

The state of care in independent acute hospitals

Findings from CQC's programme of comprehensive independent acute inspections



STATE OF CARE

Our purpose

The Care Quality Commission is the independent regulator of health and adult social care in England. We make sure that health and social care services provide people with safe, effective, compassionate, high-quality care and we encourage care services to improve.

Our role

- We register health and adult social care providers.
- We monitor and inspect services to see whether they are safe, effective, caring, responsive and well-led, and we publish what we find, including quality ratings.
- We use our legal powers to take action where we identify poor care.
- We speak independently, publishing regional and national views of the major quality issues in health and social care, and encouraging improvement by highlighting good practice.

Our values

Excellence – being a high-performing organisation

Caring – treating everyone with dignity and respect

Integrity – doing the right thing

Teamwork – learning from each other to be the best we can

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Foreword from the Chief Inspector

Independent acute hospitals play an important role in delivering healthcare services in England, providing a range of services including surgery, diagnostics and medical care. As the independent regulator we hold all providers of health care to the same standards, regardless of how they are funded.

We have now completed our first comprehensive inspection programme of independent non-specialist acute hospitals and, for the first time, we have a comprehensive picture of the quality of care they are providing. Also, importantly, it means that people can now use our reports to help them make choices about their treatment.

We have inspected and rated 206 independent acute hospitals both at an overall level and for the individual core clinical services they provide, for how safe, caring, effective, responsive and well-led they are. The majority of these hospitals are providing high-quality care for their patients. As at 2 January 2018, 62% were rated as good and 8% were rated as outstanding.

We found that most patients had prompt access to effective treatment and experienced personalised care from highly skilled and caring staff. Much of the care and treatment we have seen at independent acute hospitals is good – and we found that effective leadership at a local level, good staff engagement and a close oversight of the services being provided played a key role in ensuring high-quality care.

Our inspections also identified concerns around the safety and leadership of some services, often as a result of a lack of safety checks and poor monitoring of risks. Too often, safety was viewed as the responsibility of individual clinicians, rather than a corporate responsibility supported by formal governance processes. In particular, we found that monitoring of medical governance such as scope of practice of individual consultants was not consistently robust. Such a failure of effective governance was brought into sharp focus with the recent case of the surgeon Ian Paterson. We also found that the sector also needs to do more in monitoring and reporting clinical outcomes.

We have used our inspections and ratings to help independent acute hospitals to understand the specific areas where improvements are needed, to hold them to account to make the necessary changes, to share best practice and to help people to make more informed choices about their care. Where we found failings, we have been clear that improvements must be made, using our enforcement powers where needed to protect people.

Already, our actions are driving improvements in care for people. Providers have been quick to respond to our inspection findings, taking on board our judgements and proactively addressing areas where further work is needed to improve patient care. Of the

13 hospitals that had been re-inspected as at 2 January 2018, seven had improved. Four of these had improved from an initial rating of inadequate: two going from inadequate to good and two going from inadequate to requires improvement.

Encouragingly, we have seen evidence that our regulation is having an impact, with providers taking rapid action in response to our concerns. We want to see this continue and more providers learning from those services that are getting it right.

Professor Ted Baker
Chief Inspector of Hospitals

Summary

The independent acute healthcare sector provides a wide range of surgical, diagnostic and other services. Organisations provide care that is paid for in a number of ways, including self-funding by patients, through private and company medical insurance arrangements, or directly commissioned by NHS organisations and clinical commissioning groups.

It is a varied sector, in terms of the size and services offered within independent non-specialist acute hospitals. The sector is dominated by a number of large corporate brands that each operate a portfolio of hospitals and services.

We regulate independent acute healthcare providers in the same way as their NHS counterparts and we expect them to meet the same standards.

The overall quality of care among the core services provided in independent acute health care is good. As at 2 January 2018, we had rated a total of 509 core services – covering predominantly surgery, outpatients and diagnostic imaging, medical care, services for children and young people and critical care. Of these, 349 core services (69%) were rated as good and 36 (7%) were rated as outstanding. However, 123 (24%) core services were rated as requires improvement and one was rated as inadequate.

We aggregate core service ratings to give an overall rating for each hospital. Of the total of 206 hospitals that we had rated as at 2 January 2018, 128 (62%) were rated as good and 16 (8%) were rated as outstanding. However, 62 (30%) were rated as requires improvement. There were no hospitals with a rating of inadequate.^a

We have seen much good and outstanding care, in particular around:

- **Responsiveness** – this is a strength within independent acute hospitals, with patients having prompt access to treatment and procedures and short referral to treatment times. The managed flow of patients meant that there were few cancellations or delayed admissions or procedures. However, it should be noted that patient groups with increased needs or complex conditions are usually screened out and treated in the NHS.
- **Staff interactions with patients** – patients received a good continuity of care. Staff had the time to provide patients with individualised, one-to-one attention. Staff morale was good, and this had a positive impact on the care that people received. Patients' privacy and dignity were very well respected within independent acute hospitals, where there were more private rooms and en-suite facilities.

^a These are the ratings as at 2 January 2018. Looking at the ratings that we gave following our first inspections, there were four hospitals rated as inadequate. These have now all improved their ratings – see section 4.

- **Effective treatment** – highly skilled staff, supported by pre-selected admissions, were effective in carrying out routine elective procedures, which are the focus of much of the treatment in independent acute hospitals. Staff had excellent completion rates for training. The nature of independent acute hospitals is that patient groups with increased needs or complex conditions are usually screened out and treated in the NHS. We found that there was good pre-admission assessment of patients, which meant that the patients’ needs were well understood and could be prepared for.
- **Leadership and engagement with staff and patients** – in a number of providers, there was strong, visible, local leadership, based on a clear understanding of the service, good staff engagement and a focus on being patient-centred. Innovation, particularly around how conditions are diagnosed and treated using innovative techniques and tools, was a feature of the sector, indicating how independent hospitals continue to strive to improve care and treatment. There was good public and staff engagement in some services, with staff and people who used services providing structured feedback as well as engaging with local communities and others.

However, there were a number of areas where services needed to make substantial improvements:

- **Governance** – there was wide variation in the quality and effectiveness of governance arrangements and a number of examples of poor practice. Some providers did not have formalised governance processes in place, but instead tended to rely on informal arrangements based on longstanding relationships. There was a lack of effective oversight of practising privileges – where the organisation provides the facilities and nursing support, and the consultant clinicians are granted the right to practise in the hospital. This meant that some providers could be reluctant to challenge them. Although not employees of the hospital, regulations set out that consultants working under practising privileges are considered in the same way as directly employed staff, and the provider has the same regulatory accountability for both.

This was compounded in some cases by the ineffectiveness and informality of some Medical Advisory Committees. These are where a group of consultants, who provide services in the hospital, come together to manage the clinical governance of the hospital. We saw examples of Medical Advisory Committees not effectively managing the practising privileges of consultants, for example not ensuring that a consultant was only undertaking procedures they were experienced to do or not undertaking new or innovative procedures without effective risk assessment and monitoring.

There were also examples of poor and inconsistent monitoring of risks, without systematic processes being in place to underpin a robust culture of learning from risks and effective escalation within the provider.

- **Clinical audit** – there needs to be substantial improvement by a number of independent acute providers in terms of auditing, reporting and benchmarking outcomes. We were particularly concerned that some providers were not collecting their own outcome data. There was a lack of understanding at times because of expectations among providers that consultants were monitoring their own outcomes. We have been clear that it is the provider who is providing the care – they are allowing the consultants to work with practising privileges – so they need to be assured and able to demonstrate how the care they are providing is appropriate, and carry out proactive audits.
- **Safety culture** – in some cases there was a lack of a culture of learning from incidents and a weakness around incident reporting, where systems may have been in place but were not as robust as they needed to be. There were risks in operating theatre safety due to informal practices and consultant behaviour. For example, we saw a few instances where the World Health Organization surgical checklist was not being followed rigorously and this was not always sufficiently challenged by staff within the operating theatre. There was a lack of preparedness for patients whose condition could deteriorate. This is a necessity even where pre-assessment screening has ensured that the majority of patients are ‘well’ and fit for surgery.

Since the start of our comprehensive inspection programme, where we have identified that improvement has been needed, we have generally been impressed with how quickly providers have responded to our findings and taken action. For these organisations, they have accepted our judgement, taken on board our findings and the areas for improvement, and gone on to improve.

We have been encouraged to see locations being a lot more open with each other within their own provider organisations, and discussing how they can share learning across sites – taking the learning they receive from our inspections and learning from each other in response.

1. Introduction

The independent acute healthcare sector provides a wide range of surgical, diagnostic and other services. Organisations provide care that is paid for in a number of ways, including self-funding by patients, through private and company medical insurance arrangements, or directly commissioned by NHS organisations and clinical commissioning groups. As well as the different types of services and funding arrangements, there is also variation in the size and shape of providers.

The sector is rapidly changing in order to meet demand. Independent healthcare plays an important role in delivering healthcare services in England, with many providers providing services that are funded either wholly or partly by the NHS. NHS Partners Network calculated from NHS England statistics that, in the 2017 calendar year, 515,000 NHS elective admissions were in the independent sector; this was about 6% of total NHS elective admissions.^b

Independent acute healthcare is a varied sector, in terms of the size and services offered within non-specialist acute hospitals. The sector is dominated by a number of large corporate brands that each operate a portfolio of hospitals and services.

We regulate independent acute healthcare providers in the same way as their NHS counterparts and we expect them to meet the same standards. When we register, monitor and inspect services, we ask the same five key questions of each service: are they safe, effective, caring, responsive and well-led? After we have inspected services, we give each hospital location one of four ratings of quality: outstanding, good, requires improvement or inadequate.

The main core services provided by independent acute hospitals are surgery, and outpatients and diagnostic imaging. They also provide, to a lesser degree, medical care services, services for children and young people, and critical care. There is a strong focus on efficiency and throughput of routine procedures, including for NHS-funded patients.

Challenges for the sector

There is continuing growth of independent healthcare providers delivering surgical procedures and elective care, and in the provision of components of services in NHS trusts.

Services are changing to meet market demand, and growth is anticipated in particular in the independent provision of digitally enabled diagnostics and imaging. Independent

^b <https://www.nhspn.org/wp-content/uploads/2018/03/NHSPN-independent-sector-infographic-2018.pdf>

providers are starting to evolve their services, becoming more integrated within the patient pathway and providing part of a service such as dermatology services within an NHS trust, MRI/CT services, or minor injury services.

Services largely work within a competitive financial context that is somewhat different to the NHS – providers need to maintain their profitability and financial viability. This is a challenge for the sector in the current financial climate, and in addition the different corporate structures involved can create uncertainties when ownership changes hands, sometimes for reasons unconnected to the delivery of care itself. The competitive nature of the sector creates an incentive for less transparency about clinical outcomes and benchmarking of patient data, and sharing of information in the interests of encouraging improvement across all services.

Within the sector, there is a lack of nationally mandated data collections to evidence effectiveness and allow similar services to be easily compared. This is an area that needs more focused attention. Improvements may be possible through the Private Healthcare Information Network (PHIN), a government-mandated scheme to gather and share information about private acute healthcare, including outcomes data for benchmarking and audit.

PHIN published its first data in May and August 2017, including 149 common procedures at 286 hospitals: the number of patient admissions, typical lengths of stay, and patient satisfaction. However, there had been delays in providers submitting the required information, and there was some concern that progress towards data completeness was very slow, which has impacted on PHIN's ability to publish fair and accurate measures of performance.

This is an area in which CQC is having an impact. We require providers to monitor their clinical outcomes and compare them to external benchmarks. We are also working with medical insurers to share data on clinical outcomes, so that we can look at themes and trends and identify outliers, as well as share information on specific concerns about individual providers and locations.

This report

This report set out the findings from our programme of comprehensive inspections of independent non-specialist acute hospitals, which we started in January 2015. We provide data on all the ratings we have given to these hospitals as at 2 January 2018 – overall and key question ratings for all locations as at that date are set out in the appendix.

The report provides a comprehensive overview of the quality of care provided by the independent acute hospitals sector, and establishes a baseline from which to assess future changes in quality. It is important to note that the ratings as at 2 January 2018 will include

some locations where improvements have taken place since they were first rated. We discuss this further in section 4.

One of CQC's fundamental aims is to encourage improvement. To find out what drives high-quality care, as well as where care needs to improve, we carried out 16 semi-structured interviews with senior CQC inspection staff, and a sample of 44 location inspection reports, which amounted to 21% of all independent acute inspection reports published at the time of sampling. The sample was stratified to ensure coverage from across CQC's four regions and across all four rating bands.

The analysis focused on understanding the characteristics of care rated as good or outstanding, the characteristics of care rated as requires improvement or inadequate, and any variations in the core services of surgery, medical care, children and young people, and outpatients and diagnostic imaging.

2. Overall quality of care

Key points

- The overall quality of care among the core services provided in independent acute health care is good.
- Out of a total of 509 core services, 349 (69%) were rated as good and 36 (7%) were rated as outstanding.
- However, 123 (24%) were rated as requires improvement and one was rated as inadequate.
- Surgery and outpatients and diagnostic imaging performed well overall.
- Services for children and young people need to improve, with a substantial minority of services rated as requires improvement (14 services, 38%) or rated as inadequate (one service, 3%).

Our ratings of independent acute hospitals give a clear indication to the public about the quality of the services provided by them. They also act to encourage improvement, as a provider rated as requires improvement or inadequate can understand where it needs to make improvements and aspire to achieve a higher overall rating.

Our ratings look at the whole picture of independent acute care, providing ratings at:

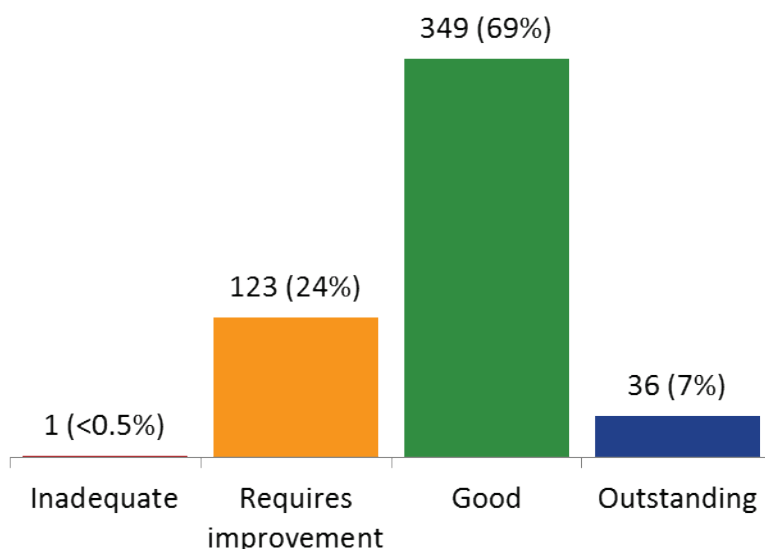
- core service level (where patients directly experience the quality of care being given, for example surgery)
- hospital (location) level (where ratings are combined from each of the core services delivered at these hospitals).

2.1 Ratings of core services

The overall quality of care among the core services provided in independent acute health care is good.

As at 2 January 2018, out of a total of 509 core services, 349 (69%) were rated as good and 36 (7%) were rated as outstanding (figure 1). However, 123 (24%) were rated as requires improvement and one was rated as inadequate.

Figure 1: Overall ratings for core services



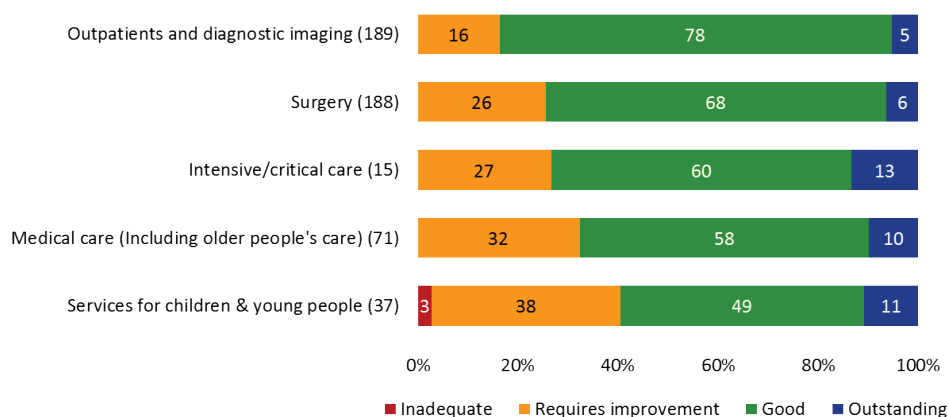
Source: CQC ratings data, 2 January 2018, 509 core services

The overall profile of the ratings for core services in independent acute locations is broadly similar to that for small acute NHS healthcare sites that do not provide emergency care. However, it is not really valid to compare independent and NHS services in this way. The independent acute sector generally focuses on patients with single conditions and routine, elective surgery. The NHS cares also for very different types of patient – those with more complex or multiple conditions, including dementia. NHS acute hospitals also mostly provide urgent and emergency care and admit patients through an emergency department, which the independent sector does not. Independent hospitals therefore have the advantage of not facing the pressure from emergencies that most NHS acute hospitals do, but this means they have less expertise and infrastructure to manage very unwell and deteriorating patients.

Overall, in independent acute healthcare, outpatients and diagnostic imaging services received the highest ratings, with 78% of services rated as good and 5% rated as outstanding (figure 2). This was followed by surgical services, with 68% rated as good and 6% as outstanding.

Services for children and young people needed the most improvement. While 49% of these services were rated as good and 11% as outstanding, 38% of services were rated as requires improvement and 3% were rated as inadequate.

Figure 2: Overall ratings for individual core services



Source: CQC ratings data, 2 January 2018

Note: this chart does not show nine core service ratings that are included in figure 1: six urgent and emergency services, two end of life care and one maternity and gynaecology rating.

Surgery

Surgical services are the main focus in independent non-specialist acute hospitals, and the quality of care in surgery is generally good. Sixty-eight per cent of services were rated as good and 6% as outstanding as at 2 January 2018.

This is where providers' experience lies, and there is a large throughput of routine operations and procedures. In good and outstanding services surgeons are skilled, having completed the same procedures many times. They are supported by experienced, specialist surgical nurses.

Independent hospitals are able to select the routine operations that they offer, and mostly screen out complex cases such as people with complex or multiple medical conditions, as many hospitals do not have post-operative high dependency or critical provision. Many providers also aim to screen out patients with dementia or a learning disability, as they do not have sufficient provision to meet their individualised care needs when undergoing surgery. However, to ensure the quality of care, we found that it is important that providers do have provision for meeting individualised care needs, such as dementia, where treatment is provided to people with this condition.

This focus on the efficient throughput of 'well patients' requiring routine procedures did mean that some services were not set up to anticipate and handle emergency situations, such as a patient with a deteriorating condition post operatively. Some independent hospitals rely on having an arrangement with a nearby NHS hospital, so that if a patient's condition did deteriorate, they could transfer them. However, we found that there were not always formal arrangements in place with NHS providers to underpin this approach.

In addition, we found that, if a patient had to go back to theatre with post-operative complications, there was often a reliance on contacting essential staff by informal routes. There were examples of insufficient reliable arrangements for ensuring clinical staff were available when needed, for example on-call rotas for anaesthetists and surgeons.

On our inspections, we were also concerned about the informality that we sometimes found within the operating theatre – for example, some theatre teams were not following effectively the World Health Organization five-step surgical safety checklist, and this was not always sufficiently challenged by staff within the operating theatre.

While in many cases services had high-quality surgical environments and equipment, occasionally operating theatres were not meeting current standards and in some cases were cluttered and not clean.

Outpatients and diagnostic imaging

The quality of care in outpatients and diagnostic imaging was generally very good: 78% of services were rated as good and 5% as outstanding. People's experience of going to an outpatient appointment tends to be good. The turnaround time for reporting diagnostic tests is generally quick and, as time-keeping is usually good, patients do not need to wait and there are very few cancellations.

Medical care

Medical care is usually a smaller service within independent non-specialist acute hospitals (although some providers are starting to grow, for example, their cancer units). Most admit very few medical patients; these are often cared for in the same wards as surgical patients and are looked after by the same ward staff or team.

Where there is a focus on medical care, we rated 58% of services as good and 10% as outstanding. The medical care provided tends to be very specialised and we found that, because they were quite small and specific, they were generally well managed. Oncology services could be an area of excellence, with a specialist focus and an individualised service.

Where improvements were needed, these tended to be in common areas of safety and effectiveness across the core services, such as incomplete or illegible records and limited clinical audit.

In terms of the treatment of older people, one area that was lacking was in dementia care. There was an overall lack of specialist provision for people living with dementia, as many providers aimed to screen out many of these patients. While many patients received one-to-one care and attention, those caring for them did not always have the specialist knowledge or sufficient access to specialist advice, which is necessary to care for these patients adequately. Providers did not always have the necessary procedures in place to support staff in these circumstances.

Children and young people's services

Services for children and young people are not widespread in the independent sector. Where services were being delivered, we found that many were not delivered well. While 49% of services were rated as good and 11% as outstanding, a substantial minority (38%) were rated as requires improvement and 3% were rated as inadequate.

Where they were outstanding, services had the right staff with the right skills, and the right escalation processes in case of problems. They had good outcomes in relation to best practice and national guidance, and they met the needs of the children and their parents, emotionally and psychologically.

For those services that need to improve, this tends to be where they treat very low numbers of children. We found that these services were not providing sufficiently trained staff, or adjusting the environment to meet the needs of children. Another concern was low compliance with safeguarding training requirements. Children could often be treated as 'small adults', with no specialist environment, equipment or staffing, and being cared for in rooms and facilities used by adults, without recognition of the child's needs.

Because of low numbers of children and young people accessing independent services, there could be a lack of specialist paediatric staff on site. As staff did not get experience with high numbers of children, this had implications for their ability to recognise issues such as safeguarding concerns. Staff might also be unable to retain their knowledge, skills and experience when their hospital treated very low numbers of children. We also had concerns at some services about having the correct experienced clinical support for a deteriorating child.

We have seen a number of instances where independent providers have withdrawn from treating children, including just before or shortly after a CQC inspection. Some providers have opted to bring together expertise in regional centres, and have stopped seeing children in their general hospitals. Providers are now more aware, following our inspections, of the training and experience that is needed to get staff competencies up to a standard where they are able to care for children effectively, and the need for more proactive planning around quality monitoring and consistent oversight of children's services.

Critical care

There is generally only a small amount of critical care provided within independent acute hospitals: 15 rated core services in total. Of these, we rated nine services (60%) as good and two (13%) as outstanding.

For those that do not have critical care facilities, we sometimes found a dependence on 999 NHS emergency services if an inpatient deteriorates. In many cases, providers did not have appropriate service level agreements in place with NHS trusts to proactively address this gap, and there needed to be more formal arrangements for critical care support provided to independent hospitals by NHS trusts.

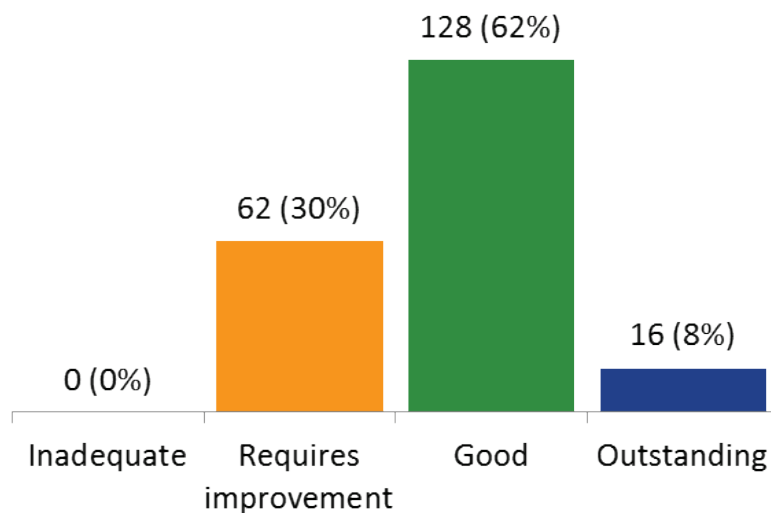
2.2 Ratings of locations

We also provide ratings for independent acute hospital locations, by aggregating the ratings that we award at each core service level.

At location level, the overall ratings were broadly similar to those for the core services. As at 2 January 2018, out of 206 locations, 128 (62%) were rated as good and 16 (8%) were rated as outstanding (figure 3). However, 62 (30%) were rated as requires improvement. There were no locations with a rating of inadequate.^c

Appendix 1 shows the overall and key question ratings for all 206 locations as at 2 January 2018.

Figure 3: Overall ratings for locations



Source: CQC ratings data, 2 January 2018, 206 locations

Examples of locations rated as outstanding: Horder Healthcare, May 2017

The Horder Centre (THC) in East Sussex, operated by Horder Healthcare, provides orthopaedic, reconstructive and total hip, knee and shoulder replacement, physiotherapy, rheumatology, hand therapy, spinal surgery and chronic pain services. One of THC's values was caring, which was embedded throughout the organisation from recruitment of staff

^c These are the ratings as at 2 January 2018. Looking at the ratings that we gave following our first inspections, there were four hospitals rated as inadequate. These have now all improved their ratings – see section 4.

and as part of their performance management. This was part of 'The Horder Way', which all staff were requested to sign up to as part of their induction.

THC was part of the Specialist Orthopaedic Alliance leading on orthopaedic service redesign as part of the national Vanguard project for NHS England. THC had undergone a complete refurbishment and redevelopment programme over the previous eight years to create a therapeutic environment to aid patient recovery ensuring the flow of services within the building matched the patient pathway.

Medical Advisory Committee (MAC) meetings were undertaken quarterly. As part of a consultant's practising privileges, they were required to attend at least two meetings a year. MAC meeting minutes showed that the meetings were used to discuss improvements to patient care and ensure care was evidence-based.

The MAC reviewed practising privileges every year. This included a review of patient outcomes, appraisals, General Medical Council registrations and medical indemnity insurance. The hospital had a process to ensure all consultants were experienced and fit to care for patients.

The teams were also responsible for ensuring investigations took place and learning was shared. This included feedback from audits, incidents, serious incidents requiring investigation and never events. They were also responsible for communicating any recommendations from the National Reporting and Learning System, Health and Safety Executive, Medicines and Healthcare products Regulatory Agency and other safety alert notices to all staff across the centre.

We found areas of outstanding practice in surgery:

- The hospital told us it was the first hospital to submit data to the Private Health Information Network (PHIN). PHIN is an independent, not-for-profit organisation that publishes comprehensive data to help patients make informed decisions regarding their treatment options, and to help providers improve standards.
- The service had direct access to electronic information held by community services, including GPs. This meant that hospital staff could access up-to-date information about patients, for example details of their current medicines.
- THC had successfully been accredited with venous thromboembolism (VTE) exemplar status. Organisations are awarded VTE Exemplar Centre status if they are able to demonstrate that they are delivering best practice as defined by the NICE Quality Standard for VTE prevention (QS3) and are taking an active role in their own local area in relation to disseminating best practice – for example, hosting VTE study days, educational events, contributing to publications and undertaking research.

Examples of locations rated as outstanding: Spire Cheshire Hospital, May 2017

Spire Cheshire Hospital is operated by Spire Healthcare plc. The hospital has 50 beds which could be occupied by inpatients or day-case patients. The hospital provides surgery, and outpatients and diagnostic imaging for adults and children and young people from birth to aged 17 years.

The hospital championed a proactive approach to raising standards and seeking improvements. They engaged with the public, community groups and staff to solicit ideas and canvass opinion, responding to feedback by acting on areas highlighted and implementing initiatives to promote satisfaction and increase their responsiveness.

The hospital was managed by a visible, competent and enthusiastic team who placed patient care as central to their success. The team inspired and motivated staff and promoted a collective ethos of patient care and improving standards.

Quality measurement and improvement was assisted by effective and well organised management and governance structures at a local level. Managers were not only aware of the risks and challenges they needed to address, but were dynamic in identifying areas for improvement and actively implementing quality advances.

In the surgery service, staff had adopted a flexible approach to working during times of high demand, with staff working together with a strong team ethos. Patients were offered flexibility in their access to treatment, and operating theatres provided surgery services to patients seven days a week. Patients could choose an appointment to suit their personal circumstances.

Theatre lists were planned around patients' needs. For example, patients with dementia or a learning disability could be placed on the beginning of the theatre list to reduce the amount of time they needed to spend at the hospital, thus reducing any anxiety. Discharge planning took place at the pre-operative assessment stage, to ensure there were no impediments in meeting the needs of patients with complex needs.

In outpatients and diagnostics, the hospital consistently exceeded performance targets around referral to treatment times for NHS patients. Appointments were flexible and the needs of NHS patients were accommodated. No patients waited longer than six weeks for magnetic resonance imaging, computerised tomography or ultrasound scanning.

All patients received comprehensive instructions and information with their appointment letters and we observed information packs containing additional useful information. Staff were aware of the hospital's values of delivering high quality clinical care supported by a customer focused service model and felt connected to the wider Spire network through management feedback and the sharing of information and good practice.

There were joined-up committee meetings which worked together to monitor, identify and respond to risks, incidents and key issues. Quality and performance were monitored through the Clinical Scorecard and key performance indicators.

The views of patients were actively sought within outpatients and diagnostic imaging using the NHS Friends and Family Test, patient satisfaction surveys and patient feedback initiatives. A child friendly feedback form was also available. A patient engagement forum had been launched to obtain feedback from past patients to improve the patient journey for future patients.

3. What drives good care, and where does care need to improve?

Key points

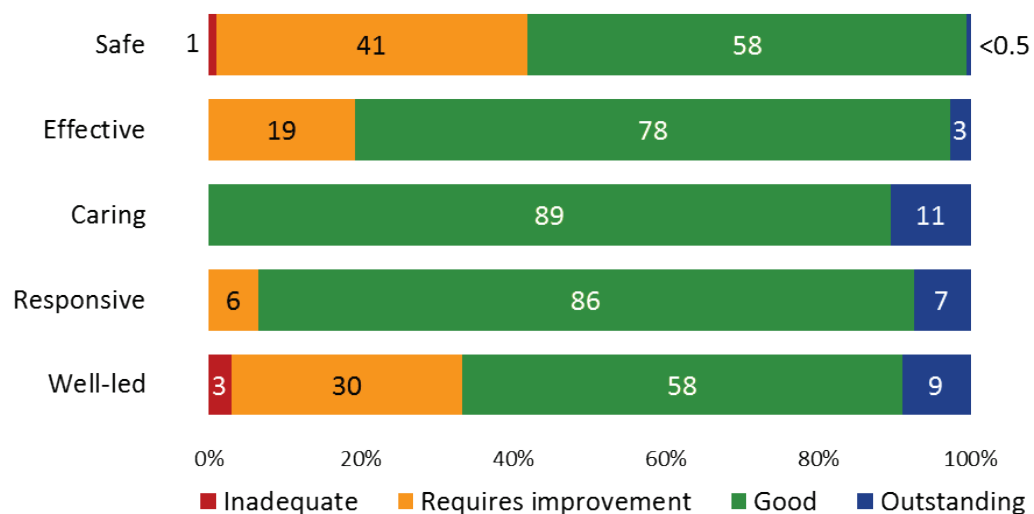
- We have seen much good and outstanding care, in particular around responsiveness of services, staff interactions with patients, effective treatment, and leadership and engagement with staff and patients.
- There were a number of areas where services needed to make substantial improvements, in respect of governance, risk management, clinical audit and safety culture.

We carried out analysis of a range of inspection reports for independent non-specialist acute hospitals, and interviewed senior CQC inspection staff, to establish the factors that underpin the good and outstanding care that we have found and also to highlight where services need to improve.

3.1 Key question ratings

Figure 4 shows the overall ratings for the 206 independent acute hospitals, as at 2 January 2018, broken down into the five key questions that we ask of all the services that we regulate.

Figure 4: Overall ratings for key questions



Source: CQC ratings data, 2 January 2018, 206 locations

We found that hospital providers and staff were overwhelmingly good (89%) or outstanding (11%) for providing a caring service. Similarly, the responsiveness of independent acute services was very high, with 86% of hospitals rated as good and 7% rated as outstanding.

Where we have concerns, it is in the safety of services – where 41% of hospitals were rated as requires improvement and 1% as inadequate – and in aspects of governance and leadership, where 30% of hospitals were rated as requires improvement and 3% as inadequate.

3.2 Good and outstanding care

We found a range of outstanding and good practice within independent acute health care across all of our five key questions.

In particular, the responsiveness of the independent acute healthcare sector is notable, with 86% of hospitals rated as good and 7% rated as outstanding as at 2 January 2018.

Responsiveness

Responsiveness is generally a great strength in the independent healthcare sector. Patients and insurers are paying for prompt access to treatment and procedures. Short referral to treatment times and turnaround of results are some of the benefits that the sector offers. Evening and weekend appointments are common in the sector, in response to patients' needs and expectations and also partly because this is when consultants are available around their NHS commitments.

In our inspections, we found that the responsiveness of independent acute providers was strong, as patients were more likely to have named consultants and good access to services. The managed flow of patients meant that there were few cancellations or delayed admissions or procedures.

This responsiveness was particularly notable in relation to outpatient and diagnostic imaging services, where accessibility and low levels of cancellations formed a key part of a high quality service.

“There was great flexibility in accommodating patients’ choice of appointment time and date, with appointments being offered to suit patients’ circumstances, including evenings and at weekends. Double or treble appointments could be allocated for patients to get actions completed on the same day, to prevent them having to undertake long journeys. Some appointments and treatments were available at very short notice. The hospital provided satellite clinics in other locations to enhance convenience and choice.”
CQC inspection report

Staff interactions with patients

Our inspections showed that there were not the same staffing issues in independent acute healthcare as in other sectors, such as shortages and high turnover. This meant that patients received a good continuity of care. Staff morale was generally good, and this had a positive impact on the care that people received. However, while staffing numbers were generally good, there were some examples where nurses lacked specialist knowledge required to care for all patients on their ward.

Our inspections showed that staff were able to spend more time with patients and this supported their very caring attitude: 89% of hospitals were rated as good for caring, and 11% as outstanding as at 2 January 2018. Patients' privacy and dignity were very well respected within independent acute hospitals, where there were more private rooms and en-suite facilities.

Patient feedback was very positive. Consultants in independent acute services were able to take the time to explain procedures to patients, explaining the benefits and potential risks of treatment, so that patients were able to make an informed decision. Staff had the time to provide patients with individualised, one-to-one attention.

Effective treatment

We found that highly skilled staff, supported by pre-selected admissions, were effective in carrying out the routine elective procedures and operations which are the focus of much of the treatment in independent hospitals. Examples were often in specialist areas such as oncology. Overall, 78% of hospitals were rated as good for their effectiveness, and 3% were rated as outstanding as at 2 January 2018.

The nature of independent acute hospitals is that patient groups with increased needs or complex conditions are usually screened out and treated in the NHS. We found that there was good pre-admission assessment of patients, which meant that the patients' needs were well understood and could be prepared for. We saw staffing models being flexed efficiently to meet these needs.

Some providers – particularly the larger corporate providers – audited and reported their outcomes, and those hospitals with very good outcomes were keen to share their success stories within their own organisations. Where this was happening, information generated was sometimes used at a corporate provider level to drive up performance at a local level.

Staff were often seen as highly skilled and had excellent completion rates for training. Some staff were encouraged and motivated to gain additional specialist skills. Some of the larger organisations supported their staff with benchmarking and league tables on training.

“Staff were encouraged and motivated to take part in learning opportunities provided by the hospital. Learning included Masters degrees, and specialist training in renal, intensive care and cardiac conditions.”
CQC inspection report

However, we found that multidisciplinary team meetings were not consistently robust in ensuring that the right clinicians were involved, and in the provider having sufficient governance to make sure their patients had been discussed where meetings took place on another site.

Leadership and engagement with staff and patients

We came across many instances where there was strong, visible, local leadership, based on a clear understanding of the service, good staff engagement and a focus on being patient-centred. This helped to create a positive organisational culture. Overall, 58% of hospitals were rated as good for the quality of their leadership, and 9% were rated as outstanding.

An important element was making sure that corporate and local level leadership worked well together. While CQC does not currently inspect at a corporate provider level, we could see that well-led services had built on corporate vision, values and governance processes and encouraged their teams to align their local vision and values to the central ethos. These local services would feed information through to the corporate board, and the board would review this and gain assurance from all their locations in this way.

“The hospital director and the matron were instrumental in leading positive and welcome changes to the hospital for both patients and staff. Their passion and commitment to their cause was both inspirational and infectious and without exception staff told us they had led the hospital to its current much improved position. The management strategy and style was both inclusive and supportive. Staff felt valued, satisfied and encouraged. Managers provided opportunities to contribute to initiatives and ideas and felt empowered and inspired to strive for advances in quality and patient care.”
CQC inspection report

Innovation, particularly around how conditions are diagnosed and treated using innovative techniques and tools, was also a feature of the sector, indicating how independent hospitals continue to strive to improve care and treatment.

“The radiotherapy department in collaboration with a London NHS trust has led a unique scalp sparing technique study. The study is aimed at improving the quality of life of patients requiring whole brain radiotherapy treatment, by trying to remove the side effect of hair loss at such an emotional time in the patient’s life. The study was the winner of the LangBuisson 2015 award for Innovation in Care.”
CQC inspection report

We found that public and staff engagement was strong in some locations, with staff and people who used services providing structured feedback as well as engaging with local communities and others. Where engagement was good, staff felt more engaged and involved and this was reflected across the organisation.

“A children and young people’s satisfaction survey had been developed to capture service user feedback from children, young people of all ages and their parents. The survey responses were small (six) as this was a pilot of a small service. All responses were positive and praised the care and support of all the staff the child and their parent had come in contact with throughout their care episode. The survey encouraged younger children to draw their experiences on the form. For example, a child had depicted themselves as having ‘new super powers’ following their surgery. The survey had been piloted, and following a review would be circulated to all children and young people attending the hospital.”
CQC inspection report

The safety of care was one of the main areas that needs to improve in independent acute hospitals (see page 29). Overall, 58% of hospitals were rated as good for safety as at 2 January 2018.

However, those that did perform well in respect of safety were focused on how risks to patients are assessed and their safety monitored and maintained – for example, training on the management of deteriorating patients, being accredited with venous thromboembolism exemplar status and assessing the risk of and responding to low staffing levels. They also ensured they had reliable systems, processes and practices in place to keep people safe. Among examples were having outstanding completion rates for mandatory training, innovative medicine management processes, excellent cleaning standards and having direct access to off-site electronic patient records.

Two hospitals received an outstanding rating for safety as a result of their robust implementation and embedding of safety systems and processes.^d

^d One of these was Nuffield Health Brentwood Hospital, featured in the boxed example below. The other was Shepton Mallet Health Partnership – the provider of this service has changed since the rating was given, and therefore the service does not currently have a rating.

Nuffield Health Brentwood Hospital, rated as outstanding for safety 14 June 2017

Brentwood Hospital in Essex is operated by Nuffield Health. The hospital opened in 1970 and it primarily serves the communities of Brentwood, Billericay, Basildon and Romford. It also accepts patient referrals from outside this area.

Surgery was the main activity at the hospital. The hospital had 41 inpatient rooms, and there was also a double room for the close monitoring of patients who had undergone microvascular Deep Inferior Epigastric Perforator flap breast reconstruction. The theatre department consisted of one digital theatre, three laminar flow theatres, and one endoscopy theatre with an adjacent endoscopy processing suite. There were six recovery bays, one of which was designated for children and young people.

Brentwood Hospital demonstrated a range of good and outstanding safety practice:

- Infection prevention and control was being maintained with innovative examples, such as experiments to show the amount of bacteria that was present on jewellery or after touching a door handle to emphasise the importance of good hand hygiene.
- The hospital was following a 'human factors' approach when investigating incidents. For example we reviewed one investigation which considered the training and competency of staff as well as custom and practice, as part of the review process.
- The safeguarding lead ran training days each month – training included 'Prevent' training to help staff identify individuals at risk of radicalisation and awareness of female genital mutilation.
- There was a good level of understanding of the duty of candour among staff, and actions and learning from incidents were discussed.
- There was a high level of compliance with mandatory training.
- Records were stored securely. We were shown the online, password-protected system for consultants to access the notes for their private patients, meaning consultants did not have to carry any patient records with them.

3.3 Where care needs to improve

Where services needed to improve, this was focused particularly in the areas of safety and leadership. In terms of safety, 41% of hospitals were rated as requires improvement and 1% were rated as inadequate as at 2 January 2018. For well-led, 30% were rated as requires improvement, and 3% as inadequate.

Governance

A significant concern that has arisen from our inspections is a substantial variation in the quality and effectiveness of governance arrangements and a number of examples of poor practice.

Some providers did not have formalised governance processes in place, but instead tended to rely on informal arrangements based on longstanding relationships – of people ‘knowing’ each other and assuming all was well. In these cases, there is a real danger that poor practices are not picked up or challenged in the way they should be.

This can have a significant impact on the safety of services, in particular where familiarisation and subsequent informality in processes may mean that systematic and robust safety procedures are not sufficiently in place to protect patients from harm. While we found evidence of this across the sector, including locations within larger corporate providers, we found that this was evident in some smaller providers where they have less formal risk management processes in place.

“The provider must ensure that there are effective governance, reporting and assurance mechanisms that provide timely information so that performance and outcomes are monitored effectively and in line with hospital policy, and risks can be identified, assessed and managed. Reporting structures and responsibilities should be clearly set out and adhered to.”
CQC inspection report

A further major concern was a lack of effective oversight of practising privileges. These are arrangements where the organisation provides the facilities and nursing support, and the consultant clinicians are granted by the provider the right to practise in the hospital through formal admitting rights. Although not employees of the hospital, regulations set out that consultants working under practising privileges are considered in the same way as directly employed staff, and the provider has the same regulatory accountability for both.

The lack of robust and effective oversight of practising privileges, and a focus of providers treating consultants as ‘customers’ bringing business to the hospital, meant that providers could be reluctant to challenge them. It is essential that providers demonstrate that they are proactively auditing and monitoring consultants’ work, and have real oversight of services in order to protect patients and ensure they are being treated safely and effectively. In many cases they could not.

This lack of oversight is compounded in some cases by informality in medical governance, and the ineffectiveness and informality of some Medical Advisory Committees. As Medical Advisory Committees are a voluntary body, they rely on clinicians being involved in their own time. There are not generally paid positions such as governance lead or clinical effectiveness lead, and the effectiveness of the committee will often depend solely on the quality of the chair. There is a tension in the fact that clinicians are not employed by the provider, but work under practising privileges – and as such can be viewed as ‘customers’ of the provider. We saw examples of Medical Advisory Committees not effectively managing the practising privileges of consultants, for example not ensuring that a consultant was only undertaking procedures they were experienced to do or not

undertaking new or innovative procedures without effective risk assessment, informed consent and monitoring.

It is essential that a provider has systematic processes in place to ensure that consultants practising privileges are effectively granted, monitored, suspended and withdrawn, as appropriate. Monitoring of practising privileges must include a range of aspects to ensure patients are protected, such as checking a consultant scope of clinical practice and that they have the competence to carry out procedures within the agreed scope, robust on-call and emergency cover, and compliance with the provider's policies relating to aspects such as informed consent and multidisciplinary team arrangements.

Risk management

We found examples of poor monitoring of risks and inconsistent monitoring of risks, without systematic processes being in place to underpin a robust culture of learning from risks and effective escalation within the provider. Organisations could be quite generic in the way they assessed operational risk management, by using standardised templates that lacked depth and not proactively identifying the risk for their individual services. We found that staff will sometimes know how they are mitigating risk, but it is not documented.

“The hospital should take action to identify and mitigate all risks specific to the hospital, and risks should be included as a standard agenda item in committee meetings with robust systems for agreeing timescales and actions and monitoring of risk.”
CQC inspection report

Clinical audit

There needs to be improvement by a number of independent acute providers in terms of auditing, reporting and benchmarking outcomes. We were particularly concerned that some providers were not even collecting their own outcome data.

“Review opportunities to collect patient outcome measures to help evaluate the effectiveness of services in outpatients and diagnostic imaging.”
CQC inspection report

There was a lack of understanding at times because of expectations among hospitals and providers that consultants were monitoring their own outcomes. We have been clear that it is the provider who is providing the care – they are allowing the consultants to work with practising privileges – so they need to be assured and able to demonstrate how the care they are providing is appropriate, and carry out audits of clinical standards and outcomes.

This has been compounded by the fact that independent acute providers are often not required to take part in national audits or benchmarking, and indeed sometimes they are not enabled to submit their data. While many providers do take the initiative and carry out their own audits, some do not proactively have their own audit programmes in place.

We also found patients would often not be aware of outcomes data when making decisions about where they wanted to be treated. Services are often promoted on the quality of the inpatient environment and access to treatment, rather than on the effectiveness of treatment and the clinical outcomes achieved.

Safety culture

We found that a key risk to the provision of safe care was a lack of a culture of learning from incidents and a weakness around incident reporting – where systems may have been in place but were not as robust as they needed to be. This included examples of where services were not always being open and transparent about patient safety mistakes in terms of their responsibilities under the duty of candour.

“The hospital should revise its systems and processes to ensure that patient harms are correctly scored and ensure duty of candour applied in all instances.”
CQC inspection report

There were risks in operating theatre safety due to informal practices and consultant behaviour. For example, we saw a few instances where the World Health Organization surgical checklist was not being followed rigorously and this was not always sufficiently challenged by staff within the operating theatre. There was a level of informality too around theatre staffing roles.

On our inspections, we found that there was a lack of preparedness for patients whose condition could deteriorate. This is a necessity even where pre-assessment screening has ensured that the majority of patients are ‘well’. As mentioned above, some hospitals rely on having an arrangement with a nearby NHS hospital, so that if a patient’s condition did deteriorate, they could transfer them. However, we found that there were not always formal arrangement in place with NHS providers to underpin this approach.

“Review how they share incidents where patients have deteriorated and review the policy for pre-assessment to make sure all patients who require a pre-assessment have one carried out to the appropriate level.”
CQC inspection report

Many providers also aim to screen out patients with dementia or a learning disability, as they do not have sufficient provision to meet their individualised care needs when undergoing surgery. However, where care was provided for people with these conditions, we found that improvements were sometimes needed to support them.

“The hospital should ensure that staff are aware of who to contact and how to care for the needs of patients living with a learning disability when they are admitted to the hospital.”

CQC inspection report

We found several examples of poor practice around record-keeping, including: incomplete or missing records; failure to include information around, for instance, relevant safeguarding issues; records not stored securely; records not reviewed in a timely manner, and entries that were not legible or complete. Some hospitals relied solely on the consultants to maintain the patients’ clinical records, particularly in the outpatient setting.

“The hospital should ensure that consultant documentation in the patient’s record is timely, legible and signed.”

CQC inspection report

On our inspections, we sometimes found a lack of hospitals addressing infection prevention and control and we found saw specific examples of poor cleanliness. This included facilities with carpets, poor provision for separate hand washing basins for patients, and staff not wearing personal protective equipment. In these cases, there were examples of a lack of appropriate risk assessments or plans in place to address and mitigate the risks identified. There was also some poor disposal of clinical waste within restricted and enclosed sluice rooms.

“The hospital should ensure that all clinical waste is correctly stored, managed and disposed of in the outpatient department and that the sluice room is securely locked when not in use.”

CQC inspection report

We found examples where consent to treatment had not always been achieved; this included not following the Mental Capacity Act properly in the best interests of the patient.

“Ensure bedrails are used with the patient’s consent or, if they cannot get consent from the patient, they apply the Mental Capacity Act to ensure bed rails are used in the best interest of the patient.”

CQC inspection report

4. Improvement

Key points

- Where we have found problems, providers have been quick to take our findings on board and make improvements.
- We have seen locations being a lot more open with each other within their provider organisations, and discussing how they can share learning across sites – taking the learning they receive from our inspections.
- Of the 13 locations that we had re-inspected as at 2 January 2018, all four of those initially rated as inadequate had improved; two of these are now rated as good.

Since the start of our comprehensive inspection programme, where we have identified that improvement has been needed, we have generally been impressed with how quickly providers have responded to our findings and taken action.

For these organisations, they have accepted our judgement, taken on board our findings and the areas for improvement, and gone on to improve. We have seen independent acute hospitals, following our inspections, become more organised about their information governance, and begin moving towards better audit and monitoring.

BMI The Blackheath Hospital – rated as good on 12 January 2017, having previously been rated as requires improvement

BMI The Blackheath Hospital is an acute independent hospital that provides outpatient, day care and inpatient services. The hospital is owned and managed by BMI Healthcare Limited. It provides a range of services on site such as physiotherapy and medical imaging, and offers a range of surgical procedures and cancer care as well as rapid access to assessment and investigation and level 2 critical care. Services are available to people with private or corporate health insurance or to those paying for one-off treatment. The hospital also offers services to NHS patients on behalf of the NHS through local contractual arrangements.

At a previous inspection in February 2015, concerns included the care of children and young people, the inpatient environment, how the hospital was monitoring the quality of care provided, the recording of information in patients' notes, and compliance with national guidance in the endoscopy unit.

Following our return inspection in July 2016, we rated this hospital as good. Many improvements had been made including the recruitment of more paediatric trained nurses

and the upgrading of the critical care unit to provide care for patients requiring level 2 care.

The hospital had taken action to minimise most of the risks to patients. There was a system for reporting and learning from incidents and safety checks including the World Health Organization checklist were completed.

Children were cared for by paediatric trained nurses, and medical staff providing treatment for children had to confirm on an annual basis that they met basic requirements for volumes of children treated. Staff had received the appropriate level training and were aware of the action to take in response to abuse or suspected abuse of children or adults.

The majority of staff had attended mandatory training and were supported to develop their clinical and leadership skills. Patients had their personal, nutritional and pain needs met by staff who were kind, friendly and treated them with dignity.

Local leadership had been improved and senior leadership had been strengthened. Staff commented positively about leaders at all levels; they felt able to raise concerns and were proud to work at the hospital. They were committed to providing high-quality care for patients

We are now starting to see more of a common language across the independent sector about what it means to provide high-quality care, very much mapped to our five key questions of safe, effective, caring, responsive and well-led.

Within a commercially sensitive business environment, we have encouraged the sharing of best practice and innovation, so that services can learn from each other.

We have seen locations within provider organisations that are now a lot more open with each other and discussing how they can share learning across sites. They are learning from each other's inspection findings, and making changes resulting in improvements to services before we inspect other locations.

Nuffield Health – their inspection journey

When the CQC inspection process began, Nuffield Health's first two inspections resulted in ratings of requires improvement, as a result of shortcomings in children's and young people's services that they had not picked up through their own internal monitoring.

The organisation responded by immediately undertaking a strategic review of the children's and young people's services at all its hospitals. Based on the reviews, Nuffield Health took the decision to suspend or stop services at those sites where the number of patients were low or the admissions infrequent, and build on best practice at the remaining sites.

Now, all of the Nuffield Health hospitals that offer children's and young people's services treat and admit sufficient numbers of children and young people so that they can ensure that staff maintain their competence and skills.

For Nuffield Health, an important part of this process was the hospitals building strong relationships with key partners such as NHS and clinical commissioning groups. This meant all groups were familiar with their services and had the processes in place to ensure all parties could respond should an issue arise. As a result, Nuffield Health say that their children and young people's services are on a strong path to grow and innovate the care they provide. Four of their hospitals have received a rating of outstanding for their children's and young people's services.

Nuffield Health say that progress has not always been easy, as much of the existing best practice guidance relates to NHS services and does not necessarily translate across to the situation in the independent sector.

"Initially it took time to work with CQC to ensure they understood exactly how our services were configured. Working together with CQC in a spirit of constructive collaboration with mutual challenge has had a real impact on our care," said Carol Kefford, Clinical Director and Chief Nurse at Nuffield Health. "I can confidently say that, without the collaborative work with CQC, we would not have been able to enhance or improve the safety and quality of care at the pace we have done."

In line with the ratings profiles above, the required areas for improvement were predominantly focused on safety and leadership. Improvement needed in safety was centred on two broad issues:

- Having reliable systems, processes and practices in place to keep people safe and safeguarded from abuse.
- Assessing risks to people who use services, and ensuring their safety is monitored and maintained.

Required areas for improvement in well-led were focussed on making sure locations have a governance framework in which responsibilities are clear, and quality, performance and risks are understood and managed.

Since the beginning of the inspection programme and up to 2 January 2018, we returned to re-inspect 13 locations (figure 5). Of these 13, seven had improved. Four improved from an initial rating of inadequate: two going from inadequate to good, and two going from inadequate to requires improvement.

A further two locations have improved from requires improvement to good, and one has improved from good to outstanding. The other six locations maintained their rating.

Figure 5: Re-inspections of locations

		LAST RATING			
		Inadequate	Requires Improvement	Good	Outstanding
FIRST RATING	Inadequate	0	2	2	0
	Requires Improvement	0	2	2	0
	Good	0	0	4	1
	Outstanding	0	0	0	0


Source: CQC ratings data, 13 re-inspected locations, 2 January 2018.













































































































































































































Name	First rating	FIRST RATING					Overall	Last rating	LAST RATING					Overall
		Safe	Effective	Caring	Responsive	Well-led			Safe	Effective	Caring	Responsive	Well-led	
Oaklands Hospital	15/03/2017	Red	Orange	Green	Orange	Red	Red	18/12/2017	Orange	Green	Green	Green	Green	Green
Baddow Hospital	11/01/2017	Orange	Red	Green	Orange	Red	Red	12/06/2017	Green	Green	Green	Green	Orange	Green
The Harley Street Clinic	17/07/2015	Orange	Grey	Green	Green	Green	Green	04/01/2017	Green	Green	Blue	Green	Blue	Blue
BMI The Blackheath Hospital	03/02/2016	Orange	Orange	Green	Orange	Orange	Orange	12/01/2017	Orange	Green	Green	Green	Green	Green
BMI The Duchy Hospital	25/07/2017	Red	Orange	Green	Green	Red	Red	29/09/2017	Green	Grey	Grey	Grey	Orange	Orange
Nuffield Health Bristol Hospital -	15/07/2015	Orange	Grey	Green	Green	Orange	Orange	04/08/2016	Green	Grey	Green	Green	Green	Green
BMI Fawkham Manor Hospital	23/02/2017	Red	Orange	Green	Orange	Red	Red	02/08/2017	Orange	Orange	Green	Orange	Orange	Orange
BMI The Harbour Hospital	27/01/2016	Green	Green	Green	Green	Orange	Green	08/09/2017	Green	Green	Green	Green	Green	Green
St Hugh's Hospital	18/03/2016	Red	Orange	Green	Green	Orange	Orange	22/12/2017	Orange	Orange	Grey	Grey	Orange	Orange
Nuffield Health Woking Hospital	13/02/2017	Green	Green	Green	Green	Green	Green	04/08/2017	Green	Green	Green	Green	Green	Green
The Priory Highbank Centre	03/05/2017	Green	Green	Green	Green	Green	Green	04/05/2017	Green	Green	Green	Green	Green	Green
Fitzwilliam Hospital	08/02/2017	Orange	Green	Green	Green	Green	Green	10/11/2017	Orange	Green	Green	Green	Green	Green
BMI The Esperance Hospital	21/10/2016	Orange	Green	Green	Green	Orange	Orange	06/09/2017	Orange	Green	Green	Green	Orange	Orange

Appendix 1

Location ratings as at 2 January 2018 – overall and key question ratings

Key:

Outstanding	
Good	
Requires improvement	
Inadequate	
Not rated	

Location name	Brand	Overall	Safe	Effective	Caring	Responsive	Well-led
134 Harley Street	-						
Ashted Hospital	Ramsay Health Care UK						
Baddow Hospital	-						
Barlborough NHS Treatment Centre	Care UK						
Benenden Hospital	-						
Blakelands Hospital	Ramsay Health Care UK						
Blandford Community Hospital	-						
BMI Bath Clinic	BMI Healthcare						
BMI Bishops Wood Hospital	BMI Healthcare						
BMI Chelsfield Park Hospital	BMI Healthcare						
BMI Coombe Wing	BMI Healthcare						
BMI Fawkham Manor Hospital	BMI Healthcare						
BMI Gisburne Park Hospital	BMI Healthcare						
BMI Goring Hall Hospital	BMI Healthcare						
BMI Hendon Hospital	BMI Healthcare						
BMI Mount Alvernia Hospital	BMI Healthcare						
BMI Sarum Road Hospital	BMI Healthcare						
BMI Southend Private Hospital	BMI Healthcare						
BMI St Edmunds Hospital	BMI Healthcare						
BMI The Alexandra Hospital	BMI Healthcare						
BMI The Beardwood Hospital	BMI Healthcare						
BMI The Beaumont Hospital	BMI Healthcare						
BMI The Blackheath Hospital	BMI Healthcare						
BMI The Cavell Hospital	BMI Healthcare						
BMI The Chaucer Hospital	BMI Healthcare						
BMI The Chiltern Hospital	BMI Healthcare						
BMI The Clementine Churchill Hospital	BMI Healthcare						
BMI The Droitwich Spa Hospital	BMI Healthcare						
BMI The Duchy Hospital	BMI Healthcare						
BMI The Edgbaston Hospital	BMI Healthcare						
BMI The Esperance Hospital	BMI Healthcare						
BMI The Hampshire Clinic	BMI Healthcare						
BMI The Harbour Hospital	BMI Healthcare						
BMI The Highfield Hospital	BMI Healthcare						

Location name	Brand	Overall	Safe	Effective	Caring	Responsive	Well-led
BMI The Huddersfield Hospital	BMI Healthcare						
BMI The Kings Oak Hospital	BMI Healthcare						
BMI The Lancaster Hospital	BMI Healthcare						
BMI The Lincoln Hospital	BMI Healthcare						
BMI The London Independent Hospital	BMI Healthcare						
BMI The Manor Hospital	BMI Healthcare						
BMI The Meriden Hospital	BMI Healthcare						
BMI The Park Hospital	BMI Healthcare						
BMI The Princess Margaret Hospital	BMI Healthcare						
BMI The Priory Hospital	BMI Healthcare						
BMI The Ridgeway Hospital	BMI Healthcare						
BMI The Runnymede Hospital	BMI Healthcare						
BMI The Sandringham Hospital	BMI Healthcare						
BMI The Saxon Clinic	BMI Healthcare						
BMI The Shelburne Hospital	BMI Healthcare						
BMI The Shirley Oaks Hospital	BMI Healthcare						
BMI The Sloane Hospital	BMI Healthcare						
BMI The Somerfield Hospital	BMI Healthcare						
BMI The South Cheshire Hospital	BMI Healthcare						
BMI The Winterbourne Hospital	BMI Healthcare						
BMI Thornbury Hospital	BMI Healthcare						
BMI Woodlands Hospital	BMI Healthcare						
Boston West Hospital	Ramsay Health Care UK						
Bupa Cromwell Hospital	BUPA Group						
Cambridge Heart Clinic	-						
Cancer Centre London LLP	Aspen Healthcare						
CESP (Somerset) LLP @ Musgrove Park Hospital	-						
Chartwell Hospital	-						
Circle Hospital (Bath) Ltd	Circle Healthcare Ltd						
CircleReading	Circle Healthcare Ltd						
Claremont Hospital	Aspen Healthcare						
Clifton Park Hospital	Ramsay Health Care UK						
Cobalt Hospital	Ramsay Health Care UK						
Cobham Day Surgery	-						
Devizes NHS Treatment Centre	Care UK						
Duchy Hospital	Ramsay Health Care UK						
Emersons Green NHS Treatment Centre	Care UK						
Epsom Day Surgery	-						
Euxton Hall Hospital	Ramsay Health Care UK						
Fairfield Independent Hospital	-						
Fitzwilliam Hospital	Ramsay Health Care UK						
Fulwood Hall Hospital	Ramsay Health Care UK						
Greater Lancashire Hospital	-						
Harley Street at Queens	HCA Hospitals						
HCA Healthcare UK at University College Hospital	HCA Hospitals						
Highgate Hospital	Aspen Healthcare						

Location name	Brand	Overall	Safe	Effective	Caring	Responsive	Well-led
Horder Healthcare	-						
Horton Treatment Centre	Ramsay Health Care UK						
Hospital of St John & St Elizabeth	-						
Kent Institute of Medicine and Surgery (KIMS)	-						
King Edward VII's Hospital	-						
Manchester Surgical Services	-						
Mount Stuart Hospital	Ramsay Health Care UK						
New Hall Hospital	Ramsay Health Care UK						
North Downs Hospital	Ramsay Health Care UK						
North East London NHS Treatment Centre	Care UK						
Nova Healthcare	-						
Nuffield Health Bournemouth Hospital	Nuffield Health						
Nuffield Health Brentwood Hospital	Nuffield Health						
Nuffield Health Bristol Hospital - The Chesterfield	Nuffield Health						
Nuffield Health Cambridge Hospital	Nuffield Health						
Nuffield Health Cheltenham Hospital	Nuffield Health						
Nuffield Health Chichester Hospital	Nuffield Health						
Nuffield Health Derby Hospital	Nuffield Health						
Nuffield Health Exeter Hospital	Nuffield Health						
Nuffield Health Guildford Hospital	Nuffield Health						
Nuffield Health Haywards Heath Hospital	Nuffield Health						
Nuffield Health Hereford Hospital	Nuffield Health						
Nuffield Health Ipswich Hospital	Nuffield Health						
Nuffield Health Leeds Hospital	Nuffield Health						
Nuffield Health Leicester Hospital	Nuffield Health						
Nuffield Health Newcastle-upon-Tyne Hospital	Nuffield Health						
Nuffield Health North Staffordshire Hospital	Nuffield Health						
Nuffield Health Plymouth Hospital	Nuffield Health						
Nuffield Health Shrewsbury Hospital	Nuffield Health						
Nuffield Health Taunton Hospital	Nuffield Health						
Nuffield Health Tees Hospital	Nuffield Health						
Nuffield Health The Grosvenor Hospital Chester	Nuffield Health						
Nuffield Health The Manor Hospital Oxford	Nuffield Health						
Nuffield Health Tunbridge Wells Hospital	Nuffield Health						
Nuffield Health Warwickshire Hospital	Nuffield Health						
Nuffield Health Wessex Hospital	Nuffield Health						
Nuffield Health Wessex Hospital*	-						
Nuffield Health Woking Hospital	Nuffield Health						
Nuffield Health Wolverhampton Hospital	Nuffield Health						
Nuffield Health York Hospital	Nuffield Health						
Oaklands Hospital	Ramsay Health Care UK						
Oaks Hospital	Ramsay Health Care UK						
One Ashford Hospital	-						
Optegra London	-						
Optegra Manchester Eye Hospital	-						

Location name	Brand	Overall	Safe	Effective	Caring	Responsive	Well-led
Orthopaedics and Spine Specialist Hospital	-						
Park Hill Hospital	Ramsay Health Care UK						
Parkside Hospital	Aspen Healthcare						
Parkside Hospital at Putney	Aspen Healthcare						
Peninsula NHS Treatment Centre	Care UK						
Pinehill Hospital	Ramsay Health Care UK						
Queen Anne Street Medical Centre Limited	-						
Renacres Hospital	Ramsay Health Care UK						
Rivers Hospital	Ramsay Health Care UK						
Rowley Hall Hospital	Ramsay Health Care UK						
Somerset Surgical Services	-						
Spencer Private Hospital	-						
Spencer Private Hospitals	-						
Spire Alexandra Hospital	Spire Healthcare Limited						
Spire Bristol Hospital	Spire Healthcare Limited						
Spire Bushey Hospital	Spire Healthcare Limited						
Spire Cambridge Lea Hospital	Spire Healthcare Limited						
Spire Cheshire Hospital	Spire Healthcare Limited						
Spire Clare Park Hospital	Spire Healthcare Limited						
Spire Elland Hospital including Longlands Consulting Rooms	Spire Healthcare Limited						
Spire Fylde Coast Hospital	Spire Healthcare Limited						
Spire Gatwick Park Hospital	Spire Healthcare Limited						
Spire Harpenden Hospital	Spire Healthcare Limited						
Spire Hartwood Hospital	Spire Healthcare Limited						
Spire Leeds Hospital	Spire Healthcare Limited						
Spire Leicester Hospital	Spire Healthcare Limited						
Spire Little Aston Hospital	Spire Healthcare Limited						
Spire Methley Park Hospital	Spire Healthcare Limited						
Spire Murrayfield Hospital	Spire Healthcare Limited						
Spire Norwich Hospital	Spire Healthcare Limited						
Spire Parkway Hospital	Spire Healthcare Limited						
Spire Portsmouth Hospital	Spire Healthcare Limited						
Spire Regency Hospital	Spire Healthcare Limited						
Spire Roding Hospital	Spire Healthcare Limited						
Spire South Bank Hospital	Spire Healthcare Limited						
Spire Southampton Hospital	Spire Healthcare Limited						
Spire Sussex Hospital	Spire Healthcare Limited						
Spire Thames Valley Hospital	Spire Healthcare Limited						
Spire Tunbridge Wells Hospital	Spire Healthcare Limited						
Spire Washington Hospital	Spire Healthcare Limited						
Spire Wellesley Hospital	Spire Healthcare Limited						
Spire Windsor Clinic	Spire Healthcare Limited						
Springfield Hospital	Ramsay Health Care UK						
St Anthony's Hospital	Spire Healthcare Limited						
St Hugh's Hospital	-						
St Mary's NHS Treatment Centre	Care UK						

Location name	Brand	Overall	Safe	Effective	Caring	Responsive	Well-led
Tees Valley Treatment Centre	Ramsay Health Care UK	Green	Green	Green	Green	Green	Green
Tetbury Hospital	-	Orange	Orange	Orange	Green	Green	Green
The Berkshire Independent Hospital	Ramsay Health Care UK	Green	Green	Green	Green	Green	Green
The Chelmsford	Aspen Healthcare	Green	Green	Green	Green	Blue	Green
The Clatterbridge Clinic	-	Green	Green	Orange	Blue	Green	Green
The CyberKnife Centre London	HCA Hospitals	Blue	Green	Blue	Green	Green	Blue
The Foscote Private Hospital	-	Green	Green	Green	Green	Green	Green
The Gamma Knife Centre at The National Hospital for Neurology and Neurosurgery	-	Orange	Orange	Orange	Green	Green	Red
The Harley Street Clinic	HCA Hospitals	Blue	Green	Green	Blue	Green	Blue
The Holly Private Hospital	Aspen Healthcare	Green	Green	Green	Green	Green	Blue
The Lister Hospital	HCA Hospitals	Blue	Green	Green	Green	Blue	Blue
The London Bridge Hospital	HCA Hospitals	Blue	Green	Green	Green	Blue	Blue
The London Clinic	-	Green	Green	Green	Green	Green	Green
The London Gamma Knife Centre at Barts	HCA Hospitals	Green	Green	Grey	Blue	Green	Green
The McIndoe Centre, part of Horder Healthcare	-	Green	Orange	Green	Green	Green	Green
The Montefiore Hospital	Spire Healthcare Limited	Blue	Green	Blue	Green	Blue	Green
The New Victoria Hospital	-	Green	Green	Green	Green	Green	Green
The Nottingham NHS Treatment Centre	Circle Healthcare Ltd	Green	Green	Green	Green	Green	Green
The Portland Hospital for Women and Children	HCA Hospitals	Green	Green	Green	Green	Blue	Green
The Princess Grace Hospital	HCA Hospitals	Orange	Orange	Green	Green	Green	Orange
The Priory Highbank Centre	Acadia	Green	Green	Green	Green	Green	Green
The Surrey Park Clinic	-	Orange	Orange	Grey	Green	Orange	Red
The Wellington Hospital	HCA Hospitals	Green	Green	Green	Green	Green	Green
The Whiteley Clinic Bristol	-	Green	Green	Grey	Green	Green	Blue
The Whiteley Clinic Limited	-	Blue	Green	Grey	Green	Blue	Blue
The Whiteley Clinic London	-	Green	Green	Grey	Green	Green	Blue
The Yorkshire Clinic	Ramsay Health Care UK	Green	Green	Green	Green	Green	Green
Thornbury Radiosurgery Centre Limited	-	Orange	Orange	Green	Green	Orange	Orange
Victoria Hospital	-	Green	Green	Green	Green	Green	Orange
West Midlands Hospital	Ramsay Health Care UK	Orange	Orange	Orange	Green	Green	Orange
Weymouth Hospital	-	Green	Green	Green	Green	Green	Green
Will Adams NHS Treatment Centre	Care UK	Green	Green	Green	Green	Green	Green
Winfield Hospital	Ramsay Health Care UK	Orange	Orange	Green	Green	Orange	Orange
Woodland Hospital	Ramsay Health Care UK	Orange	Orange	Green	Green	Green	Orange
Woodthorpe Hospital	Ramsay Health Care UK	Green	Green	Green	Green	Green	Green

* A separate registered location from the one above it, the registered provider is Standard Health Limited.

How to contact us

Call us on > 03000 616161

Email us at > enquiries@cqc.org.uk

Look at our website > www.cqc.org.uk

Write to us at >

Care Quality Commission

Citygate

Gallowgate

Newcastle upon Tyne

NE1 4PA



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Please contact us if you would like this report in another language or format.

