. In the reporting period from October 2014 to September 2015 there were 4,458 procedures undertaken at the hospital, of which 3305 were listed as primary procedures.

The most frequent primary surgical procedures, carried out, but not limited to, were:

- 259 - Excision of lesion on skin.
- 254 - Arthroscopic procedures on knees including menisectomy.
- 252 - Primary repair of inguinal hernia.
- 198 - Phaecoemulsification of lens with implant – unilateral.
- 143 - Hysteroscopy including biopsy, dilation, curettage and polypectomy.
- 160 - Replacement of knee joint.
- 128 - carpel tunnel release.
- 115 - breast augmentation.

In addition the following were carried out:

- 831 - endoscopic procedures.
- 215 - facet joint injection or radiofrequency thermocoagulation.
- 146 - image guided injections into joints.

Patients are admitted under the care of a named consultant, and medical care is supported over 24 hours by an onsite doctor, the resident medical officer (RMO). Patient care is provided by a team of trained nurses, and allied health professionals such as physiotherapists and pharmacists employed by the hospital.

We carried out announced and unannounced on-site inspections of BMI Saxon Clinic. We visited the inpatient ward, pre admission clinic, and the operating theatre department. We talked with four patients and two relatives. We interviewed 25 staff including nursing staff, RMO, consultants, administrative staff and managers. We observed care and treatment and reviewed four clinical records. Prior to, and after the inspection visits we reviewed performance about the hospital.

Requires improvement

Surgery

Summary of findings

Surgical services required improvement to be considered safe, effective and well led.

We rated responsive and caring as good.

We found:

- Systems and processes were not always reliable and appropriate to keep people safe. Infection prevention and control measures did not ensure patient safety. National guidance on cleanliness, hygiene and infection prevention and control was not always complied with. In particular sinks and taps in patient rooms did not allow effective hand hygiene practice. These identified risk issues were not always dealt with in a timely way and had remained on the risk register since 2013 with no deadline set for their closure.
- There was sufficient competent staff to meet the needs of patients however there were gaps in the management and support arrangements for some ward staff, such as completion of staff appraisals.
- Incidents were reported and dealt with appropriately and trends and actions to minimise risks were communicated to staff.
- Patient areas were visibly clean, tidy and appropriately equipped. Patients were assessed, treated and cared for in line with national guidance.
- There were effective arrangements in place to monitor and manage pain. Patient surgical outcomes were monitored and reviewed through formal national and local audit.
- Nursing, medical and other healthcare professionals were caring and patients were positive about their care and experiences. Patients were treated with dignity and respect.
- Complaints were acknowledged, investigated and responded to in a timely manner. However, verbal complaints were not treated consistently. Information about the hospital's complaints procedure was available for patients and those close to them.
- The service reviewed and acted on feedback about the quality of care received. There were good arrangements for monitoring the quality of the service provided. There was good local leadership and an open culture where staff felt valued.

Requires improvement

Surgery

Are surgery services safe?

Requires improvement

The surgery services for safety required improvement because;

- Infection prevention and control measures did not always ensure patient safety. Sinks and taps in the clinical areas and patient rooms did not conform with the Department of Health Building Note 00-10 Part C: sanitary assemblies (HBN 00-10) to allow correct hand hygiene practice. To mitigate the risks training for hand hygiene and additional hand gel was provided to staff.
- Some patient rooms were carpeted where clinical procedures were undertaken. Carpet should not be used in treatment rooms or areas where body fluid spillage is anticipated, as there is a high probability of body fluid contamination. This did not meet the requirements of Health Building Notice (HBN) 00-09: infection control in the built environment. The flooring had been replaced with vinyl flooring in some of the rooms we saw at the time of our inspection.
- Staff were not adhering to the Association of Peri Operative Practice (APOP) standards and recommendations for safe perioperative practice, 2011. Cover gowns were provided for staff but we saw these were not always worn and footwear was not changed when leaving the department and re-entering the operating theatre department.
- Audits of five steps to safer surgery were undertaken, however, these were audits of the checklists and not audits of whether the surgical safety checklists were undertaken correctly and thoroughly.

However we also saw;

- Staffing levels and skill mix were planned, implemented and reviewed. Staff shortages were responded to quickly and adequately.Staff understood and fulfilled their responsibilities to raise concerns and report safety incidents and near misses. Activity was monitored and reviewed to enable staff to identify and understand risks.
- Staff understood their responsibilities in ensuring the duty of candour was applied, and in ensuring patients, and where appropriate, those close to them were informed of near miss and actual incidents. When something went wrong, there was an appropriate investigation that involved relevant staff and lessons learned were communicated promptly to support improvement.
- There were systems, processes and standard operating procedures to keep people safe and safeguarded from abuse. These were understood by staff.
- A National Early Warning Score (NEWS) was used to identify deteriorating patients.
- There were effective handovers at shift changes, to ensure staff could provide safe and appropriate care.
- Risks to people, who used services were assessed, monitored and managed on a day-to-day basis. These included signs of deteriorating health and medical emergencies.
- Plans were in place to respond to emergency situations.

Incidents

- Staff understood their responsibilities to raise concerns, record and report safety incidents, concerns and near misses, and to report them.
- There had been 425 incidents, 145 of which were clinical, reported in the reporting period of October 2014 to September 2015 of which 256 related to the wards and operating theatre.
- There was one reported incident of a never event and no other reports of incidents of serious injury or serious incidents requiring investigation in the reporting period of October 2014 to September 2015. A never event is a serious incident that is wholly preventable, as guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and should have been implemented by all healthcare providers. The never event was reported, escalated and fully investigated in accordance with the hospital’s incident reporting policy using the hospitals root cause analysis (RCA) tool. We saw evidence demonstrating the RCA resulted in learning points which were disseminated to staff and the organisation as a whole.
- Staff were aware of the incident reporting process. Incidents were reported via paper based forms and there was an awareness of the need to complete incident forms promptly once an incident had occurred. Staff within surgery knew how to report incidents and were aware of the types of situations where incident forms should be completed including near-misses. Staff could provide examples when they had personally

submitted incident forms. Completed incident forms were reviewed and investigated by senior staff before being entered on the electronic reporting system, then passed to the director of nursing, for additional action if needed, in the absence of the risk and governance manager.

- There had been one incident venous thrombo embolism (VTE). However it was noted the target rate of 95% for VTE screening had been exceeded in each quarter of the reporting period.
- Staff received feedback about incidents and were able to describe improvements and changes made in response to incidents and near misses such as the reorganisation of a filing cabinet containing x-rays. The cabinet had become top heavy and a near miss was prevented through a risk assessment being completed and the cabinet contents being reorganised. Other examples included the reorganisation of the room used to store prosthesis. We saw this had been arranged to allow staff to easily identify the prosthesis required and reduce the risk of the wrong prosthesis being selected. Two named staff had been appointed to manage the receipt and storage of prosthesis to ensure continued maintenance of the store.
- Staff described how they received feedback about incidents from other BMI hospitals to ensure shared learning. An example given of shared learning was the introduction of pre-printed swab count boards in the operating theatres following an incident that was related to the use of these in another hospital. This meant all the necessary checks such as the number of swabs and instruments used was counted in a consistent manner.
- We spoke with the operating theatre department manager and ward manager about the risk register. They were aware of the identified risks recorded on the register. An example given by the ward manager was an infection control risk due to the absence of elbow operated taps in the patient rooms and clinical areas. This meant staff were unable to follow best practice in hand washing technique. To mitigate this risk we saw a risk assessment had been completed and additional hand gel, towels and hands free disposal containers had been provided.
- Meetings were held where clinical and non-clinical incidents were reviewed. This included reviews of mortalities. There had been no cases of mortality or unexpected deaths in the reporting period (October 2014 to September 2015.). There were minutes of these meetings and we saw evidence of how any agreed actions from them were fed back to staff in the relevant departments.
- Staff understood their responsibilities with regard to the Duty of Candour legislation. 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. Nursing staff advised they had a BMI policy, which we saw, about being open and honest when mistakes occurred and to provide an apology to patients. We saw that duty of candour had been applied with regards to the never event. The patient was informed of the incident and kept up to date in a way that was honest and understandable to them.

Safety thermometer

- Information was displayed in the hospital and the hospital website for patients which provided clear information about incidence of Methicillin Resistant Staphylococcus Aureus (MRSA), Clostridium difficile (C. difficile) and Methicillin Sensitive Staph Aureus (MSSA) and measures that were taken prevent and minimise risk of infection.
- The hospital displayed information in the ward area showing recent overall patient satisfaction rates and actions taken in response to concerns raised.
- Details of daily required staffing and actual staffing levels were displayed on a notice board in the main ward corridor for relatives and visitors to see.
- Only one incident of hospital acquired Venous Thromboembolism (VTE) of Pulmonary Embolism (PE) had occurred in the reporting period. All patients were risk assessed for VTE and completion of risk assessments were audited which showed there was 100% compliance. VTE audit was conducted on a monthly basis with results being discussed at department meetings and reported to the clinical governance team.

Cleanliness, infection control and hygiene

- Sinks and taps in the clinical areas and patient rooms did not conform to the Department of Health Note 00-10 Part C: Sanitary Assemblies, to allow correct hand hygiene practice. This had been identified on the

hospital risk register since 2013. To mitigate the risks training for hand hygiene and aseptic non touch technique was provided and offered to all staff who worked within the service. This training was also provided for new staff and updated regularly as part of the mandatory requirements, through e-learning and practical sessions to comply with national guidance on infection prevention and control (IPC).

- Some clinical areas and patient rooms were carpeted. Carpet should not be used in treatment rooms or areas where body-fluid spillage is anticipated, as there is a high probability of body fluid contamination. This did not meet the requirements of Health Building Notice (HBN) 00-09: Infection control in the built environment. There was no preventative maintenance or cleaning programme or specific risk assessment in evidence for carpeted areas as required by (HBN) 00-09. Staff were unable to confirm when the carpets or soft furnishings had last been cleaned. There was no plan for cleaning or evidence of a system on which the cleaning was based as required by the National Specifications on Cleanliness (NSC) or The Health and Social Care Act 2008: Code of Practice on the prevention and control of infections and related guidance. This risk had been entered on the hospital's risk register. We saw some rooms on the ward where the flooring had been replaced with vinyl flooring. However, there was no detailed schedule as flooring was being replaced in line with corporate budget allocation.
- We observed lack of compliance by some theatre staff with regard to the correct use of theatre attire including gowns and footwear when leaving and returning to theatre from other areas of the hospital. Standards and Recommendations for Safe Perioperative Practice 2011 by the Association of Peri Operative Practice state there must be arrangements made to ensure that there is a sufficient supply of clean cover gowns available and footwear worn in theatres should be for that use only. Cover gowns were provided but not always worn and footwear was not changed when leaving the department and re-entering the operating theatre.
- We observed correct hand hygiene being practised by staff. The most recent infection control report (November 2015) stated there had been two incidents of non-compliance observed by patients. Patients had been apologised to and appropriate action taken which included re training of staff in aseptic no touch technique.
- The wards appeared clean. There was an allocated housekeeper who was responsible for undertaking daily cleaning tasks, including deep cleans where required. A daily checklist was used to ensure all aspects of required cleaning were met.
- There was an annual infection prevention and control work plan in place which was managed by the Infection Prevention and Control (IPC) lead nurse. There were quarterly meetings and minutes circulated to all relevant staff groups and governance committees.
- The patient led assessment of the care environment (PLACE) results regarding cleanliness showed a satisfaction level of 97%.
- Patients received written information prior to admission explaining the importance of hand hygiene being practised by all people including visitors and the hospital's commitment to provide a safe environment. Patients were encouraged to challenge any member of staff they saw not washing or sanitising their hands.
- We spoke with pantry staff responsible for food preparation in the ward area who explained they were responsible for cleaning their own work area after food service was completed. They assured us they were never asked to clean other areas of the ward such as patient rooms or clinical areas. To ensure patient safety, any staff handling food had completed food hygiene training.
- During the reporting period there had been no incidents of hospital acquired infections such as MRSA or C Difficile, however there had been one incidence of MSSA.
- The hospital had policies and procedures in place to manage infection prevention and control. Staff had access to the policies on the hospital's intranet and could demonstrate how to access these.
- Nursing and medical staff had access to a microbiologist when required.
- The operating theatre department was found to be clean and tidy and the daily cleaning records were consistently completed. Servicing of ventilation and filters was undertaken by the service engineer at appropriate intervals.
- Staff were observed to use personal protective equipment when required, such as goggles/visors, aprons and gloves.

- Decontamination of instruments was managed through a service level agreement with a BMI Healthcare hub and the local hospital trust. We observed dirty and clean instrument cleaning processes which were correctly managed.
- The operating theatre manager maintained regular contact with the external decontamination service and found them to be very responsive to any concerns raised. An example given was instrument packs received had been found to have tears to the outer wraps making them unsafe for use. This had been immediately remedied by providing a thicker more resilient wrap.
- Endoscopes were safely managed and leak tests performed. Used endoscopes were initially cleaned at the Saxon Clinic prior to being transported to the local hospital trust for processing, and returned the next day. The trust providing this cleaning service had received accreditation by the Joint Advisory Group (JAG) on gastrointestinal endoscopy which operates within the care quality improvement programme of the Royal College of Physicians.
- Surgical site infection data was collected and submitted to Public Health England on a monthly basis for orthopaedic surgical procedures, which included hip and knee arthroplasty. The hospital reported two incidents of intravenous cannula site infections both under the care of the same medical team. Further investigation was undertaken and it was found when the recommended solution to clean the skin prior to insertion of the cannula was applied, this was not left on long enough to be effective. This procedure had been corrected and there had been no further reported incidents.
- The operating theatre department was found to be clean and tidy and the daily cleaning records were consistently completed. Servicing of ventilation and filters was undertaken by the service engineer at appropriate intervals.
- Staff were observed to use personal protective equipment when required, such as goggles/visors, aprons and gloves.

Environment and equipment

- The operating theatre department was clean and tidy and corridors were kept free of equipment. There were separate changing rooms and a rest room provided for staff.
- A check to ensure the correct functioning of anaesthetic equipment is essential to patient safety. Routine checks of anaesthetist equipment were undertaken in accordance with recognised guidance by the Association of Anaesthetists of Great Britain and Ireland (AAGBI), 'Checking Anaesthetic Equipment' 2012 guidance. We observed checks were completed and recorded. Daily equipment checks of essential equipment such as anaesthetic and resuscitation equipment in operating theatres were completed and recorded. Staff members had been appointed champions to lead and ensure safe management of operating theatre equipment.
- Records for planned preventative maintenance were kept and were up to date.
- The ward areas were clean and tidy with corridors free of non-essential items to allow ease of access especially in emergency situations, for example: transporting of resuscitation equipment to patient rooms.
- The resuscitation equipment and emergency medicines were stored in a tamper proof trolley and checked daily. Suction and oxygen were available as stand-alone items and not kept on the trolley.
- Piped oxygen and suction was available in three of the rooms. Separate, portable suction and oxygen was also used as required in other patient rooms. However there were no reported incidents to indicate that lack of piped gases in all rooms had resulted in patient harm.
- The oxygen cylinder was safely stored in a stand, the cylinder was full. The suction equipment had necessary tubing and catheters and was clean and in good order. Both items were included in the daily check of resuscitation equipment.
- Equipment to assist people with their mobility was available for use on the ward. The majority of patient rooms had walk in showers rather than baths. The ward manager explained allocating rooms appropriate to patients' needs was carefully planned as the majority of patients were admitted for orthopaedic treatment and were unable to use a bath post operatively. The senior managers advised of planned refurbishment with the provision of showers.
- There was a dedicated room on the ward for the storage of equipment which was found to be tidy and equipment stored safely. Equipment was labelled with a green sticker to show it had been cleaned and was fit for use.

- Both the ward and operating theatres had appropriate arrangements for managing waste. Waste was correctly disposed of, segregated and labelled. For example containers were available for the disposal of sharp medical instruments.

Medicines

- There were effective arrangements for the receipt storage, dispensing and disposal of unwanted medicines which was managed by the pharmacist.
- Medicines were stored securely in accordance with regulatory requirements. Ambient temperature of medicines' storage rooms and fridge were recorded on the ward and in the operating theatre department and were within acceptable limits. There was a procedure to follow should temperatures fall out of the defined range. Staff were aware of this process.
- Allergies were clearly recorded on the patients medicine chart and in their records.
- Medicines were contained in clearly labelled locked cupboards allowing staff to quickly locate the item required.
- There was a separate cupboard containing a supply of pre packed medicines when prescribed for patients to take home.
- There was a supply of red disposable plastic aprons for staff to wear when administering medicines. The aprons had a clear 'Do Not Interrupt' message printed on them to reduce the risk of staff being interrupted when medicines were being prepared and administered. We observed medicines were administered safely and correctly.
- There was a key safe containing a set of pharmacy keys should staff need to access the pharmacy out of hours, urgently. There were appropriate security controls in place to monitor when the pharmacy had been accessed and the stock item removed.
- We checked the records and completed random reconciliation checks of controlled drugs on the ward and in the operating theatre department. These were found to be correct.
- The management of medicines was audited, for example the number of occasions prescribed medicines were omitted and the correct storage and management of controlled drugs. Both audits showed 100% compliance.
- There had been five medicine administration errors in the reporting period. None of these incidents resulted in patient harm. The errors had been reported as clinical incidents and actions such as re assessment of staff competencies completed.

Records

- The hospital used a paper based system for recording patient care and treatment. A complete set of records for all aspects of patient care and treatment were kept on site including a record of the initial consultation and treatment provided by the admitting consultant.
- Patient records contained information of the patient's journey through the service including pre assessment, investigations, test results and treatment and care provided.
- The care pathways used included risk assessments such as risk of falls and mobility, which were found to have been correctly completed and reviewed as required.
- Some patient records were kept in patient's rooms at their bedside, such as care plans and fluid balance charts and these were found to have been completed and up to date.
- We examined four sets of patient records. We looked at records for both day case patients and inpatients which were found to have been appropriately completed. These were found to be formatted in a standard layout to allow ease of access to relevant information.
- Operating theatre records were completed and included the Five Steps to Safer Surgery checklist. The Five Steps to Safer Surgery checklist was audited which showed a high level of compliance (13 of 15 records audited were fully compliant). However, we noted that the hospital audits were around completion of the forms, not whether the checks had been completed in the spirit of the five steps to safer surgery.
- Once records were no longer required after the patient had been discharged, they were stored on site in a secure records office prior to being archived off site. Prior to filing, records were checked for completeness and to ensure all records within the file were secure.
- A clerk was employed to manage records to ensure patient records were available as required, for example to ensure files were available on site for clinic appointments or following a patient re admission. A

tracking system was used which required records to be signed in and out of the store. The tracking record was found to have been used consistently and correctly to retrieve and return patient notes.

Safeguarding

- There were arrangements in place to safeguard adults and children from abuse that reflected relevant legislation and local requirements. Staff understood their responsibilities and adhered to safeguarding policies and procedures.
- Staff completed training about safeguarding through electronic learning and had a good understanding of their responsibilities in relation to safeguarding of vulnerable adults and children.
- The ward manager explained access to face to face training sessions was not always achievable and recognised more forward planning was required to improve attendance. Training records showed the majority of staff (95%) had completed mandatory training for safeguarding of adults and children.
- Nursing and medical staff could name both safeguarding leads for adults and children who were level three trained. We spoke with members of the ward team who could not recall any recent safeguarding concerns but were able to describe how they would act upon and escalate any concerns they had, including, for example a patient who may need to be restrained. We saw guidelines for reporting and escalating concerns displayed in the ward and operating theatres.

Mandatory training

- Staff explained they received mandatory training in an effort to ensure safe care was provided. Mandatory training was completed through e-learning. Staff described a range of topics included in their training such as moving and handling and infection prevention and control. We reviewed mandatory training data for November 2015. Training figures showed good levels of compliance for example, infection prevention control awareness was 93%.
- We saw the training compliance was high with the exception of the completion of the Acute Illness management (AIM) course which was 43% compliant.
- The BMI mandatory training policy specified an 85% compliance rate at any one time. For the majority of topics the hospital had exceeded this target. Training levels were monitored and reviewed at clinical governance meetings. Heads of departments were encouraged to support staff to attend sessions to ensure compliance.

Assessing and responding to patient risk

- A pre-admission assessment was completed for all patients prior to their admission to hospital for treatment. Patients were either pre assessed at the hospital or by telephone. The pre assessment team told us they felt supported by and worked closely with the consultant anaesthetists if they identified any concerns about a patient's condition or fitness for surgery.
- Patients who were planning to undergo cosmetic surgery, were seen by the consultant and had a two week, 'cooling off' period prior to surgery being booked.
- Staff explained that during pre-assessment they recorded base line observations such as temperature and blood pressure, checked the patient's understanding of the treatment they were being admitted for, discussed discharge arrangements, and completed a range of risk assessments such as risk of falls and pressure ulcers. During the pre-admission appointment any special needs were identified and recorded such as dietary or mobility needs.
- During the pre-admission appointment patients were swabbed to assess if they had MRSA. Where results were found to be positive the admission date was deferred if necessary, and the patient provided with a treatment pack to use at home. A further appointment for the patient was rearranged once a clear swab result was received.
- Patients with known allergies wore a red bracelet which acted as an alert to any staff providing care or treatment.
- There were alarm systems to alert medical and nursing staff when immediate assistance was required in the case of an emergency.
- A National Early Warning system (NEWS) tool was used to identify the deteriorating condition of patients. This system alerted nursing staff to escalate, according to a written protocol, any patient whose routine vital signs fell out of safe parameters. We reviewed four patient charts and saw these had been correctly completed. Audits of NEWS records were completed monthly and results showed a 100% rate of compliance.
- The 'Five Steps to Safer Surgery' were used. We observed checks as they were carried out. There was

good interaction between staff and the required time was taken to complete all final safety checks prior to surgical procedures. However we noted that these checks were not used for minor operations under local anaesthetic carried out in the endoscopy theatre. Staff explained they used the hospital's pre-operative checklist. This matter was brought to the immediate attention of the operating theatre manager and director of nursing, who assured us action would be taken to rectify this.

- There was a formal arrangement for patients to be transferred to the local NHS hospital if the patient required critical care to level two or level three. These are critically ill patients, who require either organ support or closer monitoring in the immediate post-operative period.
- There were appropriate arrangements for ensuring blood required for elective surgery was available when required, and for obtaining blood in an emergency. There was access to the minimum requirement of two units of emergency supplies of O Rhesus negative blood. The blood fridge temperature and stock were checked and recorded daily. A 'responding to major blood loss' scenario was completed in August 2015.
- The practising privileges agreement required the designated consultant to be contactable at all times when they had inpatients within 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.
- If a patient became unwell after treatment, there were arrangements for the patient to be seen promptly by the resident medical officer and if necessary reassessed by the admitting consultant or anaesthetist where required.
- Patients we spoke with had been told by the nursing staff what to do if they felt unwell following their discharge home.
- The operating theatre team held daily briefing sessions known as safety huddles which we observed in action. These meetings were used for example, to check if all ordered equipment had been received, staffing arrangements and allocated responsibilities were understood, staff were aware of any changes to operating lists and if staff had any concerns.
- If changes to an operating list had to be made there was a process understood by operating theatre and ward staff. Once a change had been agreed with the consultant the original list was destroyed and a different coloured revised list was issued to relevant departments. This process was used to ensure all staff worked to the same list to ensure patient safety.

Nursing staffing

- The hospital used a staffing tool based on the analysis of the dependency of the patient and nursing activity required to meet the patients' needs. From this the number of nurses and health care assistants (HCA) required for each shift was calculated.
- The hospital only undertook elective surgery which meant the number of nursing and care staff required on any particular day could be calculated and booked in advance. During the inspection and unannounced visit, planned staffing numbers were met for each department.
- We saw that duty rotas were planned four weeks ahead and reviewed on a weekly basis. Changes to rotas were clearly recorded to ensure accuracy.
- Details of daily required staffing and actual staffing levels were displayed on a notice board in the main ward corridor for relatives and visitors to see.
- Contracted staff worked flexible hours to cover the rota and gaps were met by a separate team of bank and agency staff familiar with the hospital and team.
- Agency staff were recruited from specific agencies with which the hospital had a preferred provider arrangement. This ensured temporary staff met key requirements such as having completed manual handling training and competencies to safely administer medicines.
- Agency staff were provided with an induction programme when new to the hospital, which included access to and the location of emergency equipment and fire exits. Records of signed completed induction were maintained by the hospital.
- The ward manager explained they strived to keep agency use to a minimum and tended to use bank staff at weekends when the occupancy and dependency levels were lower. We reviewed staffing rotas and these reflected the explanation provided. For example during January 2016, 10 of 224 shifts had employed an agency staff member.

- At the time of the inspection there was one registered nurse vacancy which had been appointed to but the applicant had withdrawn. The ward manager explained further applications had since been received. They told us support was received from the human resources (HR) team and there were HR policies available for guidance.
- There were some concerns expressed by the operating theatre team about ward staffing levels which they considered led to delays in collecting patients from recovery promptly. However, we saw no evidence to show this concern had resulted in patient harm, or had been recorded as an incident or escalated for further action.
- Administrative assistants were employed in the operating theatre and on the ward to support nursing staff to concentrate on patient care.
- Handovers between staff took place between each shift. We observed a handover and it was detailed and succinct.

Surgical staffing

- Patient care was consultant led. The hospital practising privilege agreement required that the consultant visit inpatients admitted under their care at least daily or more frequently according to clinical need or at the request of the Facility Executive Director, Director of Nursing/Clinical Services, or Resident Medical Officer (RMO).
- The hospital employed two RMOs who worked one week on and one week off, 24 hours a day seven days a week, then handed over to the other RMO. A period of four hours was allocated for handover especially when an RMO new to the hospital was used.
- The RMO explained they made a routine visit to the ward each evening to check progress of patients and be aware of any potential issues that may require their attention. They confirmed they were never asked to assist in the operating theatre.
- Nursing staff and the RMO had found the consultants to be supportive and responsive when they were contacted for advice.
- Consultants were required to be within 30 minutes journey of the hospital if they had in or day patients under their care. If, on occasions, this was not possible, they were required to nominate another named consultant to provide cover. We saw that there was a variety of systems to ensure that staff knew who was providing cover, for example, emails from the consultant's secretary and information on the ward white board.
- The hospital had a Medical Advisory Committee (MAC) whose responsibilities included ensuring any new consultant was only granted practising privileges if deemed competent and safe to practise.
- The MAC periodically reviewed existing practising privileges to ensure continued compliance with the practising privilege agreement and advised the hospital about continuation of practising privileges. If there was non-compliance with practising privileges, the executive director would suspend the consultant's privileges so that they were not able to practice at the hospital until all the required information had been given
- To ensure effective planning and continuity of service consultants were required to provide the hospital a minimum of six weeks' notice of leave such as holidays. This arrangement was managed by one of the administrative assistants on a database which was regularly communicated to clinical departments.
- Nursing staff explained if a consultant was not immediately available for example they were operating, staff could refer to another consultant of the same speciality who had practising privileges at The Saxon Clinic for advice or another consultant but rarely had to do this.
- Up to date contact numbers for consultants were available to nursing staff in wards and operating theatres.
- If the consultant wished to use external staff as a first assistant the protocol required adequate notice was provided to allow time for all identity, fitness to practise and competency checks to be made to ensure patient safety.

Major incident awareness and training

- The hospital had a service contingency plan in place for staff to use in the event of interruption to essential services.
- The operating theatre manager and an operating department practitioner were part of the hospital resuscitation team. Emergency bleep holders were designated each morning at the daily morning department meeting.

- Regular scenarios for adult and child resuscitation had been practised regularly, to ensure the system worked effectively. Lessons learnt from the scenarios were disseminated to all departments.
- BMI The Saxon Clinic, had a service level agreement with the nearby hospital trust that the Saxon Clinic would accept patients if they had the capacity in the event of an emergency situation in the locality. The trust were notified daily of The Saxon Clinic's anticipated capacity.

Are surgery services effective?

Good

Surgery services were rated as good for effective because;

- Patient care and treatment was planned and delivered in line with current evidence-based guidance, standards, best practice and legislation. Patients had comprehensive assessments of their needs, which included consideration of clinical needs, mental health, physical health and wellbeing.
- Information about patient care and treatment, and their outcomes, was routinely collected and monitored.
- There was participation in relevant local and national audits, including clinical audits. Accurate and up-to-date information about effectiveness was shared internally and externally and understood by staff. It was used to improve care and treatment and patient outcomes. Staff were qualified and had the skills they needed to carry out their roles effectively.
- The Saxon Clinic had adopted an Enhanced Recovery Programme (ERP). The ERP is about improving patient outcomes and speeding up a patient's recovery after surgery Through the use of this service, which had been introduced two years ago, patients average length of stay had fallen from 3.5 to 2.4 days.
- Consultants were supported through the process of revalidation where relevant. Staff could access the information they needed to assess, plan and deliver care to patients in a timely way.
- Consent to care and treatment was obtained in line with legislation and guidance.
- Some staff were supported to maintain and further develop their professional skills and experience through the use of appraisals. However there was a low level of appraisal rate for inpatient nurses, health care assistants (HCA) and allied health professionals. This rate was reported at below 65% of appraisals being completed.

Evidence-based care and treatment

- Policies were current and referenced in accordance with the hospital clinical governance policy
- Policies were accessible on the hospital intranet and based on professional guidance such as the National Institute of Health and Care Excellence (NICE) guidance and Royal College guidelines.
- Staff were provided with new guidance as it became available such as NICE guidelines through a monthly hospital bulletin. They told us how a new carbon dioxide monitor had been purchased as a consequence of guidance received.
- We saw that the hospital had systems in place to provide care and treatment in line with best practice guidelines (NICE CG50: Acutely ill patients: Recognition of and response to acute illness in adults in hospital). For example, an early warning score system was used to alert staff should a patient's condition start to deteriorate.

Pain relief

- The surgical pathway prompted staff to assess and record if pain was being managed effectively. This was commenced in the pre-assessment clinic where actions to deal with pain management were discussed.
- Patient controlled analgesia equipment was available and staff felt they had sufficient quantities to meet the needs of the patients at any one time.
- The effectiveness of pain relief was evaluated through the use of a patient questionnaire. Questions included: 'Did staff do everything they could to help control your pain? Responses showed a satisfaction rate as excellent for 73% of respondents and very good for a further 23% of respondents.
- There was a pain control service led by two anaesthetists that was formed in August 2015. Only one meeting had taken place at the time of the inspection. Minutes of the first meeting and agreed actions in response to clinical incidents and risks were circulated to relevant clinical staff.
- Patients told us nursing and medical staff were responsive to requests for pain relief and monitored the effectiveness of medicines provided.

Nutrition and hydration

- Nursing staff completed an assessment of patient's nutritional status and their needs as part of their initial assessment.
- Staff described the pre-operative fasting guidelines used for adults. These were aligned with the recommendations of the Royal College of Anaesthetists (RCOA).
- Nausea and vomiting were assessed and recorded.
- Intravenous fluids were prescribed and recorded as appropriate.
- Patients were informed by the nurses when they could and should not eat and drink pre and post operatively.

Patient outcomes

- There were five unplanned readmissions within 29 days of discharge in the reporting period October 2014 to September 2015 however a reduction of unplanned readmissions (per 100 patient discharges) was reported in quarter four of the reporting period.
- Readmission rates within 30 days of surgery, for patients who had undergone hernia repair and knee replacement procedures were found to be similar to expected.
- During the reporting period (October 2014 to September 2015) there were seven incidents of unplanned transfers of inpatients to another hospital per 100 discharges. This was similar to the expected rate when compared to other independent acute hospitals. There were no trends, with regards to types of surgery, or concerns with individual surgeons, identified.
- Data regarding unplanned returns to the operating theatre was included in the governance report and showed a decreased incidence from 0.28% in 2012 to 0.02% per 100 patients in 2015.
- Patient Reported Outcome Measures (PROMS) such as the use of EuroQol-5D and EQ Vas index for hip replacement therapy and groin hernia repair showed the hospital was in range with the England average score and the majority of patients reported an improvement in health. These measures are based on descriptive information relating to five areas; mobility, self-care, usual activities, pain or discomfort and anxiety or depression. EQ-VAS is a visual analogue score. Patients mark on a chart their current health status, zero being the worst possible state and 100 being the best possible.
- PROMS for the Oxford hip score were used for NHS patients and showed BMI The Saxon Clinic to have achieved a score within the range of the England average. There were insufficient numbers of private patients that qualified for participation.
- Surgical site infection data was collected and submitted to Public Health England on a monthly basis for orthopaedic surgical procedures, which included hip and knee arthroplasty. The hospital reported two incidents of intravenous cannula site infections both under the care of the same medical team. Further investigation was undertaken and it was found when the recommended solution to clean the skin prior to insertion of the cannula was applied, this was not left on long enough to be effective. This procedure had been corrected and there had been no further reported incidents.
- The NHS patients participated in an enhanced recovery program (ERP).The ERP is about improving patient outcomes and speeding up a patient's recovery after surgery. It focuses on ensuring patients are active participants in their own recovery and receive evidence based care at the right time. It draws on expertise from a multidisciplinary team integrated across the healthcare community including community care, carers and occupational therapy to ensure that support is in place for the patient and their carers. The Saxon Clinic had adopted this approach for private patients. The clinics were attended by a physiotherapist, nurse and pharmacist (regarding future pain control). Through the use of this service patients average length of stay had fallen from 3.5 to 2.4 days.

Competent staff

- The hospital provided hospital and local induction, learning development and appraisals for staff.
- There had been high levels of completed appraisals for administrative staff (above 75%) and operating theatre staff (above 80%) however there was a low level of appraisal rate for inpatient nurses, healthcare assistants (HCA) and allied health professionals. This rate was reported below 65%. However, there was no target for completed appraisals.
- We spoke with some staff that had completed their appraisal. They told us they set their own learning needs and had found the process supportive.

- Successfully completed competency based training was signed off by the assessor. Competencies included such training as how to correctly maintain a controlled drug register and provide effective chaperoning to patients.
- Nursing staff told us they felt supported in their role. One HCA told us they had learnt more at the Saxon Clinic than anywhere else they have worked.
- Agency staff were provided with an induction and orientation to the hospital. We saw records of completed inductions.
- The RMO's had received appraisals. Records showed they were up to date with e-learning for example, anaphylaxis and safeguarding adults and children.
- At the time of the inspection there was one nursing staff member who had completed advanced life support training in addition to the RMO. All nursing staff had completed immediate life support training.
- Two members of operating theatre staff had completed training to perform as first assistants to the surgeon.
- Staff had received training about how to correctly use National Early Warning Score, (NEWS) calculate the patient score and escalate any concerns appropriately.
- The hospital supported student nurse placements and three nursing staff on the wards had completed training as qualified mentors.
- Registered practitioners had completed immediate life support (ILS) training to ensure staff were able to effectively respond to the needs of a deteriorating patient.
- Nursing staff had completed competencies in various areas such as medicine administration. The training for competency in scrub techniques was provided by operating theatre staff to new staff members.
- There was a process for checking General Medical Council and Nursing and Midwifery Council registration, as well as other professional registrations. We reviewed this data which showed consultants had up to date GMC registration, were on the specialist register and had insurance indemnity.
- The role of the MAC included ensuring that consultants were skilled, competent and experienced to perform the treatments undertaken. Practising privileges were granted for a consultant to carry out specified procedures.
- There were arrangements which required the consultant to apply to undertake a new technique or procedure not undertaken previously by them at the hospital. The introduction of the new technique or procedure had to have the support of the MAC, which took national specialist guidance into account, such as that of the National Institute for Health and Care Excellence (NICE). The consultant was also required to produce documentary evidence that they were properly trained and accredited in the undertaking of that procedure. Administrative and operating theatre staff were aware of this requirement and gave examples where bookings for planned treatment were queried.
- Practising privileges for consultants were reviewed annually. As well as ensuring that GMC and indemnity policies were up to date, the review included all aspects of a consultants' performance, including a review of their annual appraisal, volume and scope of activity, plus any related incidents and complaints.

Multidisciplinary working (in relation to this core service only)

- The admissions officer worked closely with the operating theatre team to prepare operating lists to ensure appropriate arrangements were made. For example if specialised equipment needed ordering for a specific operation or if there were patients or procedures on the operating list who required prioritisation such as children.
- Medical and nursing staff reported good working arrangements and relationships with the local NHS hospital.
- We observed effective team working among managers, nursing, Allied health professionals and support staff during our inspection.
- Discharge letters were sent to the patient's general practitioner (GP) with details of the treatment provided, follow up arrangements and medicines provided on the day of discharge.

Seven-day services

- The hospital undertook elective surgery only with lists planned in advance six days a week.
- Consultants were on call 24 hours a day for patients in their care.
- There was 24 hour RMO cover in the hospital to provide clinical support to surgeons, staff and patients.
- The hospital had on call arrangements for imaging and physiotherapy services if required.
- Physiotherapists visited the ward at the weekend.

Requires improvement

Surgery

- During out of hours a pharmacist was available to contact for advice and if a prescribed medicine was not available on the ward and was required urgently, the RMO could access the pharmacy with a nurse present.
- There was also an on call engineer available.

Access to information

- There were arrangements to ensure staff had necessary information to deliver effective care. Staff had access to patient records of those patients treated with in recent months should a patient be readmitted. Staff had access to NHS notes for patients receiving treatment commissioned by the NHS. This meant when a patient was admitted for surgery clinicians had all the necessary information such as test results and recent treatment available.
- Information was sent to the patients GP, following the patient's discharge from hospital.
- Staff were able to demonstrate how they could access to policies and protocols on the hospital intranet.
- The RMO had a folder with relevant evidence based protocols to refer to as required for example anti coagulation guidelines.
- Each staff member had an email address to receive notifications and hospital bulletins.
- Copies of minutes of recent meetings relevant to staff were provided and accessible.
- Minutes of meetings of the Medical Advisory Committee (MAC) were circulated to each consultant with practising privileges to ensure they were aware of items discussed and agreed actions.
- Staff had access to files in the relevant department offices such as information about Control of Substances Hazardous to Health (COSHH) relevant to their working environment.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- The service had an up to date consent policy that staff were familiar with. Compliance with the consent policy was not audited separately but consent was checked as part of the records audit and completion of the five steps to safer surgery.
- Staff we spoke with were clear about their responsibilities in relation to gaining consent from people including those who lacked capacity to consent to their care and treatment.
- The mandatory e-learning provided to staff for safeguarding included information about the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS) to ensure staff were competent to meet patient needs and protect their rights where required.
- We looked at four sets of notes and saw consent forms were fully completed, signed and dated by the consultant and patient. The forms identified the planned treatment, the associated risks and benefits and intent of treatment.

Are surgery services caring?

We rated surgery services as good for caring because:

- Patients were supported, treated with dignity and respect, and were involved in planning their treatment and care. Feedback from patients and those who were close to them was positive about the way staff treated and cared for them.
- Patients were given time to understood their care, treatment and condition prior to treatment. Patients were communicated with and received information in a way that they could understand. There were appropriate arrangements to support and meet the emotional needs of patients and staff.

Compassionate care

- Staff respected patient's privacy and dignity for example we observed that they knocked on doors before entering and introduced themselves. Patients told us they felt safe and valued the frequent checks by care staff.
- Gowns were provided when patients walked to the operating theatre to ensure their dignity was protected. Once patients were taken to the recovery department curtains were used to ensure their privacy.
- Patients spoke warmly about the caring approach and thoroughness of making safety checks on arrival to the operating department by operating theatre staff.
- We observed positive interactions between nurses, allied professionals and patients. One patient told us how they could not sleep and appreciated the time staff took to help them settle.

- The Friends and Family survey results for the period April to September 2015 which had a response rate of 61% showed 85% satisfaction with the quality of care.
- Over 80% of respondents to the inpatient survey rated the quality of care provided as excellent.

Understanding and involvement of patients and those close to them

- Staff took time to interact with people who used services and those close to them in a respectful and considerate manner.
- Patients were orientated to their rooms on arrival, by the ward administrator to help them become familiar with the room and services available.
- Patients were allocated a named nurse on admission who managed the admission process and supported the patient during their initial pre and post-operative period.
- Patients told us staff were thorough with the checks made when being received in operating theatre. Patients were given time to ask questions. They felt most of their questions had been answered during the pre-admission process and where the planned discharge date was discussed.
- The physiotherapist was observed to explain and ensure the patient understood before taking them through an exercise.

Emotional support

- Pre admission assessments included consideration of patients' emotional well -being.
- Patients felt staff had time to listen and provided reassurance if they had any concerns.
- There was a list of chaplains for staff to contact to meet patients different spiritual needs when required.

Are surgery services responsive?

Good

Overall, we have rated responsiveness as good because;

- Access to surgical services was good and managed to take account of patient needs, including those with urgent needs.
- The needs of different patients were taken into account when planning and delivering services, for example, on the grounds of age, disability or gender.
- Care and treatment was coordinated with other services and other providers.
- Cancellations were monitored and were managed appropriately.
- Patients received follow up telephone calls to check that patients had no concerns after discharge.
- It was easy for patients to complain or raise a concern. Complaints and concerns were taken seriously, responded to in a timely way and listened to. However, verbal complaints were thought of as 'informal' and were not always recorded. Improvements to the quality of service had been made in response to patient feedback and concerns.

Service planning and delivery to meet the needs of local people

- The booking system was conducive to patient needs, as where possible patients could select times and dates to suit their family and work commitments.
- Operating theatre lists for elective surgery were planned with the operating theatre manager and bookings team. This was to ensure all aspects were checked and considered before booking patient on to the list to ensure patients safety and needs were met. In addition it ensured available operating time was used effectively. Considerations of type of operation and equipment required were taken into account. The operating theatre manager explained when approving operating theatre schedules checks were also made to ensure availability of other services such as imaging.
- Surgeons were provided with allocated operating theatre times for the next year to allow prior planning of patients and operating theatre activity.
- The hospital was fully accessible to patients with a physical disability. Staff told us that those with a sensory or learning disability would be escorted by a member of staff to the relevant department if this was required.
- We saw that patients were given a copy of the letters sent to their GP outlining the treatment provided including prescribed medicines to take home and any follow up arrangements.

Access and flow

- Patients had timely access to initial assessment, diagnosis and treatment.
- The hospitals admission policy and local contracts ensured patients received a pre-operative assessment.

All patients were assessed, some by telephone, and this meant patients were identified as being safe for surgery and unnecessary cancellations were avoided where possible.
- Staff began planning the patient's discharge during the pre-admission process where they gained an understanding of the patient's specific home circumstances and likely needs following discharge.
- Patients were advised they would receive a phone call 48 hours after their discharge to check on their progress and whether they had any concerns (unless the patient had indicated they did not wish to be contacted). If staff did not receive a response to the phone call, a letter was sent. A record of follow up calls and letters sent were recorded in the patient record.
- There had been 33 reported incidents of cancelled operations during the reporting period of October 2014 to September 2015. Operations were cancelled for a variety of reasons, for example; patient assessed as unfit for surgery at pre admission, or because symptoms had diminished since the initial consultation and the patient no longer required surgery. Six of the 33 incidents were due to non-clinical issues such as equipment which had failed and could not be repaired in time. Another example was due to the patient changing their mind about having treatment.
- BMI The Saxon Clinic had exceeded the target of 90% of admitted NHS patients beginning treatment within 18 weeks of referral during the reporting period (October 2014 to September 2015).

Meeting people's individual needs

- Intentional rounding by care staff was completed throughout the patients stay. This meant patients were visited in their rooms hourly to check for example, if call bells and a drink were in reach, if the patient had pain or had any other requests.
- An interpreting service for patients who did not speak English was available and staff knew how to access it.
- The hospital only received patients as planned admissions who were all pre assessed.
- Patients specific needs such as learning needs, disabilities or mental capacity issues were identified at pre assessment, this included screening for dementia, to ensure appropriate arrangements were made to meet individual patient needs prior to admission.
- In addition, specific dietary requirements were identified at pre admission. Catering staff told us they were notified by the pre assessment team in advance of a patient's admission of specific dietary needs or allergies. Following this, patients completed menus were checked on a daily basis to ensure the correct diet was provided.
- Patients had access to hot drinks and snacks at all times if required. Over 70% of respondents during the reporting period were satisfied with the catering service provided.
- Patients received both written and verbal information about their planned treatment. Information included details of the patient's planned length of stay, details about after care in hospital and after discharge to ensure an optimal outcome from their treatment.
- Information provided pre operatively described what patients needed to do before and after surgery to ensure a desired outcome. For example to stop smoking before anaesthetic and wound management following surgery, to prevent infections.
- Patients assessed for treatment as a day case signed a document to say they understood the advice provided which included they must not eat and drink for a specified time pre operatively and should not drive post operatively.
- Day case patients who were assessed as not being fit for discharge after their procedure were transferred to the ward for overnight care if required. If this occurred it was recorded as an incident so that the incidents could be reviewed to identify trends. We saw that there were 21 conversions from day care to overnight stay during the reporting period, which is less than 1%.
- Patients' discharge plans took account of their individual needs, circumstances, ongoing care arrangements and expected outcomes.
- Patients were discharged at an appropriate time and when all necessary care arrangements were in place.
- Satisfaction with food including temperature and overall quality were evaluated through customer surveys and Patient Led Assessment of the Care Environment (PLACE). Current satisfaction rates with food were above 96%.
- We saw information for patients about the services offered and how to access them. All patient areas of the hospital were accessible to patients and relatives who had problems with mobility.
- Patients told us they had been given detailed explanations about planned treatment in addition to written information. The hospital website also

contained a range of procedure specific information which included information about various procedures, what to expect post operatively and how the patient could aid their own recovery. We also saw there was a range of procedure specific discharge instructions provided.

Learning from complaints and concerns

- Complaints were handled confidentially, with a regular update for the complainant. A formal record was kept.
- Staff understood the hospital's complaints procedure. Any concerns were addressed at the point of service where possible. Staff told us where they were unable to achieve this, the department manager was notified. Depending on the type and seriousness of the complaint this was also escalated to the executive director or director of nursing to ensure the concern was appropriately responded to. However, there was sometimes a difference with the way a complaint was recorded if it was made verbally and not in writing, where it was deemed to be informal. We found that if a similar complaint was made, but reported to different individuals, it was not always recorded. This meant that the hospital did not have an accurate record and oversight of all verbal complaints.
- Patient feedback and concerns were raised at monthly ward meetings and actions agreed. Although there had not been any complaints directly linked to the operating theatre any concerns raised by patients were discussed at the daily huddle meeting to ensure shared learning.
- Patients were aware of information relating to complaints and who to go to for assistance. Information was provided to patients in the patient room guide.
- All complaints were reviewed by the executive director and senior management team at the complaints meeting with outcomes being discussed at heads of department meetings. Quality and clinical governance meetings identified trends to ensure complaints were managed in accordance with the hospitals complaints policy.
- A box to receive completed patient feedback forms was kept at reception. These were collected and checked daily by the director of nursing so that any concerns could be responded to promptly.
- Staff were able to identify changes made in response to feedback such as the replacement of televisions in the patient rooms and the introduction of patient' rounding'.
- The number of complaints received by the hospital had decreased year on year since 2012 from 55 complaints to 33 in 2015.

Are surgery services well-led?

Requires improvement

Surgical services required improvement for well led because;

- There were integrated governance arrangements to minimise risk and ensure shared learning, however these were not always acted upon. There was lack of evidence of prioritisation of risks that had been on the risk register since 2013 with regards to providing effective infection prevention and control measures with no or limited actions and no immediate time line for resolution.
- It was not clear how often the risk register was reviewed. Not all of the risks had reports of actions being taken to mitigate risks and had been reported as far back as 2013.
- All staff told us that a refurbishment was due, but there was no plans in place when this was due to happen.
- Appraisal rates were low at 65%.
- It had been identified there was an increase of operations cancelled due to noncompliance with fasting guidance. Actions were agreed to review pre-operative admission/fasting guidance to reduce the rate of pre-operative cancellations. We asked to see the pre-operative guidance but this was unavailable at the time of inspection; however the hospital has since provided us with this guidance.

However we saw:

- Response rates to customer satisfaction surveys were low, although responses received indicated a high satisfaction with the service.
- Staff were aware of the hospitals values, based on quality and safety. The information used, within surgery for reporting performance, management and delivering quality care was accurate, valid, reliable, timely and relevant.
- Patient's views and concerns were encouraged, and when received were acted on. Information on patient

experience was reported and reviewed alongside other performance data. Clinical and internal audit processes functioned well with evidence of actions taken to resolve concerns.

- Leaders encouraged cooperative, supportive relationships among staff so that they felt respected, valued and supported. The leadership actively promoted staff empowerment to drive improvement.

Vision and strategy for this this core service

- Staff were aware of and familiar with the vision of the service. The operating theatres and wards had developed business plans for their relative departments, which was included in the hospital wide plan.
- Staff felt they had an influence with the overall development of services and were encouraged to contribute their ideas to improve the service.
- We saw the hospitals values were incorporated into the appraisal process and staff understood the aim to improve quality and surgical activity.

Governance, risk management and quality measurement for this core service

- There was a BMI and local governance framework to support the delivery of the strategy and good quality care. However, this was not always effective, for example lack of progress with outstanding risks that had been on the risk register for several years.
- BMI The Saxon Clinic published a monthly clinical governance and risk bulletin, attached to staff's payslips. This contained items such as learning from incidents and a cascade system for national alerts.
- The clinical governance (CG) committee met every other month. Senior department leads attended the governance meetings and were responsible for cascading information back to their departments. The CG committee considered a range of complaints, incidents, health and safety issues and patient satisfaction. In addition, local audits, patient safety and care were included to ensure actions were completed by target dates.
- The hospital had a schedule of audits performed throughout the year showing the frequency of local audits such as medicines and records. There was a framework showing how the information was to be reviewed and disseminated. Results were reviewed locally at governance meetings and Medical Advisory Committee (MAC) meetings then results were shared with clinical departments.
- There were plans in place to refurbish the wards to ensure there was appropriate flooring and hand washing facilities; all staff from senior staff downwards told us this. However, there was no evidence of when this would occur. We noted refurbishment of rooms and associated costs were discussed at a senior management meeting in November 2015 and plans were to be developed. However the budget did not include replacement of hand washing sinks. The development of an action plan remained outstanding in December 2015.
- Information from internal audits and risk assessments were used effectively. For example, the practice of undertaking minor operations in the outpatient department had ceased and this service was relocated to operating theatres when an internal audit identified the number of air changes was insufficient for safe practice. However there were no immediate plans to replace sinks, taps and flooring although nursing staff advised this was to be included in the planned refurbishment programme when it was formulated.
- Incidents were reviewed to identify trends. For example it had been identified there was an increase of operations cancelled due noncompliance with fasting guidance. Actions were agreed to review pre-operative admission/fasting guidance to reduce the rate of pre-operative cancellations. We asked to see the pre-operative guidance but this was not available.
- The governance processes we saw reflected the hospital's clinical governance policy. This included the requirements to use a standard agenda, and ensure sub committees provided reports, such as from the medicines management, resuscitation and infection control committees.
- Service level agreements were in place, for example to supply haematology and biochemistry services from the local trust, which were reviewed regularly.
- Audit results and proposed actions were reviewed in a range of topics such as medicines management, infection control and health and safety.
- The hospital participated in national audits including the National Joint Registry, Patient Reported Outcome Measures (PROMS), Friends and Family tests and Patient Led Assessment of the Environment (PLACE).

- The Medical Advisory Committee (MAC) met quarterly. It was attended by a group of consultants who held practising privileges and represented colleagues from each speciality service at BMI The Saxon Clinic. Its terms specified membership, quorum and responsibilities; which included regulatory compliance, practising privileges, quality assurance and proposed new clinical services and techniques.
- The MAC carried out checks before granting new consultants practising privileges, including checks on their scope of practice to ensure they were only undertaking procedures that they were competent to perform.
- There was a 100% completion of verification of registration of staff with their respective regulatory bodies such as the Nursing and Midwifery Council.

Leadership / culture of service related to this core service

- The operating theatre team was well led and found to be a cohesive motivated team.
- Staff generally found the senior managers to be visible and approachable. Staff told us how they felt supported. An example given was when the executive director visited operating theatres and assured the operating theatre manager if they felt the operating list planned was too long they could cancel the last case for safety reasons.
- Staff including administrators, nurses and catering staff told us they felt valued and supported by their immediate line managers and were listened to.
- Senior members of staff felt involved and were consulted regarding any proposed organisational changes.
- Although some nurses had expressed concern about staffing levels to us during the inspection we did not see evidence to show this concern had resulted in patient harm or that it had been recorded as an incident or escalated to senior managers for further action.
- There was evidence of high staff stability with there being only 16% vacancy level in operating theatres. The wards had one registered nurse vacancy which had been actively recruited to. Staff turnover was low with over 80% of clinical staff in operating theatres and wards having over one years' service. Many nurses and administrative staff we spoke with had been in service for over 10 years. However at the time of the inspection the quality and risk manager post had been vacant since May 2015, despite ongoing recruitment and these duties were being met by the director of nursing in the interim.
- A counselling service for staff could be accessed through a confidential help line provided by the hospital.

Public and staff engagement

- People who use services, those close to them, their representatives and staff were engaged and involved in decision-making.
- Staff received a monthly clinical governance bulletin which allowed them to see how incidents reported were used. The bulletin included audit results showing areas that required improvement.
- Staff received a monthly local letter from BMI The Saxon Clinic which was attached to their payslip to ensure all employees received this information.
- BMI The Saxon Clinic sought feedback from patients, whether they were funded privately or by the NHS via a monthly survey as well as the Friends and Family test which included simple questions about the quality of the service and whether the patient would recommend it to their friends and family. Feedback was consolidated into a monthly report.
- We saw that the patient satisfaction reports were presented at the Quality Group meetings.
- Overall findings reported in the BMI patient survey report for Saxon Clinic in 2015 were positive with over 50% of respondents saying their expectations were exceeded. However response rates were low with only 17% of patients using the BMI survey. There was a 70% response rate to the Friends & Family test. There was a summary dashboard at the beginning of the report which provided details on the top five areas which were most improved such as pain assessment and the amount of information provided.
- Information about satisfaction levels were also displayed on the hospital website for people considering using the services.

Innovation, improvement and sustainability

- The hospital had introduced intentional rounding to ensure that patients saw a nurse regularly and to reduce complaints about lack of attention during the admission phase.

Requires improvement

Surgery

- The team safety huddle’ meeting in operating theatres had been introduced to ensure a safe and effective service.
- BMI The Saxon Clinic planned to continue to develop the enhanced recovery programme for all patients to ensure the quality of the service and improve patient rehabilitation and outcomes.
- In addition there were plans to develop an ambulatory care lounge for walk in/walk out patients (these are patients who do not require admission to the ward post operatively); this was planned to be used in conjunction with a designated discharge lounge.
- BMI The Saxon Clinic had adopted the use of NHS joint schools for their private patients to improve patient outcomes.

Requires improvement

Services for children and young people

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

Information about the service

BMI The Saxon Clinic offers both day case and outpatient paediatric services for private patients only. Children from zero to three years are seen in the outpatient department for consultation. Children aged three years and above, are also seen in the outpatients department and can be admitted for day case procedures.

The hospital has three theatres, an endoscopy, and minor procedures room and outpatients department. The hospital saw 2220 children and young people between October 2014 and September 2015 in outpatients, on a private basis, 93 of which were admitted for day case surgery. The hospital does not have bedrooms and outpatients rooms that are dedicated specifically to children.

The main services provided to children and young people are ear nose and throat (ENT) surgery and urology. The hospital has two surgeons who undertake surgical procedures on children. They treat children from the age of three to sixteen years of age.

As part of our inspection, we visited departments in the hospital where children and young people were seen and treated. We spoke with 12 members of staff. This included Registered Nurses, (Child Branch), a resident medical officer, senior managers, adult nursing staff, and health support workers. We reviewed six sets of patient records and performance information about the service. During our inspection, we spoke with the parents of two children who were using the service and interviewed two further parents over the telephone.

Summary of findings

Overall, we found the children and young people's service was good in regards to caring and required improvement in safety, effectiveness, responsiveness and to be considered well led.

We found that:

- We found that the hospital did not ensure that recovery nurses had specific recovery competencies in children and young people's care. However, the two members of staff on duty at the time of our inspection were trained in paediatric immediate life support (PILS) which is the minimum standard required under 'Royal College of Anaesthetics 2015' Guidance.
- There were no specific audits for children's and young people's services.
- We did not see any child friendly easy to read information available at the hospital. However, there were some health education information leaflets for young people available at the nurses' work station.
- Theatre recovery had a dedicated recovery bay for children and young people but it only had a curtain separating it from the next bay, meaning there was a possibility of a child being recovered next to an adult.
- A passionate and motivated lead nurse led the children's and young people's service although we expressed concerns about the sustainability of their workload.
- The hospital was unable to provide us with any specific feedback from children and young people although we saw a feedback form designed for their use.

Services for children and young people

Requires improvement

- The service demonstrated that care was provided in accordance with evidence-based guidelines; however, care was not being monitored via audit to demonstrate compliance.
- Children were nursed in the rooms nearest to the nurses' work station. The rooms were not for the sole use of children and were not adapted to ensure they were suitable for the children and young people's needs.
- The hospital had cover from a resident medical officer (RMO) 24 hours a day. The RMO had some experience caring for children however they had not undergone specific training.
- The service was small and intermittent however; the hospital did not have allied staff, for example a play specialist to support children and young people during their visit to hospital.

We found some areas of good practice:

- There had been no never events involving children and young people and there was a system for reporting incidents. Staff were aware of what types of incidents should be reported and received feedback regarding incidents.
- Safeguarding systems were in place and staff knew how to respond to safeguarding concerns. All staff that came into contact with children and young people had the appropriate level of safeguarding training. There was a paediatric lead nurse for safeguarding who had also received training in female genital mutilation (FGM).
- All areas we visited were visibly clean and equipment checks were in place and up to date. Handwashing audits were being conducted with action plans in place when compliance fell. There were handwashing facilities and hand gel and hand towels at the point of care although taps were not non-touch.
- Ninety six per cent of all staff had completed their mandatory training in infection control.
- There was good use of handwashing facilities' and personal protective equipment. Medicines were stored in accordance with regulatory requirements. The management of medicines had been audited, with 100% compliance.
- Children who attended the hospital for day surgery where cared for by registered nurses, (child branch). When children zero to three years were attending outpatient's clinic for consultation a registered nurse, (child branch) attended to the clinic.
- Patient records of children and young people were stored in accordance with the hospital policy. The notes reviewed were legible and in line with General Medical Council, (GMC) guidance. All nursing assessments had been completed. Records were designed in a way that allowed essential information to be recorded and reviewed easily.
- We found that within the hospital there was a culture of support and staff felt able to speak openly with heads of departments and the director of nursing.
- Surgeons and anaesthetists that had practicing privileges at the hospital also cared for children in their NHS practice.
- There was a process in place for transferring children who were not well enough to go home after their surgery to the local NHS acute trust for continuing care.
- Pain assessments were embedded in the paediatric pathway and we saw evidence that assessments were being completed. Parents told us that their children's pain had been well managed.
- The hospital did not have a consent form specific to children and young people however there was a section pertaining to gaining consent for children, in the generic consent policy. Registered nurses (child branch) were aware of Gillick competence.
- Comprehensive information was sent to children and young people and their parents/ carers prior to surgery; however, this information was not in a child friendly format.
- There was a child friendly menu offered to children and young people. However, they could also order from the adult menu should they wish to.
- All children and young people were pre-assessed before admission for day surgery.
- Children were treated with dignity and respect. Parents we spoke to were positive about the care their children received.

Requires improvement

Services for children and young people

- We observed calm relaxed and compassionate interactions between staff and children. Nurses communicated with children using language appropriate to the child's age.
- Nurses were encouraging and supportive to both the children and their parents and recognised their emotional needs.
- Operating dates for children and young people's services were published in advance to allow the hospital to plan to have two registered nurses (child branch) on duty for children's day case lists.
- Children were routinely scheduled first on the operating lists ensuring that they were recovered and discharged at an appropriate hour of the day.
- Parents were given access to accompany their children to the anaesthetic and recovery rooms.
- A few toys were available in the outpatient areas, children were encouraged to bring in familiar toys, phones, and electronic equipment, and there was Wi-Fi within the hospital.
- We found that the hospital had a policy on caring for children and a strategy and vision that was displayed in the bedrooms.
- The hospital links into the BMI regional subcommittee for children, issues were escalated to this committee and feedback is cascaded to local directors of nursing.
- We found that within the hospital there was a culture of support and staff felt able to speak openly with heads of departments and the director of nursing.
- A passionate and motivated lead nurse led the children's and young people's service although we expressed concerns about the sustainability of their workload.
- The hospital was unable to provide us with any specific feedback from children and young people although we saw a feedback form designed for their use.

Are services for children and young people safe?

Requires improvement

We found the children's and young people's service to require improvement for be good for safe because:

- Window blinds in rooms had long cords that could be tampered with by children and young people. This was acknowledged on the hospital risk register but there were no associated action plans, and it was unclear as to how long this issue had been an identified risk.
- Infection prevention and control measures did not always ensure patient safety. Sinks and taps in the clinical areas and patient rooms did not conform with the Department of Health Building Note 00-10 part c: sanitary assemblies (HBN 00-10) to allow correct hand hygiene practice.
- Most patient rooms were carpeted. The hospital had recognised that carpets present an increased infection control risk, and the need to replace them in patient rooms and this was on the hospital's risk register and covered in the surgery and chemotherapy sections of this report.
- The resident medical officer had no formal qualification in the care of children.

However, we also found:

- The environment was visibly clean and staff followed the BMI infection control policy.
- There were systems in place to check equipment.
- Safeguarding systems were in place and staff we spoke to were able to explain the process and knew how to respond to safeguarding concerns. Non-clinical staff in the hospital had mandatory training in level one safeguarding. Registered nurses directly caring for children and young people have mandatory training in level three safeguarding.
- Staffing levels were appropriate for the service, although there was only one permanent registered nurse (child branch), employed by the hospital. The hospital employed bank nurses to provide the appropriate staffing levels when children were using the day surgery service.

- The registered nurses, (child branch) were trained in advanced paediatric life support (APLS). The hospital reported that there was 100% compliance with paediatric immediate life support (PILS) training. However, we found that in the outpatients department 71% of registered nurses (adult branch) had completed this training.
- The hospital had a process in place for the emergency transfer of a deteriorating child to the local NHS acute trust.
- All children and young people that were planned to undergo surgery, were risk-assessed to ensure that children with medical conditions could be cared for safely in an appropriate environment, with appropriate nursing and medical practitioner available.
- A registered nurse (child branch) attended all outpatient clinics where there were going to be children less than three years of age.

Incidents

- There had been no, ‘never events’ in children’s and young people’s services in the last 12 months. A never event is a serious incident that is wholly preventable, as guidance and safety recommendations providing strong systemic protective barriers are available at a national level and should have been implemented by all healthcare providers.
- There had been no serious incidences for the children and young people’s service in the last 12 months.
- The children’s and young people’s service used an electronic system to record incidents. Staff initially completed a paper incident reporting form. This form was forwarded to the head of department, then the senior management team, who then ensured the incident was recorded on the electronic system. There had been no reported incidents involving children and young people. Staff were able to describe the types of incidents they would report.
- Staff we spoke to said that feedback from incident investigations was shared at departmental meetings. A departmental manager confirmed this and we saw minutes of meetings to evidence this.
- Staff understood their responsibilities with regard to Duty of Candour legislation, which was supported by BMI’s ‘Being Open and Honest Policy. The Duty of Candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain notifiable safety incidents and provide reasonable support to that person.

Cleanliness, infection control and hygiene

- Areas we visited were visibly clean and tidy.
- We saw the daily cleaning log. Housekeepers were responsible for cleaning toys in the outpatient areas. We saw cleaning records, which were appropriate, complete, retained, and checked by the lead nurse for paediatrics.
- Staff we spoke to were aware of the hospital policy on infection prevention and control and 96% of hospital staff had completed infection prevention and control mandatory training. The ‘bare arms below the elbow’ policy was adhered to.
- There were handwashing facilities and protective personal equipment, such as gloves and aprons available. Taps on sinks were not ‘no touch’ .The hospital had recognised this and it was recorded on the hospital’s risk register. However, there was no specific plan with dates to replace the taps. Hand sanitisers were provided in the consulting rooms and treatment areas at the point of care.
- We saw signs related to hand washing techniques displayed in the ward. There were sufficient supplies of soap alcohol gel and hand towels in all appropriate areas.
- The outpatient’s manager told us that staff were trained in the five points of hand hygiene and that hand hygiene was audited monthly. The link nurse for infection control was responsible for auditing compliance with hand hygiene and was recording the audits electronically. If compliance was less than 100% the link nurse developed an action plan to address this. We saw electronic records of hand hygiene audits during our inspection and the associated action plans.
- Patient rooms were carpeted. The hospital had recognised that carpets present an increased infection control risk, and the need to replace them in patient rooms and this was on the hospitals’ risk register and covered in the surgery and chemotherapy sections of this report.
- There were no reported incidences of Clostridium difficile (C.Difficile) and Methicillin-Resistant Staphylococcus Aureus (MRSA) in the last 12 months.

Environment and equipment

- There were no rooms used solely for caring for children and young people, this meant that staff were unable to make changes to the environment to make it more welcoming to a child or young person. From a safety point of view, rooms provided were not specifically set up for children.
- The hospital had an environmental risk assessment that was completed daily as part of the BMI 'Care of Children' Policy. The checklist was not specific to the rooms in which children were being cared for it and included assessing risks such as access to the hot drinks machines, treatment room doors being locked and window security. In addition, the use of plug socket covers were an item on the environmental risk assessment checklist. The paediatric nurse told us that there was now a corporate policy of not using plug socket covers because they could break within the socket causing it to be live. There was no separate risk assessment relating to this.
- There was a daily system for checking resuscitation equipment in the ward and outpatients area. Records of checks were complete and up to date.
- There was a paediatric 'Grab Bag' stored in the sisters office in the outpatients clinic area. This was an emergency bag containing some immediate equipment that may have been needed in the event of a child or young person becoming suddenly unwell. Staff we spoke with in outpatients were aware of where the grab bag was stored should it be needed. The bag was security tagged and checked daily for tampering and opened weekly, and contents and expiry dates checked. Records were complete and up to date. The resuscitation trolley was in the outpatients waiting area and staff told us it would be brought through to the consulting area if required. There was a cardiac arrest bleep system for obtaining help in such circumstances
- The bedrooms used by children and young people had window blinds with long cords which could be tampered with. However, these were tied up when a child was using a room. This risk was acknowledged on the hospital risk register, however it was not clear for how long this had been an identified risk and there was no associated action plans to further reduce this risk recorded.

Medicines

- There were effective arrangements for the receipt storage, dispensing, and disposal of unwanted medicines managed by the pharmacist.
- The hospital had access to the electronic Paediatric British National formula (BNF). We saw this being used during our inspection. The BNF is a pharmaceutical reference book and contains advice on prescribing and pharmacology.
- Medicines were stored securely in accordance with regulatory requirements. Ambient temperature of medicines storage rooms and fridge temperatures were recorded daily on the ward and in theatre. They were all within an acceptable range and there was a process in place should the fridge temperature fall out of range. Staff we spoke with were aware of this process.
- Medicines were contained in clearly labelled locked cupboards allowing staff to quickly locate the item required.
- There was a supply of red disposable plastic aprons for staff to wear when administering medicines. The aprons had a clear Do Not Interrupt message printed on them, to reduce the risk of interruptions when medicines were being prepared and administered.
- There was a key safe containing a set of pharmacy keys should the need arise for staff to access the pharmacy out of hours. There were appropriate security controls in place to monitor when the pharmacy had been accessed and the stock item removed. We checked the log of access to out of hours medicines and found that there had been no access to gain medicines for children out of hours.
- We checked the records and completed random reconciliation checks of controlled drugs in both on the ward and theatre and found that medicines had been reconciled correctly.
- The management of medicines was audited, for example the number of occasions prescribed medicines were omitted and the correct storage and management of controlled drugs. Both audits showed 100% compliance.
- There had been five medicine administration errors in the previous 12 months. None of these incidents involved children and young people.

Records

Services for children and young people

- A paper based system was used for the recording of patients care and treatment and a complete set of patients records were kept on site. All records followed the same format, which meant information could be found easily.
- Records were designed in a way that allowed essential information, for example, allergies and medical history to be documented and easily viewed.
- We reviewed six sets of patient records of children and young people using the service. The paediatric lead nurse audited patient notes, to include for example, compliance with risk assessments and completed consent. There were completed audit checklists in the patient records. The checklist identified discrepancies in completion; however, no associated actions to effect improvements were recorded.
- The records we reviewed were legible in line with General Medical Council guidance.
- Records were stored safely in accordance with the hospital policy.
- Nursing assessments such as pain assessments and nausea assessments had been completed. Vital signs such as temperature and pulse, were clearly recorded. However, in two of the sets of patient records we reviewed there was no time out of surgery recorded for one and no Paediatric Early Warning Score (PEWS) recorded in recovery, in another set of patient's records. Notes were written in retrospect in one post-operative record but not signed in retrospect. These points had been highlighted on the record auditing form in the front of the patient's record although it was not clear if any action had been taken to address this.
- We saw completed pre-admission assessments in patient records.
- When patients' records were no longer required they were secured safety on site prior to being archived off site.
- A records clerk was employed to effectively manage the records to ensure patient records were available as required, for example to ensure files were available on site for clinic appointments or following a patient's admission. A tracking system was used which required records to be signed in and out of the records store. The tracking record was found to have been used consistently and correctly to retrieve and return patient records

Safeguarding

- There were arrangements in place to safeguard children from abuse that reflected relevant legislation and local requirements. Staff understood their responsibilities and adhered to safeguarding policies and procedures.
- All staff that had contact with children must have an appropriate level of safeguarding training as recommended by local safeguarding boards and 'Working together to safeguard children' (2015). According to hospital training records in December 2015 there was a compliance of 95% in safeguarding of children mandatory training.
- Staff told us and we saw records to support that all hospital staff, clinical and non- clinical who encountered children and young people, were trained in safeguarding of children. All registered nurses (child branch) were trained in safeguarding level 3.
- In addition, the director of nursing had undergone level three training and led on adult safeguarding.
- There were named persons for safeguarding who maintained links with the local NHS trust in line with BMI General Policy 05 'Safeguarding Children and Vulnerable Adults'.
- Staff were able to explain safeguarding arrangements and said they raised any questions with their ward manager or head of department. Staff were able to give specific examples of when they might be required to report issues to protect the safety of vulnerable patients. We saw a safeguarding folder in the ward and outpatients area, which contained safeguarding guidance and a flow chart, which outlined who to contact and how to escalate any concerns. Staff knew where to find this guidance.
- We saw that children being operated on were cared for by a registered nurse (child branch). The paediatric lead nurse told us when children under three were being seen in the outpatients department a registered nurse (child branch) was always on duty and we saw evidence of this in nursing rotas. When children over three years of age attended clinic there would not be a registered nurse (child branch) present in clinic although they would be on duty in the hospital and could be called on for advice and support.
- The paediatric lead nurse had attended training on female genital mutilation and was aware of the legal responsibility to report any cases to the police.

Mandatory training

- The resident medical officer (RMO) had been trained in European Paediatric Life support (EPLS). Some RMOs had experience and specific qualifications in caring for children, but this level of experience did not extend to all the RMOs.
- The children's nurse and paediatric lead we spoke to had been trained in Advanced Paediatric Life Support (APLS). This meant that staff had the necessary training to support children and young people in the event of an emergency. Registered nurses (adult branch) told us that they were trained in paediatric immediate life support (PILS) this included nurses working in recovery and theatre. In the outpatients department, 71% of registered nurses and 60% of health care assistants had completed their PILS training. We saw evidence of further arranged training dates with members of staff booked to attend. The hospital had reported 100% compliance with PILS training throughout the hospital.
- Registered nurses (adult branch) working in outpatients told us that that had also received scenario based training in paediatric emergencies this was confirmed by the outpatients manager.
- All staff in the outpatients department had to complete a competency checklist assessed by the lead paediatric nurse. We saw completed checks lists for registered nurses, health support workers and support staff. The competency checklist covered resuscitation, safeguarding, and general issues relating to children and young people for example, awareness of making a child welcome in the department and awareness of child health record books.
- We were told that bank nurses currently employed within the service had mandatory training and access to the BMI online training system but that the policy had changed and if new staff were taken on the bank they would not have access to the system unless they work over 80 hours per month for BMI healthcare. The mandatory training tracker confirmed this. This meant there was a risk that nurses employed on bank hours may not have had access to mandatory training.
- We were able to confirm that the bank nurse (child branch) that we spoke to did have access to BMI mandatory training. The member of staff had received some mandatory training in her substantive NHS post, copies of mandatory training already completed were sent to BMI The Saxon Clinic. The director of nursing was able to confirm this.
- We saw evidence of the lead paediatric nurse's completed mandatory training.

Assessing and responding to patient risk

- Staff were able identify and respond appropriately to changing risks to children who used services, including deteriorating health and well-being and medical emergencies. The department used a Paediatric Early Warning (PEWS) system to alert staff if a child's clinical condition deteriorated. There was an appropriate trigger system should a child deteriorate. Staff spoke confidently with regards to the action they would take.
- The hospital did not have an audit of PEWS at the time of inspection.
- BMI Policy stated that children under 12 years of age should have their weight checked by two nurses. We saw two children being admitted and this was being done according to policy.
- The anaesthetic consultant remained in the hospital until the child was discharged from recovery and had been reviewed on the ward.
- Children and young people attended the hospital for outpatient and day surgery procedures only. If there was an occasion, where a child was not well enough to be discharged home there was an 'Emergency Transfer of Patients Policy, children, and young people.' In these cases, the child or young person would be transferred to the local NHS acute hospital trust.
- The paediatric lead nurse told us that this was an extremely rare occurrence and could only recall one example from several years previously. There had been no recent transfers of a child or young people.

Nursing staffing

- The paediatric lead nurse was the only full time registered nurse (child branch) employed by the hospital. The hospital employed two additional registered nurses (child branch) on the nurse. Two registered nurses (child branch) were always on duty when children had been scheduled for surgery.
- The registered nurses that cared for adults, in the ward, told us that they did not care for children, but that they would respond to emergency involving children when required to do so. This was confirmed by the lead paediatric nurse.

Requires improvement

Services for children and young people

- Surgery on children mainly took place once a month on a specific day in order that staffing could be planned appropriately to ensure there were two registered nurses (child branch) on duty.
- Children (over three years of age,) attending outpatient appointments, were cared for in the outpatients department by registered nurses (adult branch). There were no children being seen in the outpatients department during our inspection.
- We observed the handover of a child from recovery staff to ward staff and observed good communication with staff using the paediatric pathway booklet to give a concise handover.

Medical staffing

- All consultants were registered with the General Medical Council (GMC), in addition consultant surgeons, anaesthetists and physicians were required to be on the relevant specialist register before they were granted practicing privileges, which meant competent and registered practitioners were treating children and young people.
- We checked the consultants' practising privileges who treated children in the hospital. All, according to their scope of practice, carried out similar procedures within their NHS practice. This meant that surgeons were undertaking procedures that were within their routine practice and skill set. In addition, we saw that anaesthetists had the training and skills to administer anaesthesia and care for children and young people during the pre-operative, peri-operative and post-operative phases of their care.
- There was 24 hour, seven day a week RMO cover for the children's and young people's service, which was shared with adult patients. The RMO we spoke with had experience of caring for children and young people, but did not have a formal qualification.

Major incident awareness and training

- The hospital had a service contingency plan in place for staff to use in the event of interruption to essential services. Staff were aware of the escalation process if there was an incident requiring a major response.
- Emergency bleep holders were designated each morning at the daily morning hospital meeting.
- The hospital had a service level agreement with the nearby trust for the Saxon Clinic to accept patient overflow if they had the capacity in the event of an emergency in the locality. The trust were notified daily of the anticipated capacity.

Are services for children and young people effective?

Requires improvement

We found that the hospital required improvement in regard to effectiveness because:

- The service demonstrated that care was provided in accordance with evidence based national guidelines. However, we found that care was not monitored via audit to demonstrate compliance. This was despite BMI's Care of the Child Policy stating that compliance with the policy should be measured via a variety of means and an annual audit should be undertaken.
- The paediatric lead nurse had not had an annual appraisal.

However we found that :

- The hospital had an up to date BMI Care of Children Policy.
- The paediatric lead nurse and registered nurse (child branch) that we spoke to had knowledge of Gillick competence. There was no specific consent specific for children and young people however, there was a section pertaining to children and young people within the general BMI consent policy.
- Pain assessments were embedded into the paediatric pathway.
- Staff had received training on the Mental Capacity Act (MCA) 2005 and deprivation of liberty and safeguarding.

Evidence-based care and treatment

The Hospital had a BMI Care of Children policy; this meant that the hospital had taken some steps to ensure children and young people were cared for in line with best practice for example, Royal College of Nursing (RCN) guidelines on staffing and the use of Gillick competence assessments. This is a term that is used to assess whether a child (16 years or younger) is able to consent to their own medical treatment.

Requires improvement

Services for children and young people

- The hospital did not have audits specific to the children and young people's service this meant that care was not monitored to demonstrate the compliance with best practice and guidance. This was despite the BMI Policy stating that a range of reports, visits and an annual audit of the service should be undertaken by the hospital's registered manager.
- Staff were able to access policies and procedures using the hospital's intranet system.

Pain relief

- Pain assessment charts were embedded into the paediatric pathway. The assessment tool used smiley faces where children were asked to choose the face that best described how comfortable or uncomfortable they were feeling. Records that we reviewed had completed pain assessments.
- Pain was monitored from surgery through to discharge.
- Pain management was the responsibility of the anaesthetist, who reviewed pain relief and its effectiveness in recovery and on the ward. We saw evidence of this on our inspection.
- Both the surgeon and anaesthetist were available in the hospital until at least the child had left recovery, should there be any issue with pain prior to discharge.
- Parents we spoke with told us that their child's pain had been well managed.
- The medicine records showed clear prescribing of pain relief.
- The paediatric lead nurse told us that a registered nurse (child branch) would also assess a child's pain in recovery ensuring it was well managed before taking the child back to the ward. We saw evidence of this during our inspection.

Nutrition and hydration

- The length of pre-operative fasting was appropriate.
- Full nutritional assessments were not carried out for children and young people having day surgery, however allergies were recorded in the day surgery care pathway and dietary needs were discussed at pre assessment.
- A dietician had practicing privileges within the hospital and could be referred to for advice, or patients could be referred back to their own General Practitioner (GP) if needed.

Patient outcomes

- Information about the outcomes of children and young people's care and treatment was not routinely collected and monitored.
- During our inspection we found that the hospital did not have an audit programme specific to the children and young people's service and therefore there were no outcome measures in relation to this service.

Competent staff

- All staff were required to complete both a corporate BMI local induction programme in order develop and maintain competencies relevant to their job role.
- The bank nurse (child branch) that we spoke to confirmed that she had received an annual appraisal. However, the lead paediatric nurse had not yet received her annual appraisal. Annual appraisals are a process whereby the training and development needs of staff are

assessed and staff have the opportunity to discuss their career aspirations.

- Registered nurses (adult branch) that we spoke with confirmed that they had received an annual appraisal and felt that the process had been useful.
- It had been arranged that when children over 3 years of age were seen in outpatients, the lead nurse for paediatrics was present within the hospital and could be called on if required. In addition, when children under three years of age were attending an outpatient clinic a registered nurse (child branch) would be present in clinic. There were no children using the outpatients service during our inspection therefore we were unable to observe this, although we did see that the registered nurse, (child branch) was on the duty rota when there was an ear nose and throat clinic, where children had been seen.
- The lead paediatric nurse had developed a competency check list for registered nurses (adult branch) who were caring for children over three years of age in the outpatients department.
- We confirmed, by checking the surgeons practising privileges and scope of practice, those who undertook surgery on children at the Saxon Clinic all conducted the same operations in their NHS practice. In addition the same group of anaesthetists were used for both Saxon

Clinic and the NHS. This meant that surgeons and anaesthetists were not doing surgery at the Saxon Clinic that they were not routinely doing within the rest of their practice.
- The paediatric lead nurses were being supported through Nursing and Midwifery Council revalidation by the director of nursing

Multidisciplinary working

- The lead nurse for paediatrics pre assessed every child and young person who was booked for surgery. If the child or young person had any co-exiting conditions, the child's GP, health visitor or school nurse was contacted, as appropriate, to gain further information. A recent example of this multidisciplinary working was given when a child who had a history of diabetes, had been booked for surgery.
- Staff we spoke with told us that a child's personal health record (red book) would be completed after a visit to the hospital. The red book is a record of a child's health from birth to four years and should be used by all healthcare professionals who see, review and treat children. This is to ensure that there is effective communication between healthcare professionals involved in the child's healthcare.

Seven-day services

- There was a range of out of hours services available on an on call basis, for example radiology, pharmacy and physiotherapy. However, it was extremely rare that children had treatment out of hours. The lead nurse for the service could not remember the last time this had happened.

Access to information

- Staff were able to access to the medical records of current patients of all patients that had been treated in recent months.
- Staff were able to demonstrate how they accessed policies and procedures via the hospital's intranet system.
- All staff had an e mail address and could receive hospital bulletins and updates.
- Discharge summaries were sent to GPs and health visitors, as appropriate. This was done on the day of, or the day after discharge. A fuller surgical summary was sent to the child or young person's referring GP from the consultant.

Consent

- The hospital had a general consent policy that was not specific to children and young people.
- The hospital's Care of the Child policy stated that a child's capacity to consent should be evaluated using the Gillick competencies. This assesses whether a child under the age of 16 had the maturity to make their own decisions and to understand the implications of those decisions. The nurses caring for children were fully aware of their responsibilities around Gillick competencies.
- The lead paediatric nurse told us children and young people were included and engaged in conversations around consent and share information with them.
- Staff were aware of the' Mental Capacity Act (MCA) 2005', and confirmed that they had received training regarding MCA and deprivation of liberty safeguarding. The hospital had achieved 92% compliance with this training in December 2015.

Are services for children and young people caring?

Good

We found the children's and young people's service was good in relation to caring because:

- Children and young people were treated with dignity and respect. Parents we spoke to were positive about the service and said that nursing staff were caring.
- We observed interactions between nurses and children. Nurses were relaxed and calm and tried to put children at ease and involve them and their parents in their care.

Compassionate care

- Parents spoke positively about the care provided by staff. One parent said the care was: "Brilliant" another said: "Nursing care was good."
- We observed the nurses caring for children to be communicating with them in a calm relaxed and compassionate manner, using language appropriate to the child's age and level of understanding.
- Nurses were supportive and encouraging to both the children using the service and their parents.

Understanding and involvement of patients and those close to them

- One child told us that the surgeon had been to see them and talked to them about what was going to happen. The child's mother confirmed that the staff had involved them in conversations around their care and that they had received 'good' information before coming into hospital.
- We saw an operating department practitioner (ODP) come to collect an older child to take them to theatre. The ODP involved the child in their pre-operative checks for example, asking the child when their birthday was and what procedure was going to be done. The ODP displayed a relaxed calm, friendly, and compassionate manner towards both the child and their parents.

Emotional support

- Staff provided emotional support to children and parents, for example one child we observed became anxious and distressed. The nurse caring for the child and family was reassuring and calm, spending time talking to and settling the child.
- Staff minimised emotional distress to children by encouraging parents lay or sit beside their children and distracting them whilst they were waiting for their operation. Parents were encouraged to accompany their children to the anaesthetic room and stay whilst their child was anaesthetised.
- Children were able to keep their comforters, for example blankets or favourite toys, with them both before theatre and in the anaesthetic room. In the recovery room, we saw comforters beside children in preparation for them waking from anaesthetic.
- We observed nurses walking parents back from the anaesthetic room, talking to them and giving them information about how long their child was likely to be in theatre. We saw them offering parents refreshments and chatting to them intermittently, keeping them updated and supporting them through their wait.

Are services for children and young people responsive?

Requires improvement

We found that the hospital required improvement in regard to responsive because:

- There was no child friendly information about their hospital visit available for children. The literature that was available was aimed at adult carers and parents.
- Rooms were not adapted to ensure they were suitable for the needs of children and people.
- There was a limited number of toys, although there were some suitable for younger children in the outpatients waiting area.
- The children's and young people's service was small and surgery was undertaken intermittently, however the hospital did not have play specialists to support children and young people during their visit to hospital.

However we found that:

- Operating lists were published in advance to ensure two registered nurses, (child branch) were on duty when children and young people were having day surgery.
- All children and young people were pre assessed prior to surgery.
- Children and young people and their parents and carers received a follow up telephone call within 48 hours of discharge.
- Information was given to children young people and their parents prior to admission for surgery. However, information was not child friendly and easy to read.
- Children and young people were scheduled first on the operating list.
- The hospital had Wi-Fi and children and young people were encouraged to bring in their own electronic devices.
- There was some health promotion information suitable for older children and young people.
- There was a child friendly menu offered to children and young people, this was in addition to the adult menu.

Service planning and delivery to meet the needs of local people

Requires improvement

Services for children and young people

- The services provided reflected the needs of the local population. Services were flexible, offered choice and continuity of care.
- To ensure the safe planning of children's surgical lists all operating dates were published in advance. This ensured that the hospital could plan and be compliant with the Royal College of Nursing guidance and standards, which state a minimum of two registered nurses, (child branch) should be on duty throughout the time in which children are cared for.
- Children were cared for in an area of the adult ward. The physical environment had not been adapted to ensure it was suitable for children and young people's needs.
- There was a daily environmental risk assessment used when children and young people were admitted for day surgery.
- There was no separate waiting area in outpatients for children and young people, although play areas had been provided. Available toys were limited, and there were no books/magazines for older children and young people.

Access and flow

- Services were planned to take account of the needs of children and young people, when being admitted for day surgery, as they were routinely scheduled first on the operating list. The theatre manager and director of nursing confirmed this and we saw that this happened during the inspection. This meant that children and young people's wait was minimised and they could be discharged in a timely manner.
- All children and young people using the services were private patients.
- There was access to the outpatients department from 8 am until 8pm Monday to Friday meaning that if a child had been discharged and parents had any concerns they could call the outpatients department for advice. The consultant in charge of the child's care could then be contacted and if necessary arrangements could be made for the child to be brought into the outpatients' clinic.

Meeting people's individual needs

- Parents were given an information pack which provided a range of information about the hospital and the type of surgery being undertaken. Parents we spoke with told us that the information given was useful and relevant.
- Children admitted for day surgery had their own separate room. Children were cared for in the four rooms closest the nurses' work station. Staff told us that this ensured that children could be easily observed. The rooms were not adapted to ensure that they were suitable for children and young people's needs. Although children and young people were cared for in the same environment as adults, there were some toys available and younger children were offered a colouring book and colouring pencils. The hospital had Wi-Fi access for children to be able to use phones and electronic devices.
- Parents were able to accompany their child to theatres and recovery areas and we saw this on our inspection. Recovery had a dedicated recovery bay for children and young people, however this was separated with a curtain only, and therefore children could be next to an adult in the next recovery bay.
- There were distraction toys available to be used in outpatient areas and there were some toys appropriate for younger children in the waiting areas.
- There was no child friendly or easy to read information leaflets available in the hospital. There was some health education information for young people available at the nurses' work station.
- There was no specialist learning disability nurse working within the hospital; however, good links had been made with GPs, health visiting services and the learning disability nurse at the local acute hospital trust. Advice and further information could be sought if needed.
- The lead paediatric nurse told us that the booking office or the consultant would inform them if a child or young person had a learning disability, so that any special arrangements could be made prior to admission.
- Nurses had teddy bear name badges and brightly coloured tabards over their uniforms.
- Children we saw were in their own pyjamas with their own toys and familiar things with them in their rooms.
- On discharge, parents were given the details of how to get advice if they become worried and if problems were not able to be resolved over the telephone they could bring their children back to the outpatients department, which was staffed from 8 am to 8 p.m.
- Staff told us that all children and young people being treated were pre assessed prior to surgery and we found evidence of this in the records that we reviewed.
- All children, young people, and their relatives/carer received a follow up call within 48 hours of discharge.

Requires improvement

Services for children and young people

Learning from complaints and concerns

- Complaints were handled in line with the hospital's complaint policy. If a child or young person, their relative, carer or parent wanted to make a complaint, they were directed to a senior member of staff in the first instance.
- We saw information on how to make a complaint in the reception and ward area of the hospital. The hospital had a written complaints policy that was in date and stated the process for dealing with patients complaints giving expected timeframes.
- There had been no complaints received relating to the children and young people's service in the previous 12 months.

Are services for children and young people well-led?

Requires improvement

Children and young people's services required improvement in regards to being well led because:

- BMI Healthcare held a children and young people's subcommittee, held every other month, led by BMI's director of clinical services which the hospital's paediatric lead attended. There was no medical representative, for example a paediatrician or paediatric surgeon on this committee.
- There were no specific audits around the children's and young people's service this meant that compliance with national guidelines could not be monitored. This was despite BMI policy requiring an annual audit of the service to be undertaken.
- Although we saw child friendly feedback forms we saw no evidence of responses that had been provided and no evidence of audit and opportunities taken to improve the service.
- There was no evidence that the service for children and young people was discussed or scrutinised at local level.

However, there were areas of good practice:

- There was a vision/ strategy for the service displayed in the rooms where children were cared for.
- The lead paediatric nurse, who had responsibility for leading the service, was passionate and motivated. Support was provided by the director of nursing.
- Registered nurses were caring for children who were over three years old in outpatients and their skills and competencies were monitored and overseen by the lead paediatric nurse.
- Within the hospital, there was a culture of support as staff told us that they were able to speak openly about concerns with the heads of departments and the director of nursing and they felt their concerns were heard.

Vision and strategy for this this core service

- There was a vision for the service displayed in the rooms where children and young people were cared for. The lead paediatric nurse was able to tell us that the vision and strategy was for the service, however, other staff involved in the children's service were not so well informed.
- BMI Healthcare's Care of the Child Policy, the purpose of which was to: 'Deliver a service that meets the needs of children and young people'. The policy set out a vision for how BMI hospitals should be providing care for children and young people. Staff working within the children's service were aware of this vision.

Governance, risk management and quality measurement for this core service

- There was a BMI Healthcare regional children's subcommittee. The lead paediatric nurse at The Saxon Clinic was a member. Issues could be escalated through this committee. The national director of clinical services chaired the committee and actions were cascaded to the director of nursing at the hospital.
- We saw no evidence that children's and young services were discussed regularly at a local level, despite the clinical governance meetings, which were held every other month.
- There had been a vacancy since May 2015 for the hospital's quality and risk manager, for which recruitment had been ongoing.
- There was 100% verification of registration to all respective regulatory bodies, for example Nursing and Midwifery Council.

Leadership / culture of service

- The children's and young people's service was managed by the paediatric lead nurse who was the only registered

nurse, (child branch) permanently employed by the hospital. This lead nurse was passionate and motivated. They had a good working relationship with other staff in various departments throughout the hospital.

- The paediatric lead nurse was integral to the running of the service, supported by the director of nursing.
- The paediatric nurse told us that they reported to the director of nursing and that the senior management team were supportive, visible and approachable.

Public and staff engagement

- The hospital offered children the opportunity to feedback on their experience using a child friendly feedback form, however we saw no evidence of auditing of this survey and therefore improvements that may have been made.
- Staff received a monthly clinical governance bulletin.
- Monthly newsletters from BMI The Saxon Clinic were attached to each member of staff's payslip.
- Information about patient satisfaction levels was also displayed on the hospitals website for review by people who were considering using the services.

Innovation, improvement and sustainability

- The lead nurse had not received an annual appraisal. This has meant that there had not been a recent review of their workload and its sustainability.

Requires improvement

Outpatients and diagnostic imaging

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

Information about the service

BMI The Saxon Clinic provides outpatients services for adults and children in all of its specialties where assessment, treatment, monitoring and follow up are required. This includes medical and surgical specialties, health screening, auditory, physiotherapy, dietetics and speech and language therapy, podiatry, pain management, and a nurse led travel clinic. Services are provided in 12 consulting rooms and a minor treatment room.

Physiotherapy outpatient services are provided in two consultation rooms and a larger treatment area.

Services are provided by consultant surgeons and physicians granted practising privileges, an outpatients' service manager, nursing staff and allied health professionals. The service is also supported by a resident medical officer (RMO) pharmacist and support staff. In the reporting period (October 2014 to September 2015) there were 32,359 outpatient attendances. 13,235 were first appointments and 19,124 were follow-up appointments.

The diagnostic and imaging services are situated in a separate department to the main outpatient department where x-rays and ultrasound scans are carried out.

Since January 2016 a magnetic-resonance imaging (MRI) service is provided on site in a mobile scanner unit supplied by an external provider. At the time of our inspection the MRI was not running at full capacity due to its evolving nature. Mammography and computerised tomography (CT) services were not provided at BMI The Saxon Clinic, but outsourced to an external provider nearby.

Diagnostic and imaging services are provided by 11 consultant radiologists granted practising privileges, sonographers, radiographers and support workers. In the reporting period 4245 diagnostic images were carried out. 2849 of these were diagnostic x-rays including injections carried out under x-ray guidance and 1396 were ultrasound scans.

During our inspection we visited all outpatient and diagnostic imaging areas and considered the environment and equipment. We spoke with 13 members of staff, including managers, nurses, a consultant surgeon and consultant radiologist, radiographers, allied health professionals, support workers and administrative staff. We spoke with seven patients who were using the outpatients and diagnostic imaging services. We looked at records, including seven patient records, and reviewed performance information about the service before and after our announced and unannounced visits.

Requires improvement

Outpatients and diagnostic imaging

Summary of findings

We identified the safety, and leadership of the service required improvement. We rated caring and responsiveness as good.

We inspected the effectiveness of the outpatients and diagnostic imaging services but did not provide a rating because we are not currently confident that, overall, CQC is able to collect sufficient evidence to give a rating for effective in outpatients department.

We found :

- National guidance on cleanliness, hygiene and infection prevention and control was not always complied with. In particular: carpeting, furniture and surfaces could not be adequately cleaned in outpatients; there were insufficient hand washing facilities in physiotherapy, and a lack of dirty utility facilities in the imaging department.
- Reporting of safety incidents was not consistent.
- There were limited available appointments for some imaging services.
- The needs of different people were generally taken into account; however there were no formal arrangements in place to ensure services were able to meet the individual needs of people living with dementia, or a learning disability.
- The arrangements for governance and performance management did not always operate effectively. Some long standing risks associated with infection prevention and control that were known to managers were not fully recognised, assessed or managed, and had no specific time scales attached to action plans. There were limited interim solutions to mitigate the identified risks.

We also saw elements of good practice :

- Feedback from patients and those close to them was positive. People were treated with respect and dignity at all times and were kept informed of their treatment plan and progress.
- Infection rates were low.
- There were arrangements in place for safe and effective medicines management, and to ensure there was sufficient equipment to maintain safe and effective care.
- There were clearly defined systems and processes to keep people safeguarded from abuse. Patients, staff and other people using the service were protected from the harmful effects of ionizing radiation.
- The service was adequately staffed and staff were suitably trained and supported in their learning and development.
- All referral to treatment (RTT) targets for NHS outpatients met the target of 95% or above in the reporting period.
- There was effective multidisciplinary working between nurses, specialist nurses, doctors, and allied health professionals, and staff were able to provide examples of evidence based practice that reflected national guidance.
- Complaints were acknowledged, investigated and responded to in a timely manner.
- Staff satisfaction was good and staff felt motivated and valued.

Outpatients and diagnostic imaging

Requires improvement

Are outpatients and diagnostic imaging services safe?

Requires improvement

We rated the safety of the service as requires improvement.

- The hospital reported 425 incidents in the reporting period, of which only six related to the outpatient service. All six were rated as low or no harm and appropriate action had been taken at the time to prevent similar incidents happening again. However, staff working in the outpatients', physiotherapy and imaging services gave examples of when safety incidents had occurred but had not been recorded on the hospital's incident reporting system.
- There was an infection prevention and control programme in place, led by an infection prevention and control nurse, and supported by a consultant microbiologist. However, national specifications for cleanliness were not always adhered to which meant that patients were not kept safe from the risk of infection.
- The outpatients' facility was carpeted in the majority of areas. This did not meet the requirements of Health Building Notice (HBN) 00-09: Infection control in the built environment.
- There was no preventive maintenance or cleaning programme or specific risk assessment in evidence for carpeted areas as required by (HBN) 00-09 and the National Specifications on Cleanliness (NSC) or The Health and Social Care Act 2008: Code of Practice on the prevention and control of infections and related guidance 2015. Staff were unable to confirm when the carpets, walls or soft furnishings had last been cleaned
- Some of the treatment room wall surfaces and furniture in the outpatients department were not easily cleanable and did not meet the requirements of HBN 00-09.
- Hand washing arrangements in the outpatient physiotherapy service did not meet the requirements of HBN 00-09 or HBN 00-10 Part C: sanitary assemblies. There were no hand washing facilities in any of the treatment areas in the physiotherapy department.
- There was a lack of a designated dirty utility area in the diagnostic and imaging department. This meant staff would have to dispose of clinical waste and hold, reprocess and dispose of commodes, vomit bowls and urinals in the dirty utility area located in the main outpatients' department.

We also found some elements of good in safety :

- Some staff attended a daily 'safety huddle' meeting with colleagues from other departments within the hospital, where they discussed solutions to safety issues such as staffing, equipment and resources, and where raising of safety concerns was actively encouraged.
- Infection rates were low. There had been no reported incidents of hospital acquired methicillin resistance staphylococcus aureus (MRSA) or Clostridium Difficile (C. difficile) infections in the six months prior to our visit. There had been one incidence of methicillin sensitive staphylococcus aureus, and we saw that measures had been taken to prevent and minimise the risk of infection.
- There were arrangements in place for safe and effective medicines management, and to ensure there was sufficient equipment to maintain safe and effective care.
- There were clearly defined systems and processes to keep people safeguarded from abuse.
- Risks to people, who used services were assessed, monitored and managed on a regular basis, including signs of deteriorating health and medical emergencies. Plans were in place to respond to emergency situations.
- Patients, staff and other people using the service were protected from the harmful effects of ionizing radiation used in diagnostic imaging.
- The service was adequately staffed and staff were suitably trained and supported in their learning and development.
- Staff demonstrated an understanding and gave examples of where openness relating to the Duty of Candour had been applied.

Incidents

- Staff understood their responsibilities to raise concerns, record and report safety incidents and near misses, and to report them.
- The hospital reported 425 incidents of which 145 were clinical incidents in the reporting period (October 2014 to September 2015). Six were related to the outpatients and imaging service. All six were considered to be low or moderate impact and had not caused any direct harm to patients.

Requires improvement

Outpatients and diagnostic imaging

- The hospital had reported one never event, in the previous year. A never event is a serious incident that is wholly preventable, as guidance or safety recommendations that provide strong systemic protective barriers are available at a national level, and should have been implemented by all healthcare providers. The never event had not occurred within, or had an impact upon the outpatients and imaging service.
- All deaths were recorded, and mortality and morbidity discussed monthly at the hospital's clinical governance meetings. There had been no deaths within the service, or the hospital, in the previous year.
- Staff understood their responsibilities to raise concerns, record and report safety incidents, and near misses, and to report them. There was a hospital incident policy in place, which staff knew how to access. Not all staff had access to the hospital's electronic reporting system or had been provided with the relevant training to do so. Therefore, they used a paper form to report incidents, which was then entered onto the electronic system after being seen by a senior manager. Staff told us they could not be sure that all safety incidents were reported.
- Staff told us they did not always receive feedback on incidents they had reported or those reported by colleagues.
- Safety alerts received from external sources that required action, for example alerts from the National Reporting and Learning System (NRLS) were circulated to relevant heads of departments and were effectively followed up. This meant appropriate action was taken with regards to any national alerts.

Safety thermometer or equivalent

- The hospital gathered patient information such as hospital acquired infections. The hospital website for patients provided clear information about incidence of Meticillin Resistant Staphylococcus Aureus (MRSA), Clostridium Difficile (C. difficile) and Meticillin Sensitive Staph Aureus (MSSA) and measures that were taken to prevent and minimise risk of infection. There were no reported infections related to outpatients of diagnostic imaging.
- The hospital displayed information on staff noticeboards showing recent overall patient satisfaction rates with services provided and actions taken in response to concerns raised.

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. Staff showed us the BMI policy about being open and honest and understood their responsibilities with regards to the duty of candour legislation.
- Staff provided an example of when the principles of being open had been applied within the physiotherapy service, and we saw this was recorded in the patient's notes.
- Staff told us there was regular discussion about the principles of candour at staff meetings such as the daily safety huddle and we observed this to be the case.

Cleanliness, infection control and hygiene

- There were systems in place to reduce the risk and spread of infection. There was a named nurse for infection control. There was also a system in place for staff to seek expert advice from a named microbiologist, including out of hours. However, we saw some of the treatment room wall surfaces, flooring, and furniture in the outpatients department were not easily cleanable and did not meet the requirements of HBN 00-09. Staff were unable to confirm when cleaning of the wall surfaces, flooring and furniture had last taken place as this was not recorded.
- There was carpet in some of the consulting rooms with a vinyl area around the treatment couch, including rooms where some clinical procedures occurred, as well as corridors and entrances. Carpet should not be used in treatment rooms or areas where body fluid spillage is anticipated, as there is a high probability of body fluid contamination. This did not meet the requirements of Health Building Notice (HBN) 00-09: Infection control in the built environment.
- There was no preventative maintenance or cleaning programme or specific risk assessment in evidence for carpeted areas as required by (HBN) 00-09. Staff were unable to confirm when the carpets or soft furnishings had last been cleaned. There was no plan for cleaning or evidence of a system on which the cleaning was based

as required by the National Specifications on Cleanliness (NSC) or The Health and Social Care Act 2008: Code of Practice on the prevention and control of infections and related guidance, 2015.

- The most recent infection control report (November 2015) stated there had been two incidents of non-compliance with hand hygiene observed and reported by patients in the outpatient service. Patients were apologised to, and re-training of a staff member in aseptic no touch technique had also taken place. There had been no reported cases of hospital acquired infections in the outpatients or diagnostic imaging departments in the reporting period October 2014 to September 2015.
- The lack of hand washing sinks in physiotherapy did not meet the requirements of HBN 00-09 and had been recorded as a risk on the hospital's risk register since 2012. The risks remained unresolved. As part of the mitigating action to manage the risks, antimicrobial hand rubs were supplied in all areas for use by staff, patients and visitors with clear instructions on how and when to use them. We observed they were in regular use. However antimicrobial hand rubs are not effective in destroying all resistant bacteria, for example C. difficile, and therefore this continued to pose an ongoing risk to staff, patients and visitors.
- There was no dirty utility room in the imaging department. This meant that staff would have to dispose of clinical waste and hold, reprocess and dispose of bedpans, vomit bowls and urinals in the dirty utility area located in the main outpatients' department. Access to this area was through a staff corridor and four sets of doors which presented a risk of cross contamination. This had not been identified as a risk.
- Despite some shortfalls, we saw that consulting rooms and treatment areas were generally clean, tidy and well presented. Staff told us that cleaning staff were readily available and responsive, throughout the service. We saw cleaning checklists were generally completed each day that the departments were open.
- The majority of equipment had been cleaned and had a green label marked with a date, time and signature showing it was ready for use.
- Personal protective equipment such as disposable aprons, gloves and goggles were available in treatment areas and appropriately stored, used and disposed of.
- We saw that waste was separated in different coloured bags to signify different categories of waste. Staff signed a label on bins used for the disposal of sharp objects (sharps bins) which indicated the date they were constructed. This was in line with health and safety regulation 5 (1) d, which requires staff to place secure containers and instructions for safe disposal of medical sharps close to the work area.
- Decontamination of instruments was managed through a service level agreement with a BMI Healthcare hub and the local NHS hospital trust.

Environment and equipment

- The departments were clean and tidy with corridors kept free of clutter.
- There was a range of moving and handling and exercise equipment in the physiotherapy department. Staff told us that there was always enough equipment to meet patients' needs. Training and assessment of competence of staff in the use of equipment was in evidence.
- One of the treatment rooms in outpatients had recently been decommissioned due to environmental issues. All of the staff we spoke with were aware of this and told us that alternative arrangements were in place until the issues could be resolved. The impact and sustainability of this interim arrangement had not been assessed. Correct procedures were followed to ensure that the room stayed out of use.
- All electrical equipment we saw was marked as having a portable appliance test, giving assurance that it was safe for use. There was a central register of equipment held by the hospital.
- All lockable cupboards were locked. We saw first aid boxes in clinical areas and offices and that instructions and phone numbers to summon assistance for first aid were clearly visible.
- In all the treatment areas we visited, disposable curtains were used. They were all labelled with the date on which they were due to be changed which in all cases was within six months.
- We saw trolleys used to store equipment to be used in clinical emergencies were checked daily on days when services operated. All drawers and shelves were fully stocked with consumable items and medicines that were in date. Emergency equipment was all clean and ready for use. The automatic electrical defibrillator worked, and suction equipment was in order.
- In accordance with the Ionising Radiation (Medical Exposure) Regulations (IRMER) 2000, a radiation

protection supervisor was available in the imaging department for staff to discuss radiation safety with. There was also a formal arrangement in place for staff to consult with a suitably qualified radiation protection adviser outside of the organisation, for independent advice on complying with the Ionising Radiations Regulations 1999 (IR 1999) and IR(ME)R 2000 regulations. We saw examples of when such advice had been requested and provided.

- Staff in the imaging department told us they received feedback about safety incidents and lessons learned at team meetings. We saw the minutes of imaging team meetings which confirmed this. In addition to this, the imaging manager told us that incidents were discussed at a radiation protection committee, of which we also saw the minutes.
- All radiation protection records were maintained in a radiation protection file in accordance with national and local procedures.
- We observed good practice for reducing exposure to radiation in the diagnostic imaging departments. Lead aprons were available to protect staff working with radiation. Effectiveness of their protection was checked with regular audits with no concerns identified.
- Local rules were available in all areas of diagnostic imaging we visited. We saw appropriate warning signs and lights outside of rooms in accordance with IRMER 2000.
- We saw equipment in diagnostic imaging was serviced regularly and service records were complete and in date for all diagnostic imaging equipment. There was quality assurance of all imaging machines being tested once a week. This indicated that the machines were working as they should. These mandatory checks were based on the ionising regulations 1999 and the IR(ME)R 2000.
- We saw fire equipment and safety instructions clearly displayed and accessible, and that all fire exits were clearly signposted.
- Lighting was bright in treatment areas and additional lighting was available for clinical examinations.

Medicines

- There were arrangements in place for safely managing medicines and medicinal gases, including those used in diagnostic imaging. This included systems for obtaining, prescribing, recording, handling, storage and security, dispensing, safe administration and disposal. We saw that staff had access to guidance on the safe administration of medicines.
- We looked at random sample of medicines' stock and related records and saw that these were reconciled in all cases.
- All areas used to store medicines were secure with restricted access by named staff using a keypad. This included specific procedures for staff to gain emergency access out of hours.
- Prescription stationery, including prescriptions for patients in community settings known as prescription pads, were managed safely. We saw that procedures were followed in line with national guidance to ensure unused prescriptions were securely stored and issued.
- Medicines, including those that required refrigeration, were stored safely, in accordance with local and national guidance, and were all within date. Daily checks of the fridge temperatures were carried out and recorded, and were all within the required range.
- Medicines were supplied by an approved supplier on a named patient basis and checked by pharmacists and pharmacy technicians with appropriate training in this area. The pharmacist ensured that medicines were stored and disposed of in accordance with local and national policies. If medicines were not given, the reason for this was recorded on the patient's medicines administration record.
- Staff received and acted on safety alerts relating to medicinal products in a timely manner.

Records

- The hospital used a largely paper based records system, with the exception of digital images of x- rays and ultrasounds. All the records we looked at were accurate, complete, legible, and up to date, and showed that staff were complying with the hospital record keeping policy.
- Patient records were available at each consultation and included risk assessments such as risks of falls and mobility. They included a GP referral letter or their medical records from a previous appointment.
- The physiotherapy service conducted audits of patient records on alternate months and found good levels of compliance with documentation.

- All computer systems were secure and accessed by staff with individual log in details. We saw that all paper based patient records were securely stored in areas that were accessed by staff using a secure keypad system to ensure patient confidentiality.
- Once records were no longer required after patient discharge they were stored on site prior to being archived off site.
- A records clerk was employed to effectively manage the records to ensure patient records were available as required. A tracking system was used which required records to be signed in and out of the records store. The tracking record was found to have been used consistently and correctly to retrieve and return patient records.

Safeguarding

- There were arrangements in place to safeguard adults and children from abuse that reflected relevant legislation and local requirements.
- Staff understand their responsibilities, had relevant knowledge of and adhered to the safeguarding procedures that were in place. They were able to access the hospital's protocols for safeguarding vulnerable adults and children.
- There had been no reports of safeguarding concerns within the outpatients and imaging service.
- A children's nurse attended the clinic when any child aged three years or under arrived for an appointment.
- The hospital had appointed two individuals as the location leads responsible for adult safeguarding and child safeguarding, respectively, and were trained to level three. There were systems in place to make safeguarding referrals if staff had concerns about a vulnerable adult or child. The staff we spoke with talked confidently about the types of concerns they would look for and what action they would take.
- All staff in the outpatients and imaging service had completed level two adult and children safeguarding training as part of their mandatory training.

Mandatory training

- There were systems in place to require staff to complete mandatory training in a range of subjects. Heads of department were responsible for encouraging staff to attend mandatory training and ensure compliance with attendance.
- Attendance rates for mandatory training for this service were not specified. All staff we spoke with told us they had completed mandatory training in essential safety systems, processes and practices. All staff were up to date with their immediate life support training, that was attended annually.
- The hospital reported that there was 100% compliance with paediatric immediate life support (PILS) training, however we found that in the outpatients department 71% of registered nurses (adult branch) had completed this training. We saw records that confirmed all physiotherapy staff were trained in immediate life support for adults and children.

Assessing and responding to patient risk

- Emergency equipment was available for use in the event of an emergency and staff told us they were trained in its use.
- All staff we spoke with were clear of the procedure to follow if a patient deteriorated when using the services in either outpatients or imaging. Patients who were deteriorating would be transferred to the inpatient service, or where they developed more serious complications, to the neighbouring NHS trust for urgent treatment. All transfers of this nature were recorded as an incident on the hospital's electronic reporting system. We were told by staff that there had been one recent incident of a patient transferred from the outpatients department in such circumstances.
- Staff were aware of the lone working and security policy when services were operating out of hours. Staff told us they felt assured that suitable security measures were in place to keep patients and staff safe.
- There had been a recent simulated training exercise for treating a patient who has collapsed in the new MRI mobile scanner. We noted that the exercise was formally reviewed and reported upon and that some minor policy changes had been made in response, and learning points had been shared with relevant staff.
- In the imaging department staff showed us that a safety questionnaire was completed at the patient's attendance for any diagnostic test before it was performed. This was based on the World Health Organisation (WHO) five steps to safer surgery checklist. This enabled staff to ensure a patient was not over irradiated, in accordance with IRMER regulations.
- There were visible signs to inform women of childbearing age to consider whether they may be

pregnant. The hospital's policy required imaging staff to question a female of child bearing age with regards to the possibility of pregnancy and sign a form to confirm this, which mitigated the risk in this patient group.

- There were alarm systems in place to summon assistance in the event of an emergency.

Nursing staffing

- There was an establishment of 5.6 full time equivalent nurses and 4.2 full time equivalent health care assistants in outpatients. The ratio of nurse manager to team leader was 1 to 1, a ratio of team leader to other nursing staff approximately 1 to 3.6, and a ratio of nurse to care assistants was 1 to 1.7 which meant that there were safe staffing levels.
- There was a 22% vacancy rate for health care assistants in the outpatients' service in the reporting period. The manager told us that staff and rotas were flexed to cope with the demand of clinics, including those that were scheduled at late notice, and that agency staff were never used. Staff we spoke with and the data we looked at, including duty rotas provided confirmation of this.
- There was 100% compliance with the verification of professional registration of nurses working in outpatients.
- Staff duty rotas were planned in advance. Where any changes took place, these were clearly recorded.

Diagnostic and imaging staffing

- At the time of our inspection, staff told us there was a vacancy for the head of department of diagnostic and imaging. An interim manager was in post and recruitment was underway. The interim manager had been supported in a structured induction and orientation to their new role. Some locum staff were also working in the imaging department and had all completed a competency based induction programme. An on call rota ensured that radiographers provided a 24 hour service.

Medical staffing

- Services were provided by medical consultants who had been granted practising privileges. All of the patients were under the care of a named consultant. Patients told us they saw their consultant at each appointment and felt confident that there was clear communication between the medical staff, nursing staff and other therapists.
- The hospital medical advisory committee (MAC) reviewed practising privileges to ensure continued compliance with the agreement.
- 24 hour medical care within the hospital was provided by a resident medical officer who dealt with any routine and also emergency situations in consultation with the relevant consultant. Out of hours consultants provided either telephone advice or attended in person. If a consultant radiologist was required out of hours this was managed through an on call rota system.
- Nursing staff told us they felt well supported by the consultants, both whilst they were on site and if they needed to contact them by telephone out of hours.

Major incident awareness and training

- The hospital had a service contingency plan in place for staff to use in the event of interruption to essential services. Staff were aware of the escalation process if there was an incident requiring a major response.
- Emergency bleep holders were designated each morning at the daily morning department meeting to ensure there were clear lines of accountability and responsibility in the event of an emergency. This included staff from the outpatients' department. We saw the bleep system tested and that staff responded immediately
- The hospital had a service level agreement with the nearby NHS hospital trust for The Saxon Clinic to accept patients, if they had the capacity, in the event of an emergency situation in the locality. The trust were notified daily of the anticipated capacity and any support that could be offered should it be required.

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.

We found :

- Staff in outpatients and imaging generally demonstrated awareness of the best practice guidelines for treatment they should be following. However, there

was mixed evidence with regards to how practice was audited against current evidence-based guidance, standards and best practice. This was partly attributed to some staffing issues.
- There was also limited evidence of patient reported outcome measures in the service at the time of our inspection due to low response rates. This meant that staff were unable to confirm how this information was used to improve patient services.

We also saw some areas of good practice:

- Patients had their needs assessed, their care goals identified and their care planned and delivered in line with evidence-based, guidance, standards and best practice. Patients' nutrition and hydration needs were assessed and met.
- Staff had the right qualifications, skills, knowledge and experience to do their job. Staff were encouraged to take on new responsibilities and work towards developing role related competencies.
- Staff displayed mixed understanding of their responsibilities surrounding consent. The hospital consent forms complied with department of health guidance and staff had an understanding of their responsibilities under the Mental Capacity Act 2005 (MCA).

Evidence-based care and treatment

- Staff in outpatients and diagnostic imaging had a good awareness of and had read local policies. We saw copies of signed sheets indicating that policies had been read recently. Policies we saw were current and within specified review dates.
- Policies were accessible on the hospital intranet and based on professional guidance such as that published by National Institute for Health and Care Excellence (NICE) and the royal colleges.
- Staff were provided with new guidance as it became available through a monthly hospital bulletin.
- Staff gave examples of participation in local and national professional networks relating to their specialism, where they were kept informed of and shared best practice.

Nutrition and hydration

- We saw that the patient's nutrition and hydration needs were assessed and met. We saw that if a patient required either an examination or procedure whereby they had been starved for a period of time, they were offered drinks and a snack once the procedure had been completed.
- Patients could be referred to a dietician who provided a service to the hospital on a practising privileges basis.

Pain relief

- We observed one patient attending the outpatient department for pain management and saw that a comprehensive assessment was carried out by the nurse, using a pain assessment tool. The effects of the pain relieving medicine were discussed and recorded.
- Staff told us they could contact the resident medical officer to prescribe pain relieving medication if necessary.

Patient outcomes

- We asked what national and local audits were carried out to monitor patient outcomes. Staff provided limited evidence of audits or patient reported outcome measures in the outpatients' service at the time of our inspection. There was no routine collection or monitoring of data to compare it to a similar service, or demonstrate whether intended outcomes were achieved.
- There had been one incident of a patient requiring transfer to an NHS facility due to collapsing in the department. This was not related to any clinical procedure.

Competent staff

- All staff were required to complete the BMI corporate and local induction programme, and subsequently develop and maintain competencies specific to their job role on an ongoing basis. We saw records of completed competency assessments for permanent and temporary staff that confirmed this was happening. We also saw one staff member undergoing induction working with a 'buddy,' and the list of competencies they were working towards.
- Staff had clearly defined job descriptions. No staff could recall a situation where they had been asked to act outside of their competence. Staff told us they felt satisfied with the arrangements in place to raise concerns about their scope of practice, should the need arise.

Requires improvement

Outpatients and diagnostic imaging

- The hospital medical advisory committee (MAC) reviewed practising privileges to ensure continued compliance with the agreement. If there was non-compliance with the agreement the executive director would suspend the consultant's privileges, meaning they could not practise until any investigation was concluded. There were no recent examples of when this had happened.
- Managers told us any issues arising from staff performance would be discussed on an individual basis with the staff member and their line manager. Staff provided some examples of where this had happened and demonstrated that correct processes were followed.
- We saw staff were provided with regular in-house learning and development opportunities for a range of topics, including training delivered by product manufacturers of equipment used. External learning and development was also made available to them.
- The figures provided for completed appraisals were over 75% for all staff groups working in outpatients. However figures were not broken down between outpatients, imaging and physiotherapy. Staff we spoke with in the imaging department had not all had an annual appraisal due to staff sickness and vacancies, but plans were in place to complete these. Where staff had completed an appraisal they found the process useful to discuss their progress and career aspirations with their line manager.
- The RMO had received an appraisal. Records showed they were up to date with e-learning, for example, managing anaphylaxis, and safeguarding of adults and children.
- We saw checklists for temporary staff who worked in the service. The manager told us they used the same locum staff on a regular basis. Duty rotas we looked at confirmed this.
- In addition to human resources checks, the relevant managers checked the professional registration of all staff with the appropriate regulatory bodies. These were the General Medical Council, Health and Care Professions Council and Nursing and Midwifery Council.

Multidisciplinary working

- Staff, teams and services worked together to deliver effective care and treatment.
- Staff communicated well between different staff groups within the outpatient and imaging departments and with colleagues from different services within the hospital.
- Staff were able to initiate discussions with other health care professionals in a timely manner.
- Medical, nursing, and other clinical staff reported good relationships with GPs and staff from the local NHS hospital trust

Seven-day services

- The outpatient department did not provide seven day services.
- The imaging department provided a 24 hour a day, seven day a week service for urgent examination requests through an on call service. This included a service to patients in the operating theatre when required.
- The pathology service was provided by an external agency. Phlebotomy services were provided within the hospital and histopathology was outsourced; frozen samples were sent to a local trust for analysis.
- Out of hours pathology services and physiotherapy services were available through an on call system.
- The RMO provided a 24 hour on call service to provide clinical support to surgeons, staff and patients.
- Out of hours an on call pharmacist was available for advice. If prescribed medicines were needed when pharmacy was shut there were arrangements in place for the RMO and a nurse to access the pharmacy stock.
- There was an on call engineer service in place.

Access to information

- Staff had all the information they needed to deliver effective care and treatment. They could access patient information via a secure electronic system using individual passcodes. In addition to this, administration staff had access codes to enable them to follow an individual patient pathway.
- There was timely access to test results in place. Staff accessed pathology test results electronically and in addition to this, the external pathology provider sent paper copies to consultants. This assisted staff to make appropriate decisions about a patients care.
- We saw diagnostic imaging results instantly available. Analysis and reporting took place on site in a dedicated

reporting room where data could be entered onto the hospital's electronic reporting system immediately. We saw that generally, images were reported on within 24 hours.
- Images from other hospitals could be accessed via a secure computer network in the imaging department. Staff could see what previous scans or tests had been undertaken in order that mages did not need to be repeated. This enabled staff to ensure patients did not receive greater doses of radiation than required.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- There was an up to date consent policy that staff were familiar with. Compliance with the policy was not audited.
- There were systems in place to ensure Deprivation of Liberty Safeguards (DoLS) were in place if needed. Staff said this was rare within the service but showed us an example of a recent case where the correct procedures were followed and a patient advocate was asked to attend the outpatients department during the patient's appointment.
- Patients we spoke with told us their consent was sought at each consultation and that the risks and benefits of clinical procedures had been explained to them. We saw that written and verbal consent was documented in all of the patients' notes we reviewed, and that the risks and benefits of treatment had been discussed.
- Mandatory e-learning provided to staff for safeguarding included information about the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS). Staff explained they would contact their clinical lead for advice and involve the consultant and relatives as appropriate. Consultants we spoke with had completed training with other service providers they worked with.

Are outpatients and diagnostic imaging services caring?

Good

We rated caring as good because:

- We observed staff treated patients and those close to them with kindness and respect. Patients we spoke with, and those close to them, were consistently positive of the care and treatment they received.
- We saw that privacy and dignity were upheld at all times, and that the staff were caring and respectful of each other, as well as patients.
- Patients could access both male and female chaperones in the service.
- Call bells were answered immediately, and we saw people approached in a gentle manner.
- Patients were given timely and understandable information to cope with their care, treatment or condition. We saw patients being provided with emotional support.
- Some patients were regular users of the service and described the good rapport with staff, and that they felt reassured by the care offered.

Compassionate care

- Staff treated patients with kindness, dignity and respect. Staff interacted with patients in a positive, professional and informative manner. Patients consistently described the staff as: "Attentive and caring", and told us that the staff always made time for them. We observed this throughout our visit.
- Signs on walls of the consulting rooms offered patients a chaperone if required. In addition to this reception staff asked patients if they would require a chaperone on booking in. Male and female staff acted as chaperones for patients, giving patients a choice in accordance with their preferences.

Understanding and involvement of patients and those close to them

- All of the patients we spoke with told us their treatment was discussed in detail and in a manner they were able to understand.
- Clear information was provided to patients prior to and after their appointment, including information about pricing tariffs.
- Patients had access to a variety of information leaflets in the outpatient and diagnostic imaging departments, including information about medical conditions and referral to more specialist services where required.

Emotional support

Requires improvement

Outpatients and diagnostic imaging

- Patients told us they, and those close to them, felt emotionally supported by staff and had been given information about counselling services if they required.
- Staff felt confident in managing people's emotional needs or referring to more specialist services if required.
- Consulting rooms were mainly single rooms which meant people could discuss their emotional needs in confidence.

Are outpatients and diagnostic imaging services responsive?

Good

Overall, we have rated responsiveness as good.

- Patients were seen promptly for treatment and we saw no evidence of cancelled or delayed appointments.
- All referral to treatment (RTT) targets for NHS outpatients met the target of 95% or above in the reporting period. This meant that all outpatients began their treatment within 18 weeks of referral.
- Care and treatment was coordinated with other services in a timely manner.

- We were told there were no unresolved complaints at the time of our inspection. Patients we spoke with were unaware of the correct complaints process although we saw some evidence that it was accessible. Staff could not recollect any recent complaints management training or where they had learned from complaints.

Service planning and delivery to meet the needs of local people

- There were some shortfalls in how the needs of different people were taken into account. There were no formal mechanisms in place to ensure the service was able to meet the individual needs of people living with dementia, or a learning disability. Staff had not been provided with any training in these areas and were unable to describe any formal links to obtain specialist advice in such circumstances.
- The consultants advised which clinics suited their availability following discussions with the outpatients' manager. This information was then sent to the outpatient staff to book patients. The clinic list was then shared with staff at least two days prior to the clinic.
- Receptionists booked patients in using an electronic system which allowed the reception team to track the patient journey through the hospital. If there was a clinic delay of longer than 15 minutes, the reception team informed patients of the delay and kept them up to date regularly, should this have been required.
- The imaging manager described how staffing was flexible, so the department could provide a service for patients including in the operating theatres.
- The pathology service was provided by an external agency. Phlebotomy services were provided within the hospital and histopathology was outsourced; frozen samples were sent to a local NHS hospital trust for analysis.

Access and flow

- All referral to treatment targets for outpatients being treated under the care of the NHS, met the target of 95% or above in the reporting period. This meant that all outpatients began their treatment within 18 weeks of referral.
- Most of the patients we spoke with had never been kept waiting for an appointment; others told us that if they had to wait, it had been minimal and the reception team informed them of the wait. We observed this happened.
- Some consultants received paper referrals, others received them electronically. There was variation in the time it took from receipt of referral to booking of patients in the radiology department. This was dependent on the type of test required. A protocol was followed for some diagnostic tests, for example if contrast or particular preparation was required. This required additional information prior to the test being booked. This in turn was dependent on a consultant being available to review the request. At the time of inspection, the amount of time this took was not being evaluated.

Meeting people's individual needs

- There was no evidence that information leaflets in outpatients and diagnostic imaging had been adapted for patients with a learning disability, children and older persons, or in other languages. Staff told us interpreter services were available for translation if required. A loop system was provided for people with hearing impairment in the outpatient department.

Requires improvement

Outpatients and diagnostic imaging

- We saw examples where nursing staff and consultants saw patients at short notice at the patient's request.
- Male and female staff could act as chaperones in outpatients and the imaging department, in order to meet the preferences of individual patients.
- Patients had access to drinks and snacks throughout their appointment.
- Staff told us that if a patient attended an appointment which required fasting, they would be offered a drink and a snack following their treatment. We saw that this happened.
- Patients were approached in a calm manner and addressed by name. Staff explained if there was a waiting time. If a patient required directions to a department they were directed or taken to the correct place.

Learning from complaints and concerns

- There was an up to date complaints procedure in place which set out the various stages of complaints and the time scales for responses. Staff understood the complaints procedure and tried to address concerns at the point of service delivery. They told us where they were unable to achieve this they notified the department manager. Depending on the type and seriousness of the complaint this was also escalated to the executive director and director of nursing to ensure the concern was appropriately responded to.
- Complaints were logged on the hospital's electronic reporting system to allow them to be monitored and for completion. However not all staff had access to the system. The number of complaints received by the hospital had decreased year on year from 55 complaints in 2012 to 33 in 2015.
- Complaints were discussed at hospital governance risk management meetings and heads of department meetings. This meant that the more senior staff were aware of learning, but more junior staff told us they did not always have such information shared with them.
- There were no unresolved complaints about the service during the previous year or at the time of our inspection. All of the patients we spoke with told us they had never had a cause to complain or raise any concerns. However, none of the patients we spoke with knew the correct procedure to follow and told us they would probably speak to their consultant or approach BMI Head Office. We saw evidence that the complaints procedure was accessible to patients in leaflets displayed in the outpatients and imaging department.

Are outpatients and diagnostic imaging services well-led?

Requires improvement

We rated well-led as requires improvement because:

- The arrangements for governance and risk management were not always dealt with in a timely way. Some risks that were known to senior managers and that had been recorded on the risk register dated back to 2013 and remained unresolved, with little mitigating action put in place. In particular, the infection risks associated with carpets and inadequate hand washing facilities. Not all risks had been identified or recorded on the risk register: in particular the lack of dirty utility facilities in the imaging department and lack of handwashing facilities in the physiotherapy department.
- The hospital had local strategic objectives; however there was mixed understanding from staff about the vision and values of the department and hospital. There were limited formal processes used to monitor outcomes of care, performance or make decisions, and to obtain the views of people who used the service, staff and other stakeholders. Response rates to patient satisfaction surveys were low although responses indicated a high level of satisfaction.
- There was little evidence of innovation or service development; however we noted the evolving nature of the service and the focus on introducing the new mobile MRI scanner.

We also noted some elements of good practice:

- Staff felt involved in decision making and part of the wider hospital team. Leaders encouraged co-operation and support amongst staff. Staff described how they generally felt respected, that they were able to share ideas and opinions and felt their contribution was valued by the senior management team. There was evidence of teamwork and commitment from staff to ensure the patients were treated well. We observed good team interaction and staff satisfaction.

Outpatients and diagnostic imaging

Vision and strategy for this service

- The vision and values of the service were incorporated into the appraisal system.
- Senior staff we spoke with described the vision and values of the service and felt they had contributed to their development. Junior staff felt less involved and demonstrated a mixed understanding of the vision and strategy. The vision and strategy were on display in the staff dining room.
- Staff told us of the hospital's plans for refurbishment to ensure appropriate flooring and handwashing facilities. We noted these plans and associated costs were discussed at a senior management meeting in November 2015; however there was no evidence when the plans would be implemented.

Governance, risk management and quality measurement

- The majority of staff, including leaders of the service, generally understood the challenges to good quality care and could describe the actions needed to address them.
- Most of the governance processes we saw reflected the hospital's clinical governance policy. This included requirements for a standard agenda at meetings and ensured sub committees produced reports from committees such as the medicines management, infection prevention and control and health and safety committees.
- There were arrangements in place to ensure that quality, risk management and quality issues were monitored and reported upon, including daily 'huddles' and monthly governance meetings to discuss performance and priorities. However not all the actions had specified deadlines, or were assigned to specific individuals. This meant they were often not completed in a timely manner.
- There was an unfilled vacancy for the hospital quality and risk manager which some staff thought may have contributed to the lack of regular monitoring of risk and follow up actions.
- We looked at the hospital risk register. It was not clear how often it was reviewed. Not all of the risks had reports of actions being taken to mitigate risks and had been reported a long time ago. For example, the infection risks associated with carpets in clinical areas and inadequate hand washing facilities in the physiotherapy department, and the infection risks associated with carpeting in treatment areas were known to the hospital senior management team since 2013, with no or limited actions and no immediate time line for resolution.
- Medical staff were represented by specialty at the hospital's Medical Advisory Committee. This meant they had direct access to the hospital executive management team and were able to demonstrate that regular discussion took place to agree actions to improve the service.
- There was a lack of regular audits and a small response rate for patient satisfaction surveys.
- There were regular heads of department meetings where complaints and incidents were discussed. We saw the minutes of these meetings.

Leadership and culture of service

- Staff described how they generally felt respected, that they were able to share ideas and opinions and that their contribution was valued by the senior management team. There was evidence of teamwork and commitment from staff to ensure the patients were treated well. We observed good team interaction.
- Staff we spoke with had worked in the service between four months and 27 years, and described their job satisfaction as high with no desire to move to another organisation. Staff told us this was mainly due to the support they were given by their heads of department in outpatients, physiotherapy and imaging and the opportunities to develop within their role.
- Staff with leadership responsibilities had protected time for their managerial responsibilities and had completed a twelve month leadership training specific to BMI employees.
- The staff sickness absence rate for the hospital was variable and during the reporting period was mainly higher than the England average, at around 10%. However, this had been disproportionately affected by a small number of staff being on long-term sick leave. The average for all healthcare providers, including the NHS, in England is just above 4%.
- There were low levels of staff turnover (less than 20%) between October 2014 and September 2015 for all staff groups. For healthcare providers nationally, moderate staff turnover is between 20% and 39% and high staff turnover is greater than or equal to 40%.

- In the imaging and physiotherapy departments there was a sense of all staff working together as a team including with the medical consultants. Staff told us they felt involved and included in decision making processes. The radiology department staff were knowledgeable about the senior management team and the vision of the hospital.

Public and staff engagement

- Staff received a monthly BMI newsletter attached to their pay slip to ensure timely information about service improvements and safety issues.
- There was an absence of formal systems to ensure public and professional engagement. Staff we spoke with described some methods by which they formally obtained and analysed feedback from patients and those close to them. However response rates were very low and staff could not demonstrate how such information had influenced the development and delivery of the service.
- Response rates to the hospital's patient satisfaction survey were around 70% for the BMI postcard survey and 17% for the more comprehensive survey, with 98% of patients rating their overall care and treatment as good or excellent.
- Some staff felt communication could be better and did not feel involved in the business strategy.

Innovation, improvement and sustainability

- We asked for examples of innovation and improvement. Staff told us the main focus was on planning the new facilities within the hospital which meant there were no other proposed developments until that was complete.
- The recent introduction of the mobile scanner for MRIs was seen as a major development for the imaging service. However its impact was not able to be measured due to its evolving nature.
- The hospital safety huddle meetings were seen to introduce greater awareness about safety issues and reporting.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

Actions the hospital MUST take to improve:

- The hospital must ensure that sinks and taps which conform to Health Building Note 00-10 Part C Sanitary Assemblies are available in clinical areas to allow correct hand hygiene practice.
- Improve handwashing facilities in the physiotherapy and outpatients dirty utility room.
- The hospital must ensure carpets in clinical areas are replaced with flooring that meets the requirements of Health Building Notice (HBN) 00-09: Infection control in the built environment.
- The hospital must ensure that when risks are identified that they are recorded, reviewed regularly and timely action is taken to mitigate them.

Action the provider SHOULD take to improve

Actions the hospital SHOULD take to improve:

- An audit programme should be in place to ensure compliance with national guidance and to measure patient's outcomes.
- The hospital must ensure compliance with national guidance for monitoring and reporting neutropenic sepsis, although the hospital reported that they had not admitted any patients with neutropenic sepsis.
- Implement specific children's and young people's audits, according to BMI policy, in order to measure patients' outcomes.
- Carry out a risk assessment on the children and young people's service and the areas in which children are cared for.
- Review the requirement to make child friendly information available.
- Consider the risks and sustainability surrounding the paediatric service, when one person carries sole responsibility for delivering it.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **Regulation 12 (1)(2)(a)(b)(e)(h)The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Safe care and treatment.** **The provider had not ensured the care and treatment was provided in a safe way for service users that included:** • There was no effective system for ensuring that cords on window blinds were not a risk to children. • There were sinks and taps in clinical departments which did not conform to the Department of Health Note 00-10 Part C: Sanitary Assemblies to allow correct hand hygiene practice. • Some areas where clinical procedures were undertaken were carpeted. This did not meet the requirements of Health Building Notice (HBN) 00-09: Infection control in the built environment. • There was a lack of handwashing facilities within the physiotherapy and dirty utility room in outpatients department. • There was a lack of suitable facilities for disposal of clinical waste in the imaging department.

Regulated activity	Regulation
Surgical procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance **Regulation 17(1) (2)(a)(b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Good governance.** **How the regulation was not being met:**

Requirement notices

- The provider did not operate effective systems to assess, monitor and mitigate the risks relating to the health, safety and welfare of service users including undertaking relevant audits to monitor and improve patient outcomes.
- Risks were not always identified, monitored and mitigated in a timely manner.
- This meant that the provider did not have appropriated systems and processes in place that enabled them to identify and assess risks.