BMI The Chiltern Hospital

Quality Report

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

Ratings

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

Summary of findings

Letter from the Chief Inspector of Hospitals

Our rating of this hospital stayed the same. We rated it as **Requires improvement** overall.

We found the following issue that the service provider needs to improve:

- The service provided mandatory training in key skills to all staff and processes in place to monitor compliance, but not all staff had completed this training.
- Not all areas were patients received care and treatment were fit for purpose.
- Most equipment was suitable but the paperwork to evidence that equipment had been tested and serviced to ensure it was fit for purpose was not always available, up to date or accurate.
- Despite children being seen and treated at the hospital not all staff required to completed training in paediatric basic life support (PBLS) as part of their mandatory training had done so.
- The service stored medicines safely and securely however did not always follow best practice when prescribing and recording the medicines administered in all departments.
- There was a lack of oversight of which staff had had read and were competent to use Patient Group Directions (PGDs).
- Not all departments had sufficient numbers of nurses with the right qualifications, skills, training and experience to keep people safe from avoidable harm and to provide the right care and treatment.
- Not all departments used a system to monitor safety results and in areas that did collect this data this was not displayed
- The service provided care and treatment based on national guidance and evidence of its effectiveness. Whilst managers checked to make sure staff followed guidance, this guidance was not always the most up to date.
- Children did not always have their care and treatment delivered or overseen by appropriately qualified staff in line with the provider's staffing policies and procedures.
- Not all departments had ensured their staff were competent for their roles. In the event of a paediatric emergency a competent member of staff may not always be available.
- Management of the diagnostic department was still in its infancy and was in the process of developing the right skills and abilities to run a service or had just begun to address some of the challenges in their area.
- While systems were in place to identify risks and mitigate these, the systems were not always effective in identifying where improvements were required.
- The provider had a governance framework which was used to improve their clinical, corporate, staff and financial performance. However, these were not always fully embedded into operational practice.

However, we also found the following areas of good practice:

- Staff understood how to protect patients from abuse. Staff had training on how to recognise and report abuse and they knew how to apply it.
- The service controlled infection risks and kept equipment and the premises clean.
- The service managed patient safety incidents well. Staff recognised incidents and reported them appropriately.

Summary of findings

- Staff completed and updated risk assessments for each patient. They kept clear records and asked for support when necessary.
- The service had enough medical staff with the right qualifications, skills, training and experience to keep people safe from avoidable harm and to provide the right care and treatment.
- Staff kept detailed records of patients' care and treatment. Records were clear, up-to-date and easily available to all staff providing care.
- Managers monitored the effectiveness of care and treatment and used the findings to improve them. They compared local results with those of other BMI services to learn from them.
- Staff put patients at the centre of all that they did.
- Staff took time to involve patients in their care and provided emotional support to patients to minimise their distress.
- We observed how staff demonstrated a kind and caring attitude to patients and took time to speak with patients and their relatives in a respectful, patient and considerate way.
- The hospital planned services around the needs and demands of patients, taking into account patients' individual needs.
- People could access the service when they needed it.
- The service treated concerns and complaints seriously, investigated them and learnt lessons from the results, sharing these both internally and with other BMI hospitals.
- The service had a vision for what it wanted to achieve and workable plans to turn it into action, which it had developed with staff and patients.
- The service promoted a positive culture that supported and valued staff, creating a sense of common purpose based on shared values.
- The service engaged well with patients and staff to and manage appropriate services.

Following this inspection, we told the provider that it must take some actions to comply with the regulations and that it should make other improvements, even though a regulation had not been breached, to help the service improve. We also issued the provider with three requirement notices that affected children and young people and diagnostic services. Details are at the end of the report.

Nigel Acheson

Deputy Chief Inspector of Hospitals (London and South Central)

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Medical care	Good 	Medical care services were a small proportion of hospital activity. The main service was surgery. Where arrangements were the same, we have reported findings in the surgery section. The majority of medical care provided by the service was endoscopy and oncology, this core service report has focussed mainly on these specialties. We rated this service as good because it was safe, effective, caring and responsive, and well-led.
Surgery	Good 	Surgery was the main activity of the hospital. Where our findings on surgery also apply to other services, we do not repeat the information but cross-refer to the surgery section. Staffing was managed jointly with medical care. We rated this service as good overall and good in each domain because it was safe, effective, caring, responsive and well-led.
Services for children and young people	Requires improvement 	Children and young people's services were a small proportion of hospital activity. The main service was surgery. Where arrangements were the same, we have reported findings in the surgery section. We rated this service as requires improvement because we rated well led as inadequate, safe, responsive and effective as requiring improvement. We found the service to be good in the caring domain.
Outpatients	Requires improvement 	Outpatients was a significant proportion of hospital activity. The main service was surgery. Where arrangements were the same, we have reported findings in the surgery section. We rated this service as requires improvement because there were some aspects in safe and well led that required improvement. We found the service to be good in the responsive and caring domains. We currently do not rate the effective domain.

Summary of findings

Diagnostic imaging

Requires improvement 

Diagnostics were a small proportion of hospital activity. The main service was surgery. Where arrangements were the same, we have reported findings in the surgery section.
We rated this service as requires improvement because there were some aspects in safe and well led such as medicines management that required improvement. We found the service to be good in the responsive and caring domains.
We currently do not rate the effective domain.

Summary of findings

Contents

Requires improvement

BMI The Chiltern Hospital

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 Chiltern Hospital

BMI The Chiltern Hospital is operated by BMI Healthcare Limited. The hospital/service opened in March 1982. It is a private hospital in Great Missenden, Buckinghamshire. The hospital primarily serves the communities of the South Buckinghamshire. It also accepts patient referrals from outside this area.

The hospital has had a registered manager, Fraser Dawson who has been in post since July 2016.

The hospital leadership team including directors and heads of department work at both the Chiltern Hospital and the nearby Shelburne Hospital.

Our inspection team

The team that inspected the service comprised a CQC lead inspector, four other CQC inspectors, and seven specialist advisors with expertise in surgery, children, medical care, outpatients and diagnostics. The inspection team was overseen by Amanda Williams, Head of Hospital Inspection.

How we carried out this inspection

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

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

Before visiting, we reviewed a range of information we held about the hospital. We carried out an unannounced inspection visit on 15-17 January 2019.

During this comprehensive inspection, we assessed the surgical, medical, children's, diagnostics and outpatients services. We also reviewed the overall governance processes for the hospital and reported on this as part of the well-led domain. We spoke with members of staff and patients, observed patient care, looked at patients' care and treatment records and at hospital policies.

Information about BMI The Chiltern Hospital

The hospital has three wards and is registered to provide the following regulated activities:

- Treatment of disease, disorder or injury
- Surgical procedures
- Diagnostics and screening procedures.

During the inspection, we visited all three wards, theatres, consulting rooms and x-ray. We spoke with 72 staff including; registered nurses, health care assistants, reception staff, medical staff, operating department practitioners, and senior managers. We spoke with 19 patients and one relative. During our inspection, we reviewed 37 sets of patient records.

There were no special reviews or investigations of the hospital ongoing by the CQC at any time during the 12 months before this inspection. The hospital/service has been inspected four times, and the most recent inspection took place in July/August 2016, which found that the hospital was not meeting all standards of quality and safety it was inspected against.

Summary of this inspection

Activity

- In the reporting period August 2017 to July 2018, there were 6469 inpatient and day case episodes of care recorded at the hospital; of these 14% were NHS-funded and 86% other funded.
- 38% of all NHS-funded patients and 20% of all other funded patients stayed overnight at the hospital during the same reporting period.
- There were 48398 outpatient total attendances in the reporting period; of these 93% were other funded and 7% were NHS-funded.

There were 241 surgeons, anaesthetists and physicians working at the hospital under practising privileges. The hospital employed 21.5 whole time equivalents (WTE) registered nurses, 7.3 WTE care assistants and 7.3 WTE operating department practitioners, as well as using bank and agency staff when necessary. The regular resident medical officer (RMO) was employed via an agency and worked on a 24-hour, seven-day rota. The hospital had three regular agency RMOs who provided this cover.

The accountable officer for controlled drugs (CDs) was the registered manager.

Track record on safety

- 2 Never events
- 276 clinical incidents 172 no harm, 87 low harm, 16 moderate harm, 0 severe harm, 1 death
- 0 serious injuries

0 incidences of hospital acquired Methicillin-resistant Staphylococcus aureus (MRSA),

0 incidences of hospital acquired Methicillin-sensitive staphylococcus aureus (MSSA)

0 incidences of hospital acquired Clostridium difficile (c.diff)

0 incidences of hospital acquired E-Coli

Four complaints

Services accredited by a national body:

- At the time of our inspection we were told that accreditation with the Joint Advisory Group on GI endoscopy (JAGS) was being worked towards but we were not provided with a timescale when this would be completed.
- The oncology service was accredited by Macmillan.

Services provided at the hospital under service level agreement:

- Pathology
- Clinical and or non-clinical waste removal
- RMO provision
- Grounds Maintenance
- Cytotoxic drugs service

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

Are services safe?

Requires improvement

Our rating of safe stayed the same. We rated it as **Requires improvement** because:

- The service provided mandatory training in key skills to all staff and processes in place to monitor compliance, but not all staff had completed this training.
- Not all areas were patients received care and treatment were fit for purpose.
- Most equipment was suitable but the paperwork to evidence that equipment had been tested and serviced to ensure it was fit for purpose was not always available, up to date or accurate.
- Despite children being seen and treated at the hospital not all staff required to completed training in paediatric basic life support (PBLS) as part of their mandatory training had done so.
- The service stored medicines safely and securely however did not always follow best practice when prescribing and recording the medicines administered in all departments.
- There was a lack of oversight of which staff had had read and were competent to use Patient Group Directions (PGDs).
- Not all departments had sufficient numbers of nurses with the right qualifications, skills, training and experience to keep people safe from avoidable harm and to provide the right care and treatment.
- Not all departments used a system to monitor safety results and in areas that did collect this data this was not displayed

However, we also found the following areas of good practice:

- Staff understood how to protect patients from abuse. Staff had training on how to recognise and report abuse and they knew how to apply it.
- The service controlled infection risks and kept equipment and the premises clean.
- The service managed patient safety incidents well. Staff recognised incidents and reported them appropriately.
- Staff completed and updated risk assessments for each patient. They kept clear records and asked for support when necessary.
- The service had enough medical staff with the right qualifications, skills, training and experience to keep people safe from avoidable harm and to provide the right care and treatment.

Summary of this inspection

- Staff kept detailed records of patients' care and treatment. Records were clear, up-to-date and easily available to all staff providing care.

Are services effective?

Good

Are services effective?

Our rating of effective improved. We rated it as **Good** because:

- Staff assessed and monitored patients regularly to see if they were in pain.
- Staff of different roles worked together as a team to benefit patients.
- Managers monitored the effectiveness of care and treatment and used the findings to improve them. They compared local results with those of other BMI services to learn from them.
- Staff gave patients enough food and drink to meet their needs and improve their health. The service made adjustments for patients' religious, cultural and other preferences.

However, we also found the following issue that the service provider needs to improve:

- The service provided care and treatment based on national guidance and evidence of its effectiveness. Whilst managers checked to make sure staff followed guidance, this guidance was not always the most up to date.
- Children did not always have their care and treatment delivered or overseen by appropriately qualified staff in line with the provider's staffing policies and procedures.
- Not all departments had ensured their staff were competent for their roles. In the event of a paediatric emergency a competent member of staff may not always be available.

Are services caring?

Good

Our rating of caring stayed the same. We rated it as **Good** because:

- Staff put patients at the centre of all that they did.
- Staff took time to involve patients in their care and provided emotional support to patients to minimise their distress.
- Staff involved patients and those close to them in decisions about their care and treatment.
- We observed how staff demonstrated a kind and caring attitude to patients and took time to speak with patients and their relatives in a respectful, patient and considerate way.
- Staff supported patients through their investigations, ensuring they were well informed and knew what to expect.

Summary of this inspection

Are services responsive?

Good

Are services responsive?

Our rating of responsive stayed the same. We rated it as **Good** because:

- The hospital planned services around the needs and demands of patients and considered patients' individual needs.
- People could access the service when they needed it.
- The service treated concerns and complaints seriously, investigated them and learnt lessons from the results, sharing these both internally and with other BMI hospitals.

However, we also found the following issue that the service provider needs to improve:

- Waiting times from referral to treatment and arrangements to admit, treat and discharge patients were not monitored in all departments.

Are services well-led?

Requires improvement

Our rating of well led stayed the same We rated it as **Requires improvement** because:

- Management for the department was still in its infancy and was in the process of developing the right skills and abilities to run a service or had just begun to address some of the challenges in their area.
- While systems were in place to identify risks and mitigate these, the systems were not always effective in identifying where improvements were required.
- The provider had a governance framework which was used to improve their clinical, corporate, staff and financial performance. However, these were not always fully embedded into operational practice.
- Not all areas of collected, analysed and used information to support activities.

However, we also found the following areas of good practice:

- The service had a vision for what it wanted to achieve and workable plans to turn it into action, which it had developed with staff and patients.
- The service promoted a positive culture that supported and valued staff, creating a sense of common purpose based on shared values.
- The service engaged well with patients and staff to and manage appropriate services.

Detailed findings from this inspection

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Medical care	Good	Good	Good	Good	Good	Good
Surgery	Good	Good	Good	Good	Good	Good
Services for children and young people	Requires improvement	Requires improvement	Good	Requires improvement	Inadequate	Requires improvement
Outpatients	Requires improvement	N/A	Good	Good	Requires improvement	Requires improvement
Diagnostic imaging	Requires improvement	N/A	Good	Good	Requires improvement	Requires improvement
Overall	Requires improvement	Good	Good	Good	Requires improvement	Requires improvement

Good

Medical care

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

Information about the service

The BMI Chiltern hospital provided a small medical service. The majority of medical care provided by the service was endoscopy and oncology, this core service report has focussed mainly on these specialties.

There was a dedicated endoscopy unit which operated 8am to 6pm Monday to Friday. At the time of our inspection the endoscopy unit was reported to be working towards the Joint Advisory Group (JAG) accreditation.

There were 736 endoscopy procedures carried out during January 2018 to December 2018. The endoscopy unit consisted of a treatment room, a scope washer room, drying room and a segregated recovery area for three patients. Following the endoscopy procedure, all patients returned to the ward.

Oncology care is delivered in a dedicated oncology day case unit with four individual 'pods' with comfortable reclining chairs and five en-suite bedrooms. The unit was open Monday to Friday 7.30 am to 5pm. A 24 hour, seven day a week on call service is available to oncology patients.

On average 20 patients are treated per week with breast, bowel, bladder, lymphoma, myeloma cancers and leukaemia, The hospital has a oncology lead nursing sister who is a dedicated breast care nurse along with a team of chemotherapy-trained nurses.

At the time of our inspection the hospital did not treat NHS funded oncology patients. The majority of oncology patients were funded through insurance with a minority being self-paying.

During our inspection, we visited the endoscopy and oncology unit. We spoke with four patients and family members. We spoke with 16 members of staff including, consultants, nurses, endoscopy staff and managers. We reviewed hospital policies and procedures, staff training records, audits and performance data. We looked at the environment and the equipment in use. We reviewed 14 sets of patient records and observed interactions between staff and patients.

Are medical care services safe?

Good

Mandatory training

The service provided mandatory training in key skills to all staff and made sure everyone completed it.

- The BMI Healthcare corporate mandatory training policy defined the mandatory training requirements of staff including bank workers. This included a mandatory training matrix which identified the mandatory training required dependent on job role.
- Additional mandatory training was required for staff working in the medical care service depending on their role in the department. For example, consent to examination.
- BMI The Chiltern Hospital set a target of 85% for completion of mandatory training. As of October 2018, compliance with mandatory training for staff working across the whole hospital was 93% and for staff working in the endoscopy and oncology services was 94% and 100% respectively.

- Staff working in the endoscopy and oncology services, including bank staff, had training files. We reviewed these files and found they were all up-to-date, comprehensive and provided evidence of mandatory training.

For more detailed information on mandatory training please see the surgery report.

Safeguarding

Staff understood how to protect patients from abuse. Staff had training on how to recognise and report abuse and they knew how to apply it.

- Staff working in the endoscopy and oncology services had completed mandatory training in safeguarding vulnerable adults. Information received from the hospital was not broken down into services but showed 91.9% of staff had completed level 1, 96% had completed level 2 and 100% level 3 safeguarding training against the target of 85%.
- Staff we spoke with were aware of the signs of abuse and demonstrated an understanding about safeguarding processes. They knew who the safeguarding lead was at the hospital and how to escalate if they had concerns. However, staff we spoke with had not needed to raise safeguarding concerns whilst working at the hospital.
- Staff working in the oncology service told us although their role did not require safeguarding level 3 training, one of the team had completed this level of training, as sometimes patients brought children into the unit whilst undergoing treatment.

For more detailed information on safeguarding please see the surgery report.

Cleanliness, infection control and hygiene

The service controlled infection risk well. Staff kept themselves, equipment and the premises clean. They used control measures to prevent the spread of infection.

- The hospital had an infection prevention and control lead nurse and link nurses in clinical areas.
- All areas we inspected, the endoscopy and oncology departments, were visibly clean and tidy. Staff completed daily cleaning routines and cleaning records. The records we reviewed during the inspection showed them to be up-to-date and complete.
- Since the last inspection in 2017 much of the carpet and fabric chairs at the hospital, which posed an infection control risk as not wipe clean, had been replaced. In the rooms where oncology patients received treatments and care, there was hard flooring. This meant the floor surface was easier to clean.
- 'I am clean' stickers were used on equipment in the clinical areas to identify that items had been cleaned and were ready for use.
- Both the endoscopy and oncology departments had easy access to emergency equipment, including the emergency suction equipment and defibrillator, with one set of equipment in the corridor by the endoscopy department and one set of equipment in the oncology department. Both sets of equipment were clean, tidy and dust free.
- Staff were observed to follow good infection control practices to help stop the spread of infection such as 'bare below the elbow' and cleaning their hands before and after contact with patients. Staff also had access to personal protective equipment in a variety of sizes.
- Throughout the hospital and in the endoscopy and oncology departments hand sanitiser gel was available.
- There was a lack of dedicated hand washing sinks in some clinical areas of the hospital and this included the oncology four pod-room. We were told by senior staff and saw action plans for the installation of clinical hand washing sinks in the hospital starting in February 2019.To mitigate for the lack of clinical sinks, staff either used sinks in patient bathrooms or used hand sanitiser.
- There were dedicated staff in the endoscopy suite who took the lead for decontamination of clinical equipment. Staff had undertaken training and completed a competency assessment programme.
- The endoscopy service had a good flow of scopes from dirty to clean areas and we were shown documented daily cleaning and sterility checks of endoscopy equipment.

- The endoscopy sterilisation machines were tested every morning to ensure they reached the correct temperature for the required amount of time to sterilise the used scopes. The hospital had a service level agreement with an outside contractor to service the endoscopy sterilising machine annually. We were shown documentation at the time of the inspection of the last service.
- An annual external audit by the endoscopy decontamination facilities audit institute of Healthcare engineering and estate management (IHEEM) was carried out to ensure the endoscopy decontamination facility was operating in line with the national guidance. We were shown documentation, during the inspection, of the last audit carried out January 2019 which showed the unit complied with guidelines.
- There was a weekly water check of total viable count (TVC) post disinfection of scopes. This is a quantitative estimate of the concentration of microorganisms such as bacteria, yeast or mould spores in a water sample. The results of this check went to the hospital's microbiologist, the hospital endoscopy technician responsible for the decontamination of equipment and the hospital's infection control nurse. Action would be taken if this result was out of range. During the inspection we reviewed results from these checks and could see all were in range.
- Across the hospital, including the endoscopy and oncology departments, there was an infection prevention annual audit program. This included hand hygiene audits, patient equipment audits and clinical hand wash basin audits.
- There was a Monday morning walk around of selected areas of the hospital by members of the senior management team, the hotel services manager and the infection control lead. The areas selected varied depending on when it was last visited and if any concerns had been raised. A report was completed after the walk around which included the concern or action, who was responsible for the issue and the current status. Post inspection we reviewed the reports for the endoscopy and oncology departments and could see that environment issues were raised and an action plan put in place.
- There was a BMI Healthcare corporate waste management policy which the hospital and staff followed. During the inspection we saw the correct management of containers for sharps and the use of coloured bags to correctly segregate hazardous and non-hazardous waste.
- There was no BMI healthcare policy or local hospital standard operating procedure (SOP) on the recognition, diagnosis and treatment of sepsis in adults at the hospital. However, we did see information about sepsis on staff notice boards. The hospital used the inpatient sepsis screening and action tool taken from the UK Sepsis Trust, The Sepsis Manual 4th edition 2017-2018. After talking to clinical staff it was unclear how much training staff had received to use this tool.

For more detailed information on cleanliness, infection control and hygiene please see the surgery report.

Environment and equipment

The service had suitable premises and equipment and looked after them well.

- The endoscopy and oncology departments were suitable for the level and type of care delivered.
- There was a dedicated endoscopy unit which at the time of our inspection was reported to be working towards it's Joint Advisory Group (JAG) accreditation, a formal recognition that an endoscopy service had demonstrated it had the competence to deliver against set standards.
- We were told by staff working in the unit there were some requirements that needed to be met, including electronic documentation for scopes, installing a wall in the decontamination room to separate dirty and clean areas, currently they had designated clean and dirty areas in the same room and improved ventilation. Currently the service was waiting for funding to be approved to address these issues.
- Oncology care was delivered in a dedicated oncology day case unit with four individual 'pods' with comfortable reclining chairs and five en-suite bedrooms. The rooms were comfortably furnished which patients said met their needs and included a bedside nurse call bell system.

- We reviewed the extravasation kit and the cytotoxic spillage kit in the oncology department. Both kits were in date and had been checked regularly, verified by date and signature.
- We observed during the inspection that meeting rooms, cleaning and storage cupboards and utility rooms were kept locked and secured at all times. This meant that access to areas unsuitable for patients was controlled.
- Emergency and resuscitation trolleys were secured with anti-tamper tags making it clear if someone had accessed the equipment. According to hospital policy there should be daily checks of equipment on top of the trolleys and weekly checks of equipment in the draws with staff signing to confirm that checks had been made. We inspected the resuscitation trolleys in the endoscopy area and the oncology department and found all checks up-to-date and completed. This showed there was a consistent and regular approach to safety checks.
- We reviewed the environment risk assessments for the endoscopy and oncology departments and found them to be thorough and in date. Hazards were identified, such as certain equipment and chemicals used in the areas, who was at risk and the controls to mitigate the risks.
- The majority of equipment checked in the endoscopy and oncology departments was in date for its safety testing and maintenance and had dates displayed.

For more detailed information on environment and equipment please see the surgery report.

Assessing and responding to patient risk

Staff completed and updated risk assessments for each patient. They kept clear records and asked for support when necessary.

- The hospital had an emergency resuscitation team and they met daily in the morning to allocate roles if a medical emergency should happen that day.
- The admission policy set out the safe and agreed criteria for the admission of patients to the hospital. Patients with complex co-morbidity and bariatric patients would not routinely be admitted for treatment.
- Admission exceptions were only considered with agreement from all clinicians (nursing and medical) and the senior management team involved in the care of the patient. There had to be a a multidisciplinary team meeting where risks where assessed and an action plan put in place to mitigate risks.
- Once a patient was booked for treatment in the endoscopy unit they had a pre-assessment to ensure they met the inclusion criteria. This assessment was carried out over the telephone by a registered nurse.
- Information from the endoscopy pre-assessment was recorded in the patient's care record. Information collected included health, social and emotional well-being. Information collect in pre-admission assessment was used to helped evaluate and highlight any potential patient risks. Potential risks could then be mitigated by the staff or flagged to the consultants for their attention.
- We reviewed 14 patient care records and found that all questions were covered and recorded in the patient's care records and any potential risks identified and passed to the relevant teams.
- Included in the patient care record was information on any allergies the patient might have. Care records we reviewed showed this was completed. Nursing staff told us that patients with known allergies would wear a red wristband to alert staff of their allergic status and helped to mitigate the risk of allergic reactions.
- There was a daily meeting of the endoscopy team to discuss patients attending that day for their procedures. Any potential patient risks or issues were highlighted and planned for.
- On the day of endoscopy procedures patients would be admitted to one of the hospital's wards and a registered nurse would complete further pre-procedure assessments. We reviewed patient care records and found these to be completed.
- Qualified nurses accompanied patients from the ward to the endoscopy unit where the procedure would be carried out.
- The five steps to safer surgery was used by the hospital, which included the World Health Organisation (WHO) surgical safety checklist. The safety checklist is a recognised tool developed to help prevent the risk of

avoidable harm and errors during and after procedures and should include safety-briefing, sign in, time out, sign out and debriefing. We reviewed endoscopy patients' care records and saw that it was comprehensive and included all steps to assure patient safety. WHO checklists used in the endoscopy department were part of the corporate audit programme. We reviewed audit data from October, November and December 2018 and found compliance was 94%, 97% and 100% respectively.

- After the endoscopy procedure patients were taken to the three-bedded recovery unit. Each bay had oxygen and suction and there was a patslide available. A patslide is a full body sliding board that is designed to be used when transferring a patient in a semi reclined or lying position.
- Whilst in the recovery unit patient's health and wellbeing was monitored using the nationally recognised national early warning scores (NEWS). NEWS is a chart used to quickly determine the degree of illness of a patient. It is based on six patient observations, breathing rate, amount of oxygen in the blood, blood pressure, heart rate, level of consciousness and temperature. It is used to help recognise a patient whose condition was deteriorating. Staff we spoke with could explain that NEWS had recently been updated by NHS England and NHS Improvement for use in hospitals in England to NEWS2.
- Following recovery from the procedure a registered nurse would accompany patients back to the ward for further assessment and supervision.
- Chemotherapy patients had their first cycle in the bedroom next to the nurses office. This meant staff were close by if there was a drug reaction.
- Oncology staff did not administer chemotherapy out of hours. Nurses worked within the hospital chemotherapy policy and did not administer chemotherapy to patients unless blood test results showed it was safe to do so.
- Patients requiring chemotherapy had a wallet-sized medical alert card to carry. This advised them about the risks of developing an infection and told them what symptoms to act on and the hospitals contact numbers.
- Staff, in both the endoscopy and oncology departments, were able to describe how they would escalate concerns about a deteriorating patient. The hospital had a resident medical officer (RMO) on duty 24 hours a day to provide medical attention and attend any emergencies. Staff said that they were always responsive and attended when needed. The consultant medical staff were also available by telephone in the event of any concerns about a patient.
- If a patient should deteriorate, the RMO would review and liaise with the consultants for advice about managing increased risks or to consider transfer to an acute hospital if needed.
- The hospital had service level agreements in place with the local NHS trust for transferring patients for medical reasons. Staff told us they followed the BMI policy for the transferring of patients if a transfer was required.
- Between January 2018 and December 2018 there had been 18 unplanned transfers. Two of these transfers had occurred from the oncology department.
- Patients were given out of hours telephone numbers on discharge from the hospital, in case they became unwell after their endoscopy or chemotherapy treatment. Oncology nurses provided an on-call service for patients who felt unwell and needed to contact the hospital out of hours.

Nurse staffing

The service had enough nursing staff, with the right mix of qualification and skills, to keep patients safe and provide the right care and treatment.

- Nursing staff was one of the highest risks identified on the hospital risk register as there were ongoing difficulties with recruiting nursing staff. Staff told us they used a team of regular bank nurses and agency staff to cover nursing vacancy hours.
- Nursing staff levels and skill mix were planned according to patient admissions which were known in advance.
- The endoscopy department employed two permanent members of staff and used six regular bank staff. In total there were seven registered nurses but, only one was a permanent member of staff, an endoscopy technician and two healthcare assistants. A months staffing rota showed safe staffing levels. We were told they rarely used agency staff and managed staff shortages by working paid additional hours.

- The oncology department currently had two permanent members of staff and used oncology trained bank and agency staff to fill staffing gaps. The department was currently advertising for three permanent chemotherapy nurses and a healthcare assistant. We reviewed a month's staffing rota and saw there was two registered nurses on duty when chemotherapy was being administered.

Medical staffing

The service had enough medical staff with the right qualifications, skills, training and experience to keep people safe from avoidable harm and to provide the right care and treatment.

- There was a practising privileges policy for consultant medical and dental practitioners. We noted that this was a corporate policy and overdue for renewal in October 2018. Post inspection we were sent the renewed policy dated 10 January 2019 with a renewal date January 2022.
- The hospital practising privilege policy set out the requirements for each consultant concerning their indemnity, appraisal, General Medical Council registration, Disclosure and a Barring Service (DBS) check and yearly mandatory and appraisal proof of compliance. DBS assists employers make safer recruitment decisions and prevents unsuitable or unqualified people from working with vulnerable groups.
- All medical and surgical consultants, paediatricians and anaesthetists had to complete an application to be granted practising privileges. This information was used by the hospital management team to determine whether the person had the required skills and experience to carry out care and treatment at the hospital, and they were working within their normal scope of practice. Medical staff who could not demonstrate they had the relevant skills were not granted practicing privileges.
- There were robust processes in place for reviewing practicing privileges at the hospital. The hospital director reviewed these every two years, however, certain information such as mandatory training and appraisal information were reviewed yearly. We reviewed 30 set of consultant files and found all checks had been completed.
- Each patient was admitted to the hospital under the care of a named consultant with the relevant experience in that area of medicine. The hospital required consultants to be available to attend to the patient within 30 minutes of being called, which met the recommendations set out by the Association of Independent Healthcare Organisation (AIHO). Staff in the endoscopy and oncology departments told us consultants made themselves available to provide advice over the telephone or attended the hospital when required.
- Clinical staff in the endoscopy and oncology departments told us they had a good working relationship with their consultants, they were comfortable contacting them when the need arose and found them to be helpful. During the inspection we saw interactions between the nursing teams and the consultants and found them to be friendly, professional and with mutual respect.
- Day to day medical cover was supplied by the RMO who provided a 24 hours a day, seven days a week service, on a rotational basis. RMOs were employed through a formal contract with an agency. They worked a one week on one week off rota. This ensured that their duty weeks were balanced with consolidated periods of rest.
- The RMO provided support to the clinical team in the event of an emergency or with patients requiring additional medical support. The external agency that supplied the RMOs had a standby programme which could supply additional cover if the RMO had been woken during the night and not received enough sleep to continue working during the day or for absence cover.
- 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. BMI Healthcare's practising privileges policy required consultants to remain available both by telephone and, if required, in person, or to arrange appropriate alternative named cover if they were unavailable. This was to ensure a consultant was available to provide advice or review patients at all times when there were inpatients in the hospital. Staff we spoke with confirmed this happened.

Records

Good

Medical care

Staff kept detailed records of patients' care and treatment. Records were clear, up-to-date and easily available to all staff providing care.

- Endoscopy and oncology patients that were admitted to the hospital for a procedure had a care record. This was a complete record in a booklet form, containing all information from when a patient had been booked in for a procedure until follow up care after discharge had finished. These records were used for every patient and were multidisciplinary, meaning each clinical team wrote in the same set of records.
- Where appropriate patient care records contained stickers identifying equipment used during treatment. This meant equipment could clearly be tracked and traced.
- In the oncology department if a patient called the department, either when the unit was open or to the on-call service, a 24hr triage log sheet would be completed by an oncology nurse. This recorded all the significant details including name of patient, date & time, reason for call, treatment details, action taken, any follow up actions and a staff signature box. We reviewed seven 24hr triage log sheets and found them to completed thoroughly and appropriate action taken.
- Discharge letters were sent electronically to the patients' GPs immediately after discharge, with details of the treatment, including follow up care and medications provided.
- We reviewed 14 sets of patient records across the two departments and found them to include the relevant assessments of care needs, risk assessments and were patient centred and personalised.
- Once patients had been discharged and no further follow up care was required, records would be stored by the hospital's medical records team.

For more detailed information on records please see the surgery report

Medicines

The service followed best practice when prescribing, administering, recording and storing medicines.

- Medicines and controlled drugs were securely stored in a locked cabinet, within a locked room with entry via a key pad in the endoscopy department. Keys for the drugs cupboard were kept in a key safe with only relevant staff knowing the code.
- All medicines were stored neatly with drugs all in date and documentation completed correctly.
- Medication fridges were locked when not in use and checked daily to make sure they were within the correct temperature range. Fridge temperature records we reviewed confirmed this. When we asked what would happen if temperatures went out of range we were told by clinical staff there were procedures in place that they would follow, which included contacting the pharmacy department for advice.
- The hospital had an on-site pharmacy that was responsible for the supply and top up of medicines used in the endoscopy department. However, we were told by staff working in the endoscopy department, that pharmacy were short staffed and it was easier for them to go to pharmacy for anything they needed.
- Chemotherapy used in the oncology service was prescribed through an electronic prescribing system. We saw oncology nurses using the electronic prescribing system to perform checks and record administration.
- Chemotherapy was supplied pre-prepared to the pharmacy department at the hospital.
- Medicines were securely stored in a locked cabinet or in locked fridges, within a locked room with entry via a key in the oncology department. All medicines were stored neatly with drugs in date and documentation completed correctly.
- We saw two nurses check the chemotherapy medication prior to it being administered to the patient. The nurse checked the patient's details to be sure the right dose was given to the right person, at the right time and by the right route.

For more detailed information on medicines please see the surgery report

Incidents

The service managed patient safety incidents well. Staff recognised incidents and reported them

appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support.

- Staff reported incidents using the electronic reporting system. Staff in the endoscopy and oncology departments said they felt confident to report incidents and knew what constituted as an incident.
- From January 2018 to December 2018 there had been 2 incidents reported relating to the endoscopy service and 12 incidents relating to the oncology service. All incidents were graded as no or low harm.
- Both of the endoscopy incidents related to problems with equipment. The oncology incidents were related to patients reacting to their medication (33%), medication errors (25%), medication not ordered (17%), transfer to an NHS hospital needed (17%) and problems with medication bag (8%).
- There had been no never events reported relating to either the endoscopy or oncology services in the last 12 months. A never event is a serious incident which is wholly preventable, where 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.
- Staff could give us examples of when change was needed as a result of an incident. For example, there had been a change in the process for entering a patient's weight on the e-prescribing system after a patient's weight had been entered incorrectly and the wrong dose of chemotherapy given.
- Staff we spoke with said they received feedback from reported incidents, both those relating to their immediate area of work and those that had been reported elsewhere in the hospital. This promoted shared learning from incidents throughout the hospital.
- The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of 'certain notifiable safety incidents' and provide reasonable support to that person.
- Staff we spoke with in the endoscopy and oncology departments could explain duty of candour and understood their responsibility to be open and honest with the family when something had gone wrong. The lead nurse in the oncology department explained how they had applied and documented duty of candour when the wrong dose of chemotherapy had been administered to a patient.

For more detailed information on incidents please see the surgery report

Safety Thermometer

- The NHS safety thermometer is a tool for measuring patient safety. It focuses on the most common harms to patients in healthcare.
- BMI Healthcare used the NHS safety thermometer and reported measures on a monthly basis relating to the following, pressure ulcers, falls, urinary tract infection (UTI) in patients with a catheter and venous thromboembolism (VTE).
- BMI The Chiltern hospital collected this data from patients on the wards and used it to monitor performance and put in measures to improve patient care.

For more detailed information on safety thermometer please see the surgery report

Are medical care services effective?

Good

Our rating of effective stayed the same. We rated it as **good.**

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence of its effectiveness. Managers checked to make sure staff followed guidance.

- Medical care patients' care and treatment took account of national guidance. Policies and procedures we

reviewed in the endoscopy and oncology departments referenced national guidance including the National Institute for Health and Care Excellence (NICE), the Royal College of Nursing, and other relevant bodies.

- The endoscopy service continued to work towards Joint Advisory Group (JAG) accreditation. Senior staff in the endoscopy department were part of the British Society Gastroenterology group. This was an organisation focused on the promotion of gastroenterology within the United Kingdom.
- All policies were available on the hospital's electronic system. Staff demonstrated to us how they were able to locate them easily when required.
- The National Institute of Health and Care Excellence (NICE) guidelines were reviewed at BMI corporate level, cascaded to the individual hospitals and shared with staff. Policies based on best practice and clinical guidelines were developed nationally and cascaded to the hospitals for implementation. These were reviewed by the clinical governance board and recorded on a local register. Staff were required to sign to say they had read the policies.
- When we reviewed minutes from the clinical governance meetings we could see that updates to national guidance was an agenda item. It was the heads of departments responsibility to ensure these changes were incorporated into the working practices of the hospital.
- The hospital had a clinical audit programme, which was set corporately by the BMI Healthcare group. This meant that the hospital could benchmark the results from the audits with other hospitals of a similar size within the BMI Healthcare group. Audits included consent, resuscitation, hand hygiene, health and safety, the WHO safer surgery checklist, and medicines management. Information on audits was coordinated by the Quality and Risk Manager who produced monthly reports to share with the departments. Depending on the audit results, heads of departments would decide what actions were required. For example, we were told of times the infection control lead would run extra hand hygiene training if audit results were seen to be dropping.
- The hospital audit results were used to benchmark the hospital against other hospitals in the BMI Healthcare group. This information was included in the quality and risk manager's monthly reports.

For more detailed information on evidence-based care and treatment please see the surgery report.

Nutrition and hydration

Staff gave patients enough food and drink to meet their needs and improve their health. The service made adjustments for patients' religious, cultural and other preferences.

- Endoscopy patients were advised about pre-surgery fasting (that is omitting food and fluids except water before operation) times during the pre-assessment process.
- Nursing staff from both the endoscopy and oncology departments asked about any food intolerance or allergies as part of their pre-assessment and recorded the information the patient care records. This also included specific dietary requirements, such as vegetarian or halal. This information was passed to the catering team who prepared the meals. We saw this information captured in the patient care records we reviewed.
- Clinical staff completed the malnutrition universal screening tool (MUST) as part of the patient's risk assessments during their pre-assessment. This was used to identify patients at risk of malnutrition. Staff could contact a dietician, from the local NHS trust, for additional advice if needed.

Pain relief

Staff assessed and monitored patients regularly to see if they were in pain.

- Patients we spoke with were very satisfied with how staff had managed their pain and commented on the prompt response and action taken by nursing staff when they were experiencing pain.
- During the inspection we observed nursing staff asking patients about their pain levels and provide medication to help reduce the level of pain.

- The resident medical officer (RMO) could prescribe additional pain relieving medication for patients, or if there were significant concerns, nursing staff would speak with the patient's consultant.
- We reviewed patient care records and saw that pain was assessed, documented and managed well throughout the patients care.

Patient outcomes

Managers monitored the effectiveness of care and treatment and used the findings to improve them. They compared local results with those of other BMI services to learn from them.

- The hospital participated in the BMI Healthcare corporate audit programme.
- The hospital participated in national audit programmes such as the Patient Reported Outcome Measures (PROMs) and the Patient Led Assessment of the Care Environment (PLACE). PROMs measured a patient's health status or health-related quality of life at a single point in time, and was collected through short, self-completed questionnaires. The PLACE audit was a national system for assessing the quality of the hospital environment, and focuses entirely on the care environment and not clinical care provision or staff behaviours.
- Monthly PROMs data was reported to the BMI Healthcare corporate quality and risk team. This enabled patient outcomes at the Chiltern Hospital to be compared to the BMI Healthcare average and national average.
- As part of the BMI Healthcare organisation the hospital contributed to the Private Healthcare Information Network (PHIN). Data was submitted in accordance with legal requirements which were regulated by the Competition and Markets Authority (CMA).
- Information on patient outcomes was disseminated to the hospital teams via the monthly quality and risk reports and the quality health reports.This information was also given to the Medical Advisory Committee (MAC). The MAC's role was to ensure clinical services, procedures or interventions were provided by competent medical practitioners at the hospital.
- We reviewed three months of quality and risk reports and saw that audit results for the endoscopy and oncology departments were consistently above 90%.

Competent staff

The service made sure staff were competent for their roles.

- There was a BMI Healthcare corporate induction programme for new staff and local induction processes dependent on the hospital department they worked in. Staff we spoke with confirmed that induction was relevant, useful and met their needs in the new workplace.
- All staff working in the endoscopy and oncology departments had to complete competency training on specific areas in order to work in the service. This included clinical skills, medicine management, governance, infection prevention and control and record keeping.
- Each member of staff, including bank staff, had their own training folder. We reviewed these folders for staff working in both the endoscopy and oncology department and saw certificates showing records of mandatory training taken and completed competency training.
- These folders were used by the registered nurses in their revalidation. Revalidation is the process where registered nurses and midwives are required every three years to demonstrate to the Nursing and Midwifery Council (NMC) they remain fit to practice.
- During the inspection and post inspection we asked if there was a competency framework or training matrix which detailed the competences needed for each grade of staff working in the endoscopy and oncology departments. We were not provided with this information. Therefore, we could not be ensured there had been an evaluation of the competencies required for each role in the teams, or an understanding of the current skills and experience of team and any skill gaps.
- Oncology nursing staff told us they had received limited training in end of life care. However, they told us they had strong links with the local hospice teams who would provide support when needed.

- All staff received yearly appraisals and data supplied following the inspection showed that 100% of endoscopy staff and 100% of oncology staff were compliant.
- Staff we spoke with said that the appraisals were useful and worthwhile. They helped identify where further training might be required or a time to discuss with their manager, further career aspirations.
- There was a BMI Healthcare corporate practising privileges policy. This document provided details of the criteria and conditions under which licensed registered medical practitioners would be granted authorisation by the hospital to undertake care and treatment of patients.
- All consultant staff were required to provide evidence of their accreditation, validation and appraisal before the hospital granted them practising privileges. The hospital medical advisory committee and the hospital director were responsible for granting and reviewing consultants practicing privileges every two years to ensure the consultants were competent in their roles. The hospital also ensured yearly, that consultants had appropriate professional insurance in place; GMC registration and current licence to practice; an appraisal and personal development plan; infectious disease immunisation status; and their mandatory training was up-to-date. We reviewed 30 set of consultant files and found them to be thorough and up to date.

Multidisciplinary working

Staff of different kinds worked together as a team to benefit patients.

- Staff we spoke with in the endoscopy and oncology departments and the wider hospital told us there was effective working between all staff groups.
- Oncology nurses told us that patients were discussed and treatment protocols agreed by the cancer multidisciplinary team (MDT), as part of the BMI Healthcare hospitals group cancer standards. This ensured a team of experts came to a decision in line with national guidance about the best treatment for patients rather than one doctor making the decision alone. This matched government standards. The nurses told us they did not always attend but would always be copied into minutes from the meetings.
- The oncology nurses told us they had good working relationships with the pharmacy department, the resident medical officer and their oncology consultants and worked as a team.
- There was clear communication between staff from different teams, such as endoscopy nurses and ward staff. We observed safe and effective handovers of care between the ward and endoscopy staff.
- Our observations of practice, review of records and discussions with staff during the inspection, confirmed good multidisciplinary working between the different teams involved in a patient's care and treatment.

Seven-day services

- The endoscopy department operated Monday to Friday.
- The oncology department was open Monday to Friday 8am to 4pm. Outside these hours there was an out of hours on call service where patients could telephone and speak to an oncology nurse if they needed help or advice.
- Nursing cover was available on the wards, all day, every day, when the hospital was open.
- All clinical heads of departments rotated on a weekly basis to cover clinical care issues out of hours. These staff members would attend in person if there was a clinical risk/concern to deal with.
- The resident medical officer (RMO) was on-call at all times and was based at the hospital, should staff need to escalate concerns about a patient. The RMO told us they were woken at night infrequently and therefore were normally able to rest between midnight and 7am.
- Consultants were required as part of the BMI practising privileges agreement to be contactable by phone and able to attend the hospital within 30 minutes, if they had admitted patients at the hospital. It was their responsibility to arrange appropriate cover if they could not be available. Nursing staff said they had no problems getting in contract with their consultants if they were needed.
- The radiology department provided an on-call service outside of normal working hours and at weekends. Staff could contact the radiologists out of hours to authorise requests and review results but there were no documented on-call arrangements.

Good

Medical care

- The pharmacy service opening hours were 8am to 6pm. Outside of these hours the RMO and nursing staff dispensed medications which had already been prescribed, with access to an on-call pharmacist as needed.
- There was a laboratory to process blood tests on site between 8.30am and 4.30pm Monday to Friday.

Health promotion

- There was no formal health promotion programme for endoscopy or oncology patients. However, we saw a range of health promoting leaflets and posters displayed in prominent areas, such as the hospital waiting rooms.
- The BMI Healthcare website offered advice on a range of health topics, including six tips to getting a good night's sleep.
- Staff working in the endoscopy and oncology departments told us they took opportunities to discuss healthy lifestyles where appropriate with their patients and relatives.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. They followed the service policy and procedures when a patient could not give consent.

- There was a BMI Healthcare corporate consent for examination and treatment policy (April 2018). This contained all matters concerning obtaining consent including, the training required to take consent, whose responsibility it was to obtain consent and when to use implied, verbal and written consent.
- Consent forms we reviewed in the endoscopy and oncology departments were completed correctly and identified the procedure planned and detailed the risks and benefits. The hospital consent forms complied with Department of Health guidance.
- We were told by the oncology nurses that consent was obtained each time a patient attended for chemotherapy treatment and we saw evidence of this in the patient records.
- We observed staff asking patients' verbal consent before performing therapeutic treatment and post-procedure observations.
- Training on mental capacity and deprivation of liberty safeguards (DoLs) was included in the mandatory safeguarding adults training.
- Staff we spoke with were able to describe how DoLS might be required and that would contact the director of clinical services and involve the consultant and relatives as appropriate. However, none of the staff we spoke had had the need to apply for a DoLS or complete a mental capacity assessment.

Are medical care services caring?

Good

Our rating of caring stayed the same. We rated it as **good.**

Compassionate care

Staff cared for patients with compassion.

- Staff throughout the hospital put patients at the centre of what they did.
- During the inspection we saw pleasant interactions between staff and patients. Staff spoke with patients and relatives in a kindly manner, using supportive language.
- Feedback from the patients we spoke with at the time of the inspection and from our observations, showed staff in the endoscopy and oncology departments treated patients and their families with kindness and were attentive and always found the time to chat with them.
- Staff understood and respected the personal, cultural, social and religious needs of people and how these may relate to care needs. For example, they checked how patients preferred to be addressed and recorded this in the care pathway.
- Staff at the hospital encouraged patients to complete patient satisfaction questionnaires to review and improve patient experience. The results of the questionnaire were collated by an external company and a monthly report provided to the hospital for review and analysis. This information was cascaded down to

the hospital teams. The monthly report showed patient response rates, rating within categories and ranking against all BMI hospitals. At the time of inspection the hospital was rated 43 out of 55 BMI hospitals nationally.

- The hospital used the NHS Friends and Family Test (FFT). This is a tool that gives people that use the service the opportunity to highlight both good and poor patient experience.
- We were not supplied with the individual FTT performance data for the endoscopy department. However, from January 2018 to December 2018 the overall hospital had received an average recommend rate of 96% with a test response rate of 52%.
- We saw many examples of compliments that the oncology department had received about the kindness and compassion displayed by staff. During the inspection we saw many letters and cards sent to the oncology department which complimented staff on their kindness and compassion. Examples included:-
  - 'thank you so so much for caring for me and making my visits to the hospital such a pleasure. It is really appreciated.'
  - 'thank you all for the care and support you have given me again in 2018'
  - 'excellent care, comfortable surroundings. I was very well looked after.'

Emotional support

Staff provided emotional support to patients to minimise their distress.

- When talking to staff, it was clear how passionate they were about caring for their patients and how they put patients' needs at the forefront of everything they did.
- Patients were given appropriate and timely support and information to cope emotionally with their care, treatment or condition. This could be in the form of talking with staff, being provided with information leaflets, or being signposted to other support services. For example, clinical psychologists or Macmillan cancer support.
- During the inspection we saw staff giving emotional support to patients. They understood that each patient was an individual and took time to get to know their patients. This meant they could give the right emotional support for that patient and their families when needed.
- The pre-admission assessment process in the oncology department was used to help relieve patients and their families of anxieties about coming to the hospital and the treatment they were about to undertake. Patients were told what to expect during their treatment. It also gave them the opportunity to visit the hospital and view the department and meet the staff who would be looking after them during their stay which helped relieve anxieties.
- The hospital did not have its own chaplaincy service but had links with local services who attended if requested.

Understanding and involvement of patients and those close to them

Staff involved patients and those close to them in decisions about their care and treatment.

- Patients we spoke with in the endoscopy and oncology departments told us they were fully involved and informed about their care and treatment. They had also been made aware of any costs they may incur. They told us they were given time to discuss any issues they might have with all the staff involved. They felt involved in making decisions about their treatment at each stage.
- Staff in the oncology department acknowledged chemotherapy affected the patient and those close to them. Therefore they would, if agreed with the patient, consider both the patient and their families in care planning.
- Patients told us they were given clear explanations about the risks and benefits of the planned treatment through discussion with their consultant and at pre-assessment discussions.
- We heard and saw through patient cards and letters that oncology patients felt actively involved and could ask questions about their care. Examples included:
  - 'the staff are like my best friends in here, I can talk about everything with them'
  - 'if you have concerns about any aspect of your treatment the staff are very approachable'

- 'discussed side effects of treatment and gave effective advice'

Are medical care services responsive?

Good

Our rating of responsive stayed the same. We rated it as **good.**

Service delivery to meet the needs of local people

The service planned and provided services in a way that met the needs of local people.

- The hospital had admission criteria which meant that the hospital only admitted patients whom the hospital had facilities to care for.
- The majority of patients who attended the BMI Chiltern hospital were privately funded or insured patients and procedures were planned. However, the hospital also worked with local commissioning groups to support NHS patients treated with a number of procedures including endoscopy.
- Between January 2018 and December 2018 94.8% of endoscopy patients were non-NHS funded and 5.2% of endoscopy patients were NHS funded.
- Between January 2018 and December 2018 100% of oncology patients were non-NHS funded.
- The hospital could complete simple blood tests inhouse. This meant results could be obtained quickly. For more complex blood tests, samples would need to be sent to an external local laboratory. The hospital sent samples to this laboratory three times a day. This frequency of pick-ups helped get results back to the hospital quicker.
- The hospital had free Wi-Fi which patients could connect to.
- Patients and relatives attending the hospital had access to free car parking within the hospital grounds.

For more detailed information on planning and delivery to meet the needs of local people please see the surgery report.

Meeting people's individual needs

The service took account of patients' individual needs.

- The endoscopy and oncology patient's individual needs were discussed during booking and pre-admission assessment. This information was used by staff to provide care and treatment in a safe way and mitigate any possible risk to the patient. If during pre-admission assessment, staff identified the service could not meet the patient's needs, staff would not treat the patient at the hospital and refer the patient to an alternative health care provider who could support the patient. The hospital did not have the facilities to support the care of patients with high complex needs. Therefore, this patient group was not admitted to the hospital. However, patients who had a learning disability or dementia could be admitted but only after the appropriate risk assessments had been carried out.
- Staff we spoke with told us they had completed dementia training but rarely treated parents living with dementia. 92% of staff at the hospital had completed mandatory dementia training.
- Patients received an information leaflet explaining different endoscopy and chemotherapy procedures prior to their appointments at the hospital. These leaflets were designed to address patient's questions about their forthcoming procedures.
- Staff told us, if needed, interpreting facilities were available to support patients whose first language was not English. The need for interpreting services would be established at booking and was the responsibility of the booking team to arrange when needed.
- In the hospital reception we saw signs telling hearing impaired patients there was a hearing loop. This is a special type of sound system for use by people with hearing aids. The hearing loop provides a magnetic, wireless signal that can be picked up by the patient's hearing aid when it is set to a certain setting. This can help reduced background noise and competing sounds that lessen clarity of sound in a public area.
- Procedure lists in the endoscopy department were mixed sexed. However, staff told us how they helped to maintain patient dignity. They did this by using dignity shorts in certain procedures. Dignity shorts were worn underneath open-back hospital gowns to help preserve

the patient's dignity and give comfort during the procedure. Curtains and walls separated the patients in the 3-bed recovery area which was used for patients waiting and recovering from procedures.

- Endoscopy patients were not allowed to drive for four hours after their procedure and to have a responsible adult with them for 12 hours after their procedure. Patients who did not have this kind of support could stay on the inpatient wards.
- The oncology team had updated their information for patients and put together an extensive library of material. This included leaflets on all aspects of cancer care and treatment, including leaflets on understanding cancer and chemotherapy, coping with fatigue, healthy eating during treatment and the emotional aspects of cancer. They also could provide information on turban and wigs and how to cope with hair loss.
- The oncology department offered the services of a reflexologist. Reflexology is a popular form of complementary therapy for people with cancer, with some patients finding it helped with symptoms such as pain, sickness and anxiety. During our inspection we saw comments from patients who had found this service useful, with one patient saying 'it was lovely to have reflexology after treatment, it was very relaxing after the stress of chemotherapy'.
- Blankets and heat pads were offered to oncology patients during their treatment.
- The oncology department also offered patients the use of cold caps before, during and after chemotherapy treatment. A cold cap is a device you wear on the head to cool the scalp to try and prevent or reduce hair loss. The use of cold caps would be explained to patients during their pre-assessment visit to the department.
- The hospital provided suitable meals and drinks for their patients. The patients and staff we spoke with talked highly of the service offered by the catering team. We were told and saw during the inspection oncology patients being offered a range of alternative food choices if the menu choices did not appeal to them due to side effects of chemotherapy.
- Patients in the endoscopy department were offered fresh water and food when safe to do so after treatments. Patients in the oncology department could access fresh water, fresh juice and hot drinks.
- The catering team told us they took pride in presenting quality meals for patients, staff and visitors to the hospital.

For more detailed information on meeting individuals needs please see the surgery report.

Access and flow

People could access the service when they needed it.

- The hospital followed corporate and local policies and procedures for the management of the patient's journey, from the time of booking the appointment until discharge and after care. Staff we spoke with were aware of these policies and procedures.
- The hospital had a written inclusion and exclusion criteria for patients attending the hospital. This meant the hospital only admitted patients they had the facilities and expertise to care for.
- The hospital offered a flexible service that included variable appointment times and choices regarding when patients would like their treatment, subject to consultant and nurse availability.
- The hospital had established a clear booking process for appointments and hospital admissions. Patients we spoke with told us the hospital had a good and efficient booking process. Oncology patients booked their treatment appointments directly with the oncology team rather than through the booking team.
- Patients were added by the booking team to the hospital's patient information management system. This meant that patient details and appointments could be tracked by staff working throughout the hospital.
- The endoscopy department conducted their patient pre-assessment appointment over the telephone. Due to the nature of the treatment, oncology patients attended their pre-assessment appointment at the hospital in the oncology department.
- Endoscopy and oncology procedures were day-cases but both types of patients could be admitted to the

inpatient ward and stay overnight if the need arose. For example, if the patient was frail or nauseous or had no support at home. We were given examples by staff when this had happened.

- There was no formal monitoring of referral to treatment time for private patients. Therefore, the service could not identify if there were problems relating to procedure delays and the reasons for them. As per NHS guidelines, NHS patients attending the hospital had their RTT recorded. Information provided by the hospital post inspection was split into medical speciality, therefore it was difficult to see the RTT time for NHS endoscopy patients.
- None of the patients we spoke with or feedback we reviewed from patients, had complained of long wait times for appointments.
- Post inspection we requested data for the number of cancelled procedures for non-clinical reasons. The hospital did not supply this information. Therefore, we were unsure if this information was being collected and used to improve the services offered.

Learning from complaints and concerns

The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with all staff.

- The hospital followed the BMI Healthcare corporate complaints policy. The hospital's executive director had overall responsibility for the management of complaints.
- The hospital received 132 complaints between August 2017 and July 2018. With two being referred to the ombudsman or Independent Healthcare Sector Complaints Adjudication Service in the same reporting period.
- Staff working in the endoscopy and oncology departments told us they always tried to address complaints or concerns immediately to see if they could be addressed by the team.
- We were told by staff in the endoscopy and oncology departments they had received no complaints in the last 12 months.
- However, staff in both departments could explain the procedure for investigating complaints and how learning from complaints would be shared with the team.
- Information supplied by the hospital post inspection confirmed the endoscopy and oncology departments had received no complaints in the last 12 months

For more detailed information on learning from complaints and concerns please see the surgery report.

Are medical care services well-led?

Good

Our rating of well-led stayed the same. We rated it as **good.**

Leadership

Managers at all levels in the service had the right skills and abilities to run a service providing high-quality sustainable care.

- The overall responsibility for the endoscopy department was with the theatres head of department (HoD). However, the endoscopy department was managed day-to-day by a senior nurse. This position was currently an interim position as the previous senior sister had recently retired.
- Staff we spoke with in the endoscopy department spoke highly of the day-to-day manager, who had previously been part of the team. During our inspection we could see the close working relationship between the manager and their team.
- The oncology department was managed by the oncology head of department, who was a registered oncology nurse. During our visit to the oncology department we could see that the manager and team worked well together to help continually improve the service offered in the department.
- When we spoke to the endoscopy and oncology managers they had a good understanding of the challenges to quality and sustainability in their departments, and were able to tell us the actions

needed to address them. They told us they felt supported by the senior management team and were able to discuss any issues with them, were listened to and their views respected.

- They also told us about additional training and the support given to them by the senior management team to help support them in their roles. For example, root cause analysis training.

For more detailed information on leadership please see the surgery report.

Vision and strategy

The service had a vision for what it wanted to achieve and workable plans to turn it into action, which it developed with staff and patients.

- The BMI corporate vision was to deliver the highest quality outcomes, the best patient care and the most convenient choice for patients. The senior management team had implemented a local vision for the hospital based on a care, compassion, competence, communication, courage and commitment. The local BMI vision was displayed throughout the department and staff knew what this was.
- The endoscopy department's vision was to achieve JAG accreditation and knew what action they still needed to take to achieve this. Currently the service was waiting for funding to be approved to address the outstanding issues.
- The oncology department's vision was to be able to offer an inpatient service as well as developing their chemotherapy service. The development of an inpatient service was part of the hospitals long term future but there was no timescales or funding in place to achieve it.
- All staff working in the endoscopy and oncology departments were aware of their individualised departments vision and the overall hospital strategy.
- The hospital had made changes since our last inspection in 2017. For example, upgrading the reception area of the hospital and replacing carpets with a hard floor in many areas of the hospital. Although timescales were unknown and funding was waiting approval, the staff we spoke with said the executive team had started to deliver on the hospital's vision and strategy, and therefore believed that the vision for their own departments would happen in the future.

For more detailed information on vision and strategy please see the surgery report.

Culture

Managers across the service promoted a positive culture that supported and valued staff, creating a sense of common purpose based on shared values.

- All staff we met during the inspection were welcoming, friendly and helpful. It was evident that staff cared about the services they provided.
- Staff we spoke with in the endoscopy and oncology departments told us they were proud to work at the hospital and were committed to providing the best possible care and treatment for their patients.
- Staff we spoke with talked of a team spirit in the hospital and being there for each other, like a family.
- Staff acknowledged that the senior management team had worked hard to improve the culture of the hospital. They felt more informed about what was happening in the hospital. We were told the senior management team were approachable and visible, and had an 'open door' policy to discuss concerns.

For more detailed information on culture please see the surgery report.

Governance

There were effective structures, processes and systems of accountability to support the delivery of the strategy and good quality, and sustainable services.

- BMI The Chiltern hospital had a governance framework in place through which the hospital were accountable for continuously improving their clinical, corporate, staff, and financial performance.
- Patient outcomes, the audit program and hospital meetings fed into the governance framework. Each

month the quality and risk manager would produce a hospital quality and risk report and a quality health report which was circulated to the senior management team for them to review and act on if needed.

- These reports would also be reviewed by the heads of departments to understand how their departments were performing. They could see the key quality issues of safety, risk, clinical effectiveness and patient experience for their departments. It was up to the heads of departments to disseminate this information to their teams and to act on any issues arising.
- We were told by heads of departments that information would be shared with their teams in many ways including, at handovers, on notice boards and in departmental meetings.
- Post inspection we reviewed minutes from departmental meetings. Meetings had a set agenda which included standard agenda items such as, the risk register, infection control and audits, and other issues needing to be discussed, such as staffing levels. This showed that information was shared and discussed within the department teams.

For more detailed information on governance please see the surgery report.

Managing risks, issues and performance

The service had systems in place to identify risks, plan to eliminate or reduce them, and cope with both the expected and unexpected.

- The hospital operated a hospital risk register which was regularly reviewed and updated to ensure risks were monitored and appropriately managed.
- The departments had their own risk registers which were managed by the heads of departments and fed into the hospital risk register.
- We reviewed the risk registered from the endoscopy and oncology departments and could see risks we had been told about on inspection reflected what staff had told us during the inspection. For example, staffing levels in the oncology department.
- From talking to staff and reviewing documentation we were assured the endoscopy and oncology departments were able to recognise, rate and monitor risk. This meant the departments could identify issues that could cause harm to patients and staff and threaten the achievement of their services.
- There was a systematic corporate programme of clinical and internal audit to monitor quality, operational and financial processes in BMI hospitals. During our inspection we could see from talking to staff and reviewing documentation that the endoscopy and oncology departments were carrying out these audits and identifying and taking action where required.
- The hospital had a daily meeting held at 9am, Monday to Friday. Representatives from each department attended these meetings. The meeting covered a range of subjects including risk review, recent incidents, health and safety updates, training compliance review, and any concerns that affected the hospital. This enabled staff to gain a wider view of risk, issues and general performance within the hospital. It was up to the departmental representative to feed information from the daily meeting back down to the members of their team. Staff we spoken with in the endoscopy and oncology teams said this was a good way to be kept informed and they thought it had helped with communication throughout the hospital.

For more detailed information on managing risks, issues and performance please see the surgery report.

Managing information

The service collected, analysed, managed and used information well to support all its activities, using secure electronic systems with security safeguards.

- The endoscopy department, since our last inspection, had implemented an electronic medical record system. This system included, a practice management tool for managing patient lists, the ability to attach and watch back image and video clips, equipment management, and electronic capture of consultant and nursing notes and observations. The database could be used to support the measuring of quality and patient outcomes.
- Senior nursing staff in the department had been trained to use the system and had rolled out training to the rest of the team and the departments consultants. We were

told by staff there had been initial problems changing to a new electronic system. However, six months on, the system had become accepted by all staff and embedded into their working practices.

- The oncology department had implemented a new prescribing system for chemotherapy patients. The system was a computer e-prescribing application that provided a complete end-to-end chemotherapy prescribing solution including predefined regimens, prescribing, scheduling, dispensing through to chemotherapy administration and reporting. The system had been brought in, to reduce the risk of transcribing and calculation errors, allow greater effectiveness of prescribing by the clinical team and save time for the oncology staff.

For more detailed information on managing information please see the surgery report.

Engagement

The service engaged well with patients, staff, the public and local organisations to plan and manage appropriate services.

- Since the last report in 2017, the hospital had engaged with staff through the staff survey and staff forums to help develop a plan for the hospital called 'passport to change'. The passport outlined what changes managers were responsible for and what changes staff were responsible for.
- The staff forums were also used to create the vision, values and objectives for the hospital, and the staff development plans.
- Staff we spoke with in the endoscopy and oncology departments could tell us about the ways that the senior management team had engaged with them and said it made them feel valued.
- We were told about a new staff newsletter, called chinwag, that was circulated to staff. This included information on new starters, BMI policies updates and upcoming events.
- Senior management told us they focused on retention as well as recognition of staff. As they believed this would help with both staff recruitment and retention. We were told of ways the hospital was rewarding staff. This included, staff parties and outings, a staff minibus to help transport staff to and from the hospital and, allowing staff to use the hospital's gym prior to services starting in there for the patients.
- The hospital actively gathered patient's views and experiences through questionnaires, which helped develop hospital services.

For more detailed information on engagement please see the surgery report.

Learning, continuous improvement and innovation

The service was committed to improving services by learning from when things went well or wrong, promoting training and innovation.

- All staff involved with the endoscopy and oncology departments were passionate about developing their service, giving the best care and treatment possible and increasing the number of patients seen at the hospital.
- The hospital had recently recruited a practice-based educator to help support the development of the clinical staff and to highlight staff who had the prospect to advance in the organisation.
- The senior nurse in the oncology department was currently developing a patient feedback form especially for oncology patients, as it was felt the general patient feedback form did not cover all the areas relating to this service. Once designed it would be sent to the BMI Healthcare corporate team for sign off. This questionnaire would then be used in all BMI Healthcare hospitals that saw oncology patients.
- The hospital had an ongoing refurbishment programme. Both patients and staff commented to us how this was making the hospital look more welcoming and professional.

Good

Surgery

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

Information about the service

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

Surgical services for children and young people are reported in children and young people's report.

In this section, we also cover hospital-wide arrangements such as how they deal with risks that might affect the hospital's ability to provide services (such as staffing problems, power cuts, fire and flood), the management of medicines and incidents, in the relevant sub-headings within the safety section. The information applies to all services unless we mention an exception.

The Chiltern Hospital is part of the BMI South Buckinghamshire Hospitals group. The senior management is shared between this hospital and The Shelburne Hospital, which we inspected at the same time.

The hospital is registered for 66 inpatient beds, all were in single, ensuite rooms across 3 wards;

Misbourne Ward – oncology and endoscopy

Chalfont Ward – 24 rooms, inpatients and day case patients

Shardeloes Ward – 20 rooms, day case patients

As part of the inspection of surgical services we inspected the Chalfont and Shardeloes wards.

The surgical service had three operating theatres, two with laminar flow, and a three bedded recovery area. The department operates between 8am to 8pm Monday to Friday and occasional Saturdays 8.30am to 5pm.

The inpatient and day-case activity for the period August 2017 to July 2018 comprised both non-NHS funded and NHS funded patients. Inpatient activity was 86% non-NHS funded and 14% NHS funded patients. Day-case activity was 20% non-NHS funded and 38% NHS funded. During the period August 2017 to July 2018 the surgical department saw 1,463 inpatients and 4,788 day-case patients.

The service carried out a range of surgical procedures including, but not limited to, cataract lens implants, hip and knee replacements and athroscopic knee procedures. A small proportion of surgery carried out was cosmetic.

Are surgery services safe?

Good

Our rating of safe stayed the same. We rated it as **good.**

Mandatory training

The service provided mandatory training in key skills to all staff and made sure everyone completed it.

- The hospital had a corporate mandatory training programme, which included but was not limited to topics such as infection prevention and control, moving and handling, fire safety, conflict resolution, safety, health and the environment, and information governance. The mandatory training programme was tailored to the individual needs of staff and relevance to their role.

- The BMI healthcare corporate mandatory training policy defined the mandatory training requirements of staff including bank workers. This included a mandatory training matrix which identified the mandatory training required dependent on job role.
- Agency staff completed training with the agency for which they worked.
- Staff completed training through the corporate learning system 'BMI Learn'; which was an online resource of training modules, e-learning courses, and some face-to-face sessions.
- Staff could view their individual training needs, current compliance and access e-learning courses through the hospital's electronic training system. The system also alerted both managers and staff when mandatory training was due to be completed. They could access e-learning courses at work or home, and were compensated for training they completed in excess of their contracted hours.
- Staff we spoke with told us they were up-to-date with most of the statutory and mandatory training.
- As of October 2018, compliance with mandatory training for staff working across the whole hospital was 93%. The corporate mandatory training policy states a target of 100% compliance for this training.
- Hospital-wide data provided by the hospital following the inspection showed that 89% of theatre clinical staff and 86% of clinical ward staff were compliant with immediate life support training which did not meet the hospital target of 90% or the corporate target of 100%.
- The resident medical officers (RMOs) received their mandatory training from their agency and were not allowed to work at the hospital unless this had been completed.
- The RMOs were trained in advanced life support (ALS) and other clinical staff trained in immediate life support (ILS). Non-clinical staff completed basic adult life support training (BLS).
- Hospital-wide data provided by the hospital following the inspection showed that 89% of theatre clinical staff and 86% of clinical ward staff were compliant with immediate life support training which did not meet the hospital target of 90% or the corporate target of 100%..
- All theatre staff had competency and mandatory training files. We reviewed the files and found they were all up-to-date, and provided evidence of completion of mandatory training and competencies. This was a significant improvement since our last inspection.
- Agency staff working in the surgery services had a local induction which covered the layout of the department, emergency procedures, paperwork and where to access essential information. Agency staff we spoke with told us the local induction was useful and provided them with the information they required to work effectively and safely.
- Senior staff across the hospital monitored mandatory training compliance and arranged both external courses and in-house training to provide multiple platforms for learning. We heard about scenario based training life support training provided by an external organisation which staff found useful. Staff received formal feedback from these training sessions. We reviewed one report which was detailed and provided areas for improved as well as praise.

Safeguarding

Staff understood how to protect patients from abuse. Staff had training on how to recognise and report abuse and they knew how to apply it.

- The service had a corporate safeguarding policy which incorporated Mental Capacity, Deprivation of Liberty Safeguards and PREVENT advice. PREVENT aims to safeguard vulnerable people from being radicalised to supporting terrorism or becoming terrorists themselves. The policy included what action staff should take if they had concerns a patient had undergone female genital mutilation (FGM).
- The required level of safeguarding training for staffing working at the hospital was included in the BMI healthcare corporate mandatory training policy. All staff required safeguarding adults level one, clinicians and all non-clinical staff in a managerial role required level two training and the director of clinical services, who was the safeguarding lead for adults required level three training.

- Consultants had to submit evidence they had completed their mandatory safeguarding training in their substantive post, for their practising privileges to be renewed.
- Staff told us they completed safeguarding children and vulnerable adults modules in their mandatory training. Evidence provided by the hospital showed 90.37% of relevant staff had completed level one safeguarding children training, 94.64% had completed level two safeguarding children training and 100% had completed level three safeguarding children training. For adults safeguarding training the completion rates were; level one 91.85%, level two 95.54% and level three 100%.
- The director of clinical services (DCS) was the hospital safeguarding lead for vulnerable adults and children, and trained to level three. Staff also had access to the BMI regional safeguarding lead trained to level four.
- Staff we spoke with had a good understanding of their responsibilities in relation to safeguarding of vulnerable adults and children and could explain how to respond to and escalate a concern or make a referral.
- Both wards at the hospital had folders containing safeguarding information. Staff displayed safeguarding information posters on office walls, which contained information on how to contact the local safeguarding authority.
- All staff were subject to Disclosure and Barring Service (DBS) checks. DBS helps employers make safer recruitment decisions and prevent unsuitable people from working with vulnerable groups.
- The hospital had a chaperoning policy and staff knew how to access it. We saw signs instructing patients to request a chaperone if they wanted one.

Cleanliness, infection control and hygiene

The service controlled infection risk well. Staff kept themselves, equipment and the premises clean. They used control measures to prevent the spread of infection.

- The service had corporate policies to manage infection prevention and control (IPC). Staff demonstrated how to access policies easily.
- There was a BMI healthcare corporate waste management policy which the hospital and staff followed. During the inspection we saw the correct management of containers for sharps and the use of coloured bags to correctly segregate of hazardous and non-hazardous waste.
- All clinical areas we visited in theatres and on the wards were visibly clean, well maintained and tidy. The wards, theatre rooms, reception and other areas we inspected were visibly clean and well maintained.
- Staff followed the hospital's policy on infection control, for example, complying with 'arms bare below the elbow' not wearing jewellery and the use of personal protective equipment (PPE), for example the use of gloves and aprons. PPE was available and hand wash gel was easily accessible in the clinical areas, individual patient rooms and the corridors. All hand wash dispensers that we checked were full and in working order.
- Housekeeping staff followed a weekly cleaning schedule. Ward managers checked and signed off the weekly cleaning schedules. Staff escalated any concerns or issues to them.
- The hospital had an IPC lead nurse and link nurses in clinical areas. The link nurses were responsible for collating audit data of cleaning schedules and producing actions to address compliance when necessary. For example, involvement in hand hygiene audits.
- The hospital had recorded nine surgical site infections in the reporting period August 2017 to July 2018. We were not provided with evidence to demonstrate how this compared with other BMI hospitals.
- The hospital followed current Department of Health guidance 'Who to Screen' for MRSA on the taking of swabs prior to admission. During the reporting period August 2017 to July 2018 the hospital reported no incidences of hospital acquired Meticillin-resistant Staphylococcus aureus (MRSA), Meticillin-sensitive staphylococcus aureus (MSSA), Clostridium difficile (c.diff), E-Coli.
- Staff completed annual training on infection prevention and control (IPC) as part of their mandatory training. Theatre and ward staff were required to complete two IPC training modules; IPC in healthcare and IPC high impact interventions. Hospital-wide data provided after

the inspection for these two modules showed theatre based staff compliance rates were 86% and 93%, and ward based staff compliance rates were 91% and 100% respectively.

- During our inspection we reviewed monthly infection prevention and control audits from the ward and theatres from the three months prior to our inspection. These covered hand hygiene, patient equipment, invasive device management and theatre asepsis. All achieved 100% compliance. This was an improvement since our last inspection.
- The hospital had a contract in place for decontamination and sterilisation of surgical instruments, which took place off-site. The BMI organisation, and this hospital, used a track and trace system to trace all reusable accessories to ensure appropriate maintenance, correct decontamination and traceability to associated patients.
- Quarterly IPC meetings took place, with performance in IPC audits such as hand hygiene discussed at these meetings and other areas of concern found at the hospital. This included the lack of a separate hand-washing sink on Chalfont ward. Senior staff were aware of this, and had agreed long-term plans to remodel the layout of the room and with staff using hand gel as an additional step at the current time.
- Lack of dedicated hand washing sinks in some clinical areas was highlighted in the previous inspection report 2016. During the current inspection we found this still to be the case. However, this was noted on the hospital risk register and plans had been developed to rectify the issue. The hospital ensured staff had access to hand sanitiser gel throughout the hospital.
- In the pre-assessment area there were carpets and patient chairs were fabric covered and therefore could not effectively be cleaned. The hospital recognised this was an infection control risk and there was a rolling programme for removal of carpets. We observed the carpets were clean and staff signed and dated to show carpet cleaning schedules were complete, including when a deep clean was completed. As the pre-assessment rooms were carpeted, nursing staff did not take blood in the department, instead patients attended the pathology department.
- In addition, since the last inspection carpets had been replaced in wards, patient room and reception areas. The hospital had an on-going programme to replace all carpets throughout the hospital.
- Emergency equipment, including the emergency suction equipment and the defibrillator kept on in theatre and inpatient wards were clean, tidy and dust free.
- The hospital provided patients with a leaflet in their pre-admission information pack that explained how good hand hygiene prevented and controlled infection. It included information about hand washing, good hand washing technique and when the use of hand sanitiser gel was appropriate.
- Also included in the pre-admission information pack was a leaflet about surgical site infection. This included information for the patient on how to spot the signs and symptoms of an infection and what action needed to be taken.
- The hospital had a water safety committee that met every three months. There was a set agenda which included water flushing round the hospital, the results of water testing and risk assessments for legionella and pseudomonas. We reviewed documentation that showed that regular water testing was being carried out.
- The hospital had a microbiologist on call to give advice and who attended the IPC committee meetings and the water safety committee. From the minutes we reviewed we could see the microbiologist attended these meetings.

Environment and equipment

The service generally had suitable premises and equipment and looked after them well.

- The ward and theatre environments were suitable for the level and type of care delivered. In-patients had an individual room with ensuite bathroom and toilet facilities. The rooms were comfortably furnished which patients said met their needs and included a bedside nurse call bell system.
- The recovery area had space for four trolleys for patients recovering from surgery. The design and layout of the area was functional however space was limited limited

by the nature of the building. The hospital had developed plans to redesign the recovery area. Due the extensive nature and cost of the work needed, redevelopment work had not yet begun.

- Staff used portable screens to separate patients. The fabric of the building meant they were unable to have fixed curtain rails on the wall.
- The recovery area was also used for paediatric patients who had undergone surgery. Given the limited space this meant that there could be both adult and paediatric patients recovering from surgery in the same area, which is not in line with best practice. The hospital had risk assessed the area and action are being taken to address the situation. Our concerns are covered in the children and young peoples report.
- The area identified for paediatric patients to recover was also over-looked, through a window, by the theatre suite office. There was a concern that this presented a safeguarding and privacy and dignity risk should non-hospital staff be visiting the office.
- Both wards and the theatre suite had resuscitation trolleys for emergency use secured with tamper proof tags. Staff performed daily checks on the resuscitation equipment stored on top of the resuscitation trolleys and weekly checks on the contents. We reviewed a section of the records for trolley checks and found that they were consistently recorded for the two month period prior to our inspection. There was clear indication when the hospital was closed and therefore when checks did not need to be performed.
- The theatre suite had a difficult airways trolley with records confirming that this was checked weekly.
- Equipment and consumable items such as dressings were neatly stored on shelves raised off the floor which enabled cleaning of the storage areas. Staff maintained stock levels well for both reusable and single use items. Equipment in general was stored appropriately, with clear labelling in storage rooms.
- The theatre department ordered operating equipment sets from a BMI central hub. If equipment was unavailable they had a good relationship with the local NHS trust to 'borrow' equipment sets in an emergency.
- Staff understood their responsibility to ensure they segregated and disposed of clinical waste appropriately. Clinical waste bins were clearly labelled and we observed staff kept the rooms used to store clinical waste clean and tidy to minimise infection risk. There was a contract in place with an external supplier to dispose of clinical waste, which was stored securely until collected.
- Staff had access to the use of a hoist for transferring patients. The hospital provided disposable slings for individual patient use. Staff told us they received training on the use of the hoist.
- The hospital serviced and tested clinical equipment according to manufacturer's guidance; there were a number of service level agreements in place for servicing of equipment.
- The hospital participated in the Patient-Led Assessments of the Care Environment (PLACE) assessments. PLACE assessments provide a framework for assessing quality against common guidelines and standards in order to quantify the environment's cleanliness, food and hydration provision, the extent to which the provision of care with privacy and dignity is supported, and whether the premises are equipped to meet the needs of people with dementia or with a disability. The hospitals PLACE scores for 2018 were better than the England average and the BMI corporate score in all but two domains, the condition, appearance and maintenance of the hospital and ward food which was better than the national average but not as good as the BMI corporate score.
- There was sufficient equipment to maintain safe and effective care, such as anaesthetic equipment, theatre instruments, blood pressure and temperature monitors, commodes and bedpans.
- Theatre staff checked anaesthetic machines daily and the tubing weekly. Records we reviewed during the inspection showed that these checks were carried out.
- Theatre ventilation complied with national guidance HTM 03-01. By complying with the guidance this meant that there were sufficient air changes to reduce the risk of infection.
- The hospital had its own onsite maintenance team who kept records of equipment across all departments, this included current service history, and when the next service was needed.

- Equipment was labelled to show purchase, service and calibration dates where appropriate. We checked a random selection of equipment across the ward and theatres, including blood pressure monitors, hoists, scales and operating and anaesthetic equipment and found they all had current electrical testing and maintenance dates displayed.
- The hospital had a tracking system for details of specific implants and equipment to be recorded and reported to the national joint registry. We saw that all equipment, implants and prosthesis were tracked and traced. All records that we looked at had clear evidence of this with batch numbers recorded.
- Clinical specimens were labelled and stored securely in monitored specimen fridges. Both the theatre and ward specimen fridges had consistent records of daily high and low temperature to provide assurance that they were operating correctly.
- At the previous inspection concerns regarding security in the operating department. Our concerns had been addressed and access to the operating department was now secure.

Assessing and responding to patient risk

Staff completed and updated risk assessments for each patient. They kept clear records and asked for support when necessary.

- Risk assessments were carried out for people who used the hospital and risk management plans were developed in line with national guidance.
- The service had a current corporate admission policy with a strict admission criterion. Patients with complex co-morbidity and bariatric patients were not accepted as the service did not have the facilities for complex care.
- Patients were required to complete a pre-admission questionnaire to assess if there were any health risks that may compromise their treatment. Nurses discussed the health questionnaires with patients in the pre-admission clinics. If staff identified a patient as being at risk, they discussed these concerns with the patient's consultant, the resident medical officer (RMO) or anaesthetist as appropriate. If a patient's ECG result indicated abnormalities, the RMO reviewed the results and they arranged a referral to a cardiologist.
- Consultant anaesthetists reviewed pre-admission records on a weekly basis and patients identified as being slightly more complex were risk assessed by an anaesthetist to confirm their suitability for surgery at the hospital. Patients booked for endoscopy or local anaesthetic received a telephone pre-assessment.
- All patients having a general anaesthetic were assessed in a nurse led pre-operative assessment clinic prior to their surgery. Pre-operative assessments took place at the hospital. Pre-operative assessment is a clinical risk assessment where the health of a patient is considered to ensure that they are fit to undergo an anaesthetic and therefore the planned surgical operation. It also provides an opportunity to ensure that patients are fully informed about the surgical procedure and the post-operative recovery period and can arrange for post-operative care at home.
- Staff assessed patients for key risks at their pre-assessment and continued to monitor these before and after their surgery. These included risks about mobility, medical history, skin damage and VTE. Patients had to meet certain criteria before they hospital would accept them for surgery, these minimised the risk of harm to the patient due to lack of appropriate facilities.
- Patients were swabbed to assess for any colonisation of MRSA at the pre-assessment clinic as per hospital policy. If results were found to be positive the patient was provided with a treatment protocol to use at home, according to the hospital's MRSA policy. If necessary surgery would be deferred until patient had a negative swab result.
- Staff completed patient risk assessments using nationally recognised tools, such as the Waterlow score to assess patients risk related to pressure ulcers, mobility, moving and handling, venous thromboembolism (VTE) and the national early warning score (NEWS2). VTE compliance was audited quarterly and records showed that this was 100%. Records we reviewed during our inspection confirmed this was the case.
- The NEWS2 is a scoring system applied to a patient's physiological measurements to indicate early signs of deterioration in their condition. We saw that these were

documented in the patient's records and included actions to escalate for review . This meant that patients who were deteriorating or at risk of deteriorating were recognised and treated appropriately.

- Staff were able to describe how they would escalate concerns about a deteriorating patient. The hospital had an RMO on duty 24 hours a day to provide medical attention and attend any emergencies. Staff said that they were always responsive and attended when needed. The consultant medical staff were also available by telephone in the event of any concerns about patient care.
- The RMO was the doctor responsible for the care of the patients in the absence of the consultant. The RMO was trained in advanced life support and held a bleep for immediate response, for example, in the case of cardiac arrest.
- At our last inspection we had concerns that staff were not fully engaged with the WHO 5-steps to safer surgery process and did not recognise the importance of its completion for ensuring patient safety.
- During this inspection we observed the theatre team used the World Health Organisation (WHO) 5 steps to safer surgery, surgical checklist, and the Surgical Safety Checklist for Cataract Surgery which were designed to prevent avoidable mistakes. This included checks such as patient identify, allergies and ensuring the consent form had been signed. We observed staff using the checklist prior to surgery during the inspection. The 5 steps to safer surgery checklist was audited monthly and we reviewed the audits during our inspection and saw that they were 100% compliant.
- We observed and reviewed six WHO 5 steps to safer surgery surgical checklists and saw that it included all steps to assure patient safety during the anaesthetic and surgery period. We also observed patients being transferred from theatre to the recovery area, and saw that the anaesthetist, surgeon and scrub nurse verbally handed over the care and treatment carried out in theatre and discussed medication which had been prescribed for both recovery and the ward.
- The hospital had a sepsis screening tool and sepsis care pathway for staff to use if they suspected a patient had sepsis. The tool was line with current best practice principles from The UK Sepsis Trust. Staff we spoke with were aware of the screening tool and pathway and told us they would escalate any patients displaying these symptoms to the RMO. Sepsis training was part of the mandatory training Care and Communication of the Deteriorating Patient (CCDP) module. It is acknowledged that this was a relatively new course and the hospital were in the process of training all clinical staff. After the inspection we received hospital-wide training rates which showed 62% of theatre straff and 89% of ward staff had completed the training.
- Staff had immediate access to blood products, to stabilise patients with life threatening haemorrhage. Staff also had access to on-call facilities which included a radiographer, theatre team, engineer, senior practitioner and senior manager if required in an emergency.
- The practising privileges agreement, that all consultant staff worked under, stated that consultants should be available to attend the hospital to respond to any urgent concerns within 30 minutes. The RMO and nurses told us that consultants were easily contactable 'out of hours',such as at night or over a weekend should staff be concerned with a patient's condition. Individual consultants remained responsible for the overall care of their admitted patients and made arrangements for colleagues to cover in their absence.
- There were arrangements in place with a local NHS trust to provide 24-hour emergency support should patients require high dependency nursing or urgent diagnostics.
- If a patient's condition deteriorated, service level agreements were in place for transfer of the patient to the local NHS trust by ambulance. There were strict guidelines for staff to follow which described processes for stabilising a critically ill patient prior to transfer to another hospital. Nursing staff and the RMO were aware of the correct process to follow to ensure prompt and timely intervention for a patient who required additional medical treatment.
- During the 12 months prior to our inspection there had been four transfers of patients to another hospital.
- A small proportion of surgery was cosmetic. A senior staff member told us the consultant would manage their patients from admission to discharge allowing for a 'cooling off' period and refer for any psychological

assessment prior to surgery. A 'cooling period' is an agreed length of time in which someone can decide on whether to proceed with surgery or not. This is in line with nationally accepted best practice.

- Patients who had concerns following discharge, including day surgery could call the hospital or the corporate BMI 24-hour telephone advice line or access 'live support' on the BMI website.
- The hospital also had a 48 hour follow up call service and staff on the ward were scheduled to provide this.
- The hospital carried out scenarios with staff for emergency situations such as fire and cardiac arrest. Staff were provided with feedback and any lessons learnt were shared with the department.
- The hospital's resuscitation team's responsibilities were reviewed at the daily comms cell meeting. Each member of the team was allocated a specific role such as leader, airway management, defibrillation, recorder and runner. This was in line with best practice guidance issued by the Resus Council (UK).
- Nursing staff on the ward had to complete acute illness management training, every three years as part of their mandatory training. Hospital-wide data provided by the hospital after the inspection showed, as of January 2019, 89% of ward staff had completed this training against a target of 85%.
- All staff completed adult basic life support, immediate or advanced life support training depending on their role. Hospital-wide data provided by the hospital after the inspection showed, as of January 2019, 75% of theatre based staff and 100% of ward based staff had completed adult basic life support training, and 89% of theatre based staff and 86% of ward based staff had completed adult immediate life support.
- Theatre staff attended a safety huddle each morning, where the operating list was discussed. This was to ensure all patient needs and risks for that day were identified. We observed a huddle during our inspection and noted effective communication with all staff involved.
- Nursing staff on the wards undertook handover between each shift (day shift to night shift, and vice versa), which included an update on all patients currently admitted and highlighted any specific concerns (such as infection risks or safeguarding concerns) to all staff.
- The hospital had an in date major incident policy and a business continuity plan. These included the loss of mains electricity and generator power, fire alarm activation or system failure, and loss of staffing. We saw business continuity action cards for each major incident which detailed the actions staff should take, and useful contacts and telephone numbers. Action cards were held on reception desks to provide immediate guidance to staff should a major incident arise.

Nursing and support staffing

- **The service had enough nursing staff, with the right mix of qualification and skills, to keep patients safe and provide the right care and treatment. However there was high usage of bank and agency staff within the service.**
- The hospital manager meet with heads of department on a daily and weekly basis to review staffing, to ensure it met the needs and dependency of patients.
- Any shortages in staffing were discussed at the daily 'comms cell,' which was attended by a representative from all hospital departments. The comms cell was a meeting held at 9am every morning to review hospital activity and raise any concerns, staffing brief, emails, governance and team meetings, newsletters and noticeboards. We attended a comms cell during our inspection and noted effective communication with staff from all departments involved.
- At the last inspection we had concerns regarding staffing levels and competencies in theatres. Staff used in the role of surgical first assistants (SFA) had not been assessed as competent We saw the role of SFA had not been identified correctly on the theatre rota. During this inspection we found that this situation had improved. We saw evidence of staff competencies for the SFA role. We saw theatre rota's clearly showing the role of SFA identified and staffed accordingly.
- The theatre department staffing comprised of 17.9 WTE and part time staff made up of nursing staff, operating department practitioners (ODPs) and HCAs.

- Senior staff at the hospital told us that there were ongoing difficulties with recruitment and this was recorded on the risk register. Theatre staffing was planned using the theatre TM1 Tool. This tool is designed to automate analysis of a number of key theatre department process measures. The TM1 increases the efficiency of the department by refining staff allocation to patient numbers and procedure mix and therefore reducing staffing costs, creating capacity for additional caseload, improving patient safety and ultimately increasing satisfaction for patients, consultants and staff. The theatre department also used the BMI Resource Model in theatres which incorporated the Association for Perioperative Practice (AfPP) guidelines for safer staffing. The AfPP is a professional body for healthcare workers setting standards and guidance on best practice in operating departments
- The theatre manager provided the theatre rotas two-three weeks in advance. We reviewed staff rotas from September to October 2018 and saw that all shifts were filled. The theatre department used regular bank staff and agency staff.
- Nursing staff levels and skill mix were planned according to patient admissions which were known in advance. Staffing levels on the wards were calculated using the electronic BMI Healthcare Nursing Dependency and Skill Mix Planning Tool. This was an evidence based electronic patient acuity and dependency monitoring tool and ensured safe staffing numbers were planned according to the number of patients. The tool could be manually adjusted to take account of individual patient needs. The tool was populated five days in advance and reviewed on a daily basis.
- A minimum of two registered nurses were always on duty on the wards, one of whom was always a substantive member of staff, plus a minimum of one HCA. Nurse staffing was determined by the numbers of patients booked for admission and with the use of the nurse planning tool.
- There was at times a high use of agency staff due to difficulties with recruitment and retention of staff. For theatres, from August 2017 to July 2018, an average of 53% of planned staffing hours were covered by agency staff and bank staff.
- Evening day case patients sometimes returned late from theatre, after 9pm and some then needed to stay overnight. This created additional pressure for the night staff.

Medical staffing

The service had enough medical staff, with the right mix of qualification and skills, to keep patients safe and provide the right care and treatment.

- There was a corporate Practising Privileges Policy for Consultant Medical and Dental Practitioners. The policy covered dentists however there were no dentists employed at this hospital. We noted that this was a corporate policy and overdue for renewal in October 2018. Following our inspection the provider submitted a renewed policy dated 10 January 2019 with a renewal date of January 2022.
- The hospital practising privilege agreement set out the requirements for each consultant concerning their indemnity, appraisal, General Medical Council registration, Disclosure and a Barring Service (DBS) check and yearly mandatory and appraisal proof of compliance. DBS assists employers make safer recruitment decisions and prevents unsuitable or unqualified people from working with vulnerable groups, including children.
- Medical care was consultant led under practising privileges. A practising privilege is, “Permission to act as a medical practitioner in that hospital” (Health and Social Care Act, 2008). The hospital had granted 241 consultants/health professionals practising privileges, including but not limited to; specialist surgeons such as orthopaedic, ear nose and throat and urology, and anaesthetists.
- Consultants led and delivered the surgical service at the hospital. Surgeons and anaesthetists were required to be able to attend within 30 minutes drive of the hospital, in case they needed to urgently visit a patient. All consultants carried out procedures that they would normally carry out within their scope of practice within their substantive post in the NHS.
- 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. BMI

Healthcare's practising privileges policy required consultants to remain available both by telephone and, if required, in person, or to arrange appropriate alternative named cover if they were unavailable. This was to ensure a consultant was available to provide advice or review patients at all times when there were inpatients in the hospital. Staff we spoke with confirmed this happened.

- The practising privilege agreement also required that the consultant visit inpatients admitted under their care at least daily or more frequently according to clinical need, or at request of the executive director, director of clinical services or resident medical officer (RMO).
- Nursing and theatre staff told us they could contact any consultant, out of hours or when not on-site, if they needed advice about the best care and treatment for a patient. They told us they had a good working relationship with the medical staff, who normally attended the hospital promptly when called in.
- Patients we spoke with told us the consultant and anaesthetist had seen them prior to and after surgery.
- Day to day medical cover was supplied by the RMO who provided a 24 hours a day, seven days a week service, on a rotational basis. RMOs were employed through a formal contract with an agency. They worked a one week on one week off rota. This ensured that their duty weeks were balanced with consolidated periods of rest.
- The RMO provided support to the clinical team in the event of an emergency or with patients requiring additional medical support. The external agency that supplied the RMOs had a standby programme which could supply additional cover if the RMO had been woken during the night and not received enough sleep to continue working during the day or for absence cover.
- The RMO attended the twice daily ward handovers and performed a handover once weekly to their colleague coming on duty.

Records

Staff kept detailed records of patients' care and treatment. Records were clear, up-to-date and easily available to all staff providing care.

- Patient individual care records were written and managed to ensure that they were accurate, complete, legible, up to date and stored securely. The computers were password protected and we observed that these were locked when not in use. This was in line with the Data Protection Act 1998.
- Patient care records were retained and stored securely within medical records department or an off site electronic archiving database. As consultants handle sensitive personal data they were required to register with the Information Commissioners Office (ICO) as independent data controllers. They were required to work to the standard set by the Information Commissioner, this included how patients care records were stored and transported.
- Medical records storage had improved since our last inspection with the addition of tracking of notes for traceability. The hospital had set up a tracking system for notes leaving and returning to the secure note storage area.
- The hospital dedicated medical records department had responsibility for filing, storing and maintaining an adequate medical record for patients treated. Staff within this department ensured that medical records were readily accessible for each episode of patient care. Appropriate staff had electronic access to the archived records. Staff within the medical records team provided support, or electronic access at the request of a clinician as required. Evidence provided by the service showed that no patient during the 12 months prior to our inspection had been seen without their records being available.
- All patient care records were in paper format and kept on the ward for three to five days post discharge. This was in case a patient contacted the ward with a question or concern regarding their surgery after returning home.
- Patient care records were stored in a cupboard behind the nurses' station on the ward. The cupboard was locked and there was always staff at the station which meant that records were not accessible to the public. Records not in use were stored on site for a period of one year following discharge in the key code locked records room.

- All information needed to deliver safe care and treatment was available and easily accessible to the relevant staff for example test and imaging results, care and risk assessments, care plans and case notes.
- We reviewed eight sets of medical records. We found documentation from all staff was completed thoroughly, with risk assessments, treatment plans, consent forms and completed medication charts, which had all been reviewed by a pharmacist.
- All patients received appropriate pre-operative assessments prior to admission for surgery. The service used a criteria based on type of surgery to determine which patients received initial telephone assessments. The pre-operative assessment paperwork was fully completed and formed part of the paper record.
- Discharge letters were sent electronically to the patients' GPs immediately after discharge, with details of the treatment, including follow up care and medications provided.
- Where appropriate patient care records contained stickers identifying equipment and implants used during surgery. This meant that they could clearly be tracked and traced.
- Staff used specific care pathway paperwork for each patient which ensured they kept records appropriate. For example, patients admitted for hip surgery had their clinical entries recorded in the 'Primary hip replacement care pathway' documentation.
- The care records contained pre-operative assessments, records from the surgical procedure and anaesthetic, recovery observations, nursing and medical staff notes and discharge checklists and assessments. The records also included multidisciplinary clinical notes, including those from physiotherapists.
- Theatre staff maintained a log of implants on their prosthetics register to enable traceability if an incident occurred. Theatre personnel retained a sticker from each implant in the register as well as in the patient notes.

Medicines

The service followed best practice when prescribing, giving, recording and storing medicines. Patients received the right medication at the right dose at the right time.

- The pharmacy team completed regular audits including missed dose, controlled drugs and medicines reconciliation. The team shared audit results at the medicines management meetings held every two months, with managers cascading the information at team meetings, confirmed in the minutes we looked at.
- Medicines were appropriately prescribed, administered and supplied to people in line with the relevant legislation, current national guidance and best practise evidence.
- All medication on the wards and in the theatre department was stored securely in locked trolleys, cupboards and fridges with stock medications stored in locked cupboards in the key code locked clinical room.
- There was a small stock of 'to take out' (TTO) medicines available in the ward. These consisted of antibiotics and pain relief and could be dispensed by the nursing staff following prescription by the RMO or consultant.
- We reviewed a random selection of medications stored on the wards and the theatre department and found all to be neatly stored and within expiry date.
- We checked the controlled drugs (CDs) on the wards and in the theatre department and found that these were correctly stored and matched the register. Two registered nurses checked CDs daily and staff had consistently done this throughout the six-month period reviewed prior to inspection.
- The Shardeloes ward was used primarily for day case patients and not open every day. We noted gaps in the daily checks in the CD register. We highlighted this to the ward manager during the inspection. It was confirmed that the missing dates correlated to the days the ward had been closed. The service put in place a process to ensure that the CD register was annotated appropriately when the ward was closed.
- The locked medicine fridges and separate blood fridge in the theatre department, were temperature monitored daily to confirm that the fridge temperature was suitable

for the storage of medications. We reviewed checklists which showed all anomalies were recorded and the action taken to resolve noted. The ambient temperature of clinical rooms was also monitored and recorded.

- Patients told us nursing and medical staff had given clear instructions and advice about any medications they needed to use at home, prior to discharge from the ward. Patients made staff aware of any allergies at their pre-assessment. The information was recorded on the front page of the care pathway so the information was immediately visible to reduce the risk of harm to patients and patients wore a red wristband to make staff aware they had an allergy.
- Staff had to access medication guidance, for example the hospital's medicines policy and current British National Formularies.
- Pre-assessment nursing staff supplied one medication to patients under a patient group direction (PGD). This was part of an enhanced recovery program for hip replacement patients, A PGD provides a legal framework that allows some registered health professionals to supply and/ or administer a specified medicine(s) to a pre-defined group of patients, without them having to see a doctor. A PGD is used in situations that offer an advantage to patient care, without compromising patient safety. The PGD was reviewed and found to be authorised and in date for use.
- The resuscitation trolleys contained emergency medicines including those for the treatment of anaphylactic shock. Anaphylaxis is an adverse allergic reaction which can be life threatening and requires immediate treatment.
- There was piped oxygen in all 66 patient rooms and these were set up ready for post-operative patients. Staff told us that oxygen therapy was prescribed as needed and this was confirmed in patient records we reviewed.
- Medical gas cylinders were stored safely and in an upright position in line with best practice.

Incidents

The service managed patient safety incidents well.

- Staff recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support.
- The hospital had a system for recording and reporting incidents. All staff we spoke with understood their responsibilities to raise concerns, record safety incidents, concerns and near misses, and to report them internally and felt confident to do so.
- Staff told us they were encouraged to report incidents and received feedback when they had been involved in an incident. Staff also reported that they received feedback about incidents that had occurred within the hospital and other hospitals within the BMI organisation through the monthly corporate clinical governance and risk bulletin. Information was also cascaded through the daily comms cell meeting, team meetings and at handovers.
- The hospital measured their own safety performance against hospitals of a similar size within the BMI organisation.
- Minutes from the medical advisory committee (MAC) meetings showed the hospital presented a summary of the most recent incidents but this did not include the actions taken, to show how the hospital had shared learning with medical staff. There was no evidence of sharing of learning from incidents at other BMI hospitals at departmental level, although senior staff discussed these at their meetings, such as the clinical governance group.
- From July 2017 to June 2018, staff had reported 276 hospital-wide clinical incidents, the majority (62.3%) were graded as no or low harm with 16 incidents graded as moderate harm but none as severe. One death had been reported.
- There had been two never events during the same period. A never event is a serious incident which is wholly preventable, where 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 events related to 1. a retained object and 2. an anaesthetic error. For both incidents a root cause

analysis had been completed, a debrief held with staff and learning shared locally and regionally, with an agreed action plan. The root causes were determined to be human error and staff not adhering to corporate policy. We saw action plans had been written regarding both events with actions assigned to key individuals with target dates for completion.

- There were no regular mortality and morbidity meetings to discuss unexpected deaths or adverse incidents affecting patients. The hospital told us such cases would be included in the clinical governance and medical advisory meetings as required. We reviewed minutes of these minutes which confirmed this to be the case.
- 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 and apology to that person. Staff we spoke with understood their responsibility to be open and honest with the family when something had gone wrong. Senior staff were aware of their role to investigate a notifiable safety incident, keep the family informed and offer support.

Safety Thermometer

- The hospital measured safety performance and also submitted safety data to the BMI Healthcare organisation. The hospital was performing within the expected parameters when compared to similar sized hospital within the group.
- During the reporting period August 2017 to July 2018 the hospital reported nine surgical site infections, however no pressure ulcer, no catheter or urinary tract infections or venous thromboembolism episodes and no patient falls.
- The service did not display safety information on the ward for patients and visitors to view.

Are surgery services effective?

Good

Our rating of effective stayed the same. We rated it as **good.**

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence of its effectiveness. Managers checked to make sure staff followed guidance.

- Staff followed The Royal College of Surgeons' Standards for consultant led surgical care and the recommendations from the Association of Anaesthetists of Great Britain and Ireland (AAGBI).
- Staff assessed patients pre-operatively with investigations and blood tests based on NICE guidelines to ensure they were fit for surgery.
- The National Institute of Health and Care Excellence (NICE) guidelines were reviewed at BMI corporate level, cascaded to the individual hospitals and shared with staff. Policies based on best practice and clinical guidelines were developed nationally and cascaded to the hospitals for implementation. These were reviewed by the clinical governance board and recorded on a local register. Staff were required to sign to say they had read the policies.
- All BMI corporate policies were available on the hospital's electronic system. Staff demonstrated to us how they were able to locate them easily when required.
- Staff running the pre-operative assessment clinic followed the National Institute for Health and Care Excellence (NICE) guidance CG3 'Preoperative tests for elective surgery', to ensure patients had relevant tests performed prior to surgery, to minimise the risk of complications or harm.
- The hospital offered an advanced recovery programme which meant that patients were mobilised out of bed on the day of their operation to help prevent post-operative complications and to encourage early rehabilitation.
- The hospital had a clinical audit programme, which was set corporately by the BMI Healthcare group. This meant that the hospital could benchmark the results from the audits with other hospitals of a similar size within the BMI Healthcare group. Audits included consent, resuscitation, hand hygiene, health and safety, the WHO safer surgery checklist, and medicines management.
- The hospital participated in national audit programmes for example: Patient Reported Outcome Measures

(PROMS), National Joint Registry (NJR) and the surgical site infection surveillance programme conducted by Public Health England. BMI Healthcare participated in the Private Healthcare Information Network (PHIN). This enabled comparison with data available from NHS providers to assist with information transparency and patient choice.

- The hospital used a number of different care pathways depending on the type of surgery a patient was having, to ensure staff followed a set care pathway that met the needs of each patient.

Nutrition and hydration

Staff gave patients enough food and drink to meet their needs and improve their health. The service made adjustments for patients' religious, cultural and other preferences.

- Staff completed the malnutrition universal screening tool (MUST) to assess patient's nutritional status and their needs when they were first admitted and updated this during their stay. This is used to identify patients at risk of malnutrition. Staff could contact a dietician, from the local NHS trust, for additional advice if needed. Patient notes we reviewed demonstrated the MUST tool was being used.
- Nausea and vomiting were formally assessed and recorded and patients were prescribed anti-emetic medicines (medicines to prevent/ relieve sickness) post-surgery. This was followed by a gradual re-introduction of food and fluids.
- Intravenous fluids were prescribed as appropriate and recorded according to hospital policy. We observed that fluid balance charts were used to monitor patients' hydration status.
- Nursing staff advised patients about fasting times prior to surgery at pre-assessment. Nursing staff utilised the Royal College of Nursing clinical practice guidelines for perioperative fasting in adults and children. They also completed the MUST tool as part of the patient's risk assessments during their pre-assessment.
- Specific dietary needs were also recoded at pre-assessment, so the catering team could be informed and provide suitable food for the patient during their stay.

Pain relief

Staff assessed and monitored patients regularly to see if they were in pain. They supported those unable to communicate using suitable assessment tools and gave additional pain relief to ease pain.

- Patients we spoke with were very satisfied with how staff had managed their pain and reported being pain free. Patients commented on the prompt response and action taken by nursing staff when they were experiencing pain.
- We observed nursing staff answered call bells quickly and provided medication to help reduce the level of pain.
- Staff assessed patient's pain as part of the national early warning score (NEWS2) assessments. This ensured that pain management was monitored and patients received pain control medication in a timely way. We saw this took place in the medicine charts we reviewed.
- As part of the NEWS2, we saw staff asked patients to score their pain using a scale of zero to three. For patients with persistent pain, a patient controlled anaesthesia pump was used, there was a separate risk booklet for staff to complete to ensure all associated risks were monitored.
- Patient care records showed that anticipatory pain relief was prescribed and pain was assessed in recovery and on the wards. Nursing staff discussed post-operative pain relief with patients as part of their pre-assessment and gave them written information as well to support these discussions.
- The resident medical officer (RMO) could prescribe additional pain relieving medication or if there were significant concerns nursing staff would speak with the patient's consultant.

Patient outcomes

Managers monitored the effectiveness of care and treatment and used the findings to improve them. They compared local results with those of other services to learn from them.

- The hospital compared results on hip and knee audit and patient outcomes with other locations within the region and across BMI Healthcare group through the

corporate quality dashboard. The dashboard compared a number of metrics including but not limited to; return to theatres, unplanned readmissions, transfers out, and infection rates reporting data from similar sized hospitals and the other local BMI locations.

- Monthly PROMs data was also reported on in the quality account, these enabled patient outcomes at the Chiltern Hospital to be compared to the BMI healthcare average and national average.
- As part of the BMI Healthcare organisation the hospital contributed to the Private Healthcare Information Network (PHIN). Data was submitted in accordance with legal requirements which were regulated by the Competition and Markets Authority (CMA).
- From July 2017 to June 2018, there were four unplanned transfers to another hospital, five unplanned readmission within 28 days of surgery and seven unplanned returns to theatre. Information from the hospital showed all staff had taken appropriate action at the time of the incident. Escalation procedures had been effective in managing the risks to patients.

Competent staff

The service made sure staff were competent for their roles. Managers appraised staff work performance and held supervision meetings with them to provide support and monitor the effectiveness of the service.

- At the last inspection we had concerns regarding staffing competencies in theatres. During this inspection we found that this situation had improved.
- Nursing staff registrations were checked against the Nursing and Midwifery Council (NMC) registers, nurses were not allowed to practice until they could provide up to date registration evidence and revalidation where appropriate. Revalidation is the process that all registered nurses and midwives in the UK need to follow every three years to maintain their registration with the Nursing and Midwifery Council.
- We saw evidence of completed competencies for health care assistants (HCAs) working in pre-assessment. Also, across the hospital some HCAs had completed the 'Care certificate'. This is a set of standards that social care and health workers stick to in their daily working life.
- The registered staff we spoke with confirmed that they were supported by the hospital with revalidation.
- Staff received yearly appraisals during the period October to September. Staff we spoke with said that the appraisals were useful to identify progression opportunities and as a result they were undertaking management and specialist courses.
- Poor or variable staff performance was identified through complaints, incidents, feedback and appraisal. Staff were supported to reflect, improve and develop their practice.
- All staff were subject to disclosing and barring service (DBS) checks. The Disclosure and Barring Service helps employers make safer recruitment decisions and prevent unsuitable people from working with vulnerable groups
- There was a BMI Healthcare corporate induction programme for new staff and local induction processes dependent on the hospital department. Staff we spoke with confirmed that induction was relevant, useful and met their needs in the new workplace.
- Staff received the appropriate training to meet their learning needs to cover the scope of their work and were given protected time for training. For example, in the theatre department they had one afternoon per month when there were no surgical procedures performed which staff used for electronic training and also for external trainers/speakers to attend.
- The theatre manager had oversight of theatre staff competencies and we saw that each staff member had an individual folder containing well organised certificates and competency evidence in the theatre resource room. This was an improvement since our last inspection.
- The RMO received mentorship from the director of clinical services but reported that they also received support from the other consultant staff.
- Consultants only performed surgical procedures which they undertook in the NHS. As all the consultants held NHS contracts they maintained their skills by working in the trust and had their appraisals completed by their NHS Medical Director.

- There was a process for the granting of practising privileges and the management of checks to ensure General Medical Council (GMC) registration, indemnity cover renewal and mandatory training and appraisals were undertaken. BMI Healthcare Practising Privileges Policy required clinicians with practising privileges to produce a number of pieces of evidence to confirm their eligibility to practice at the hospital.

Multidisciplinary working

Staff of different kinds worked together as a team to benefit patients. Doctors, nurses and other healthcare professionals supported each other to provide good care.

- All of the necessary staff including those in different teams, and services, were involved in assessing, planning and delivering care and treatment and there was effective multidisciplinary team (MDT) working across the hospital. This included surgeons, theatre and ward staff and therapy staff, such as physiotherapists and radiologists.
- Throughout the inspection, our observations of practice, review of records and discussions with staff confirmed good multidisciplinary working between the different teams involved in a patient's care and treatment.
- There was clear communication between staff from different teams, such as theatre staff to ward staff and between the ward staff and physiotherapists. We observed safe and effective handovers of care, between the ward, theatre and recovery staff.
- Nursing, theatre staff and the RMO told us it was easy to contact a consultant if they needed advice. The consultant had overall responsibility for a patient's care.
- The hospital had a number of service level agreements for pathology, pharmacy, cardiac catheterisation lab, chemotherapy and some diagnostic imaging tests. Hospital staff did not raise any concerns about contacting or using these services.
- The pharmacy technician attended pre-admission clinics and physiotherapy staff mobilised patients post-surgery.
- Medical, nursing and theatre staff reported good working arrangements and relationships with the local NHS acute trust. The hospital had arrangements with the local trust to provide 24-hour emergency support should patients require high dependency nursing and we heard how there was collaborative support for loaning theatre operating equipment sets between the hospital and the local NHS trust.
- Pre-assessment staff told us the liaised with a patient's GP if there were any concerns about tests results or the needed confirmation of any medications the patient was taking. When the hospital discharged a patient, they sent a letter to the patient's GP.
- Physiotherapy staff recorded if they made a referral to social services or other community services as part of the pre-admission discharge planning process.

Seven-day services

- Routine surgery occurred Monday to Friday, 8.30am to 6.30pm with some late finishes until 8pm. There was occasional extra or urgent work at weekends. Theatre staff were on-call should there be any unplanned returns to theatre. Nursing cover was available on the wards when the hospital was open both during the day, and overnight for patients who required an overnight stay.
- The RMO was on-call at all times and was based at the hospital, should staff need to escalate concerns about a patient. The RMO told us they were woken at night infrequently and therefore were normally able to rest between midnight and 7am.
- The radiology department provided an on-call service outside of normal working hours and at weekends. Staff could contact the radiologists out of hours to authorise requests and review results but there was no documented on-call arrangements.
- Physiotherapy staff supported effective recovery and rehabilitation by providing sessions to inpatients daily, including at weekends.
- The pharmacy service opening hours were 8am to 6pm, to provide additional support to the wards. Outside of these hours the RMO and nursing staff dispensed medications which had already been prescribed, with access to an on-call pharmacist as needed. Staff told us that the process generally worked well and could not describe any concerns.

Good

Surgery

Health promotion

- The service's website offered advice on a range of health promotion information and posters were seen promoting good heart health and keeping fit.
- Staff on the ward encouraged patients to mobilise early post surgery to help prevent post-surgical complications and encourage independence.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff understood their roles and responsibilities under The Mental Health Act 1983 and the Mental Capacity Act 2005.

- Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. They followed the service policy and procedures when a patient could not give consent.
- Consent forms were completed correctly within patient records we looked at and appropriately identified the procedure planned and detailed the risks and benefits. The hospital consent forms complied with Department of Health guidance.
- All patients told us they had been able to make an informed decision about surgery, before signing the consent form. The consultant discussed the risks and benefits of surgery with them and these were included on the consent form. The four consent forms we checked confirmed this.
- We observed staff asking patients' verbal consent before performing therapeutic treatment and post-operative observations.
- Patient names were displayed, initial and last name on the door of their room and on the whiteboard at the nurse's station, which was visible to patients and visitors. Staff told us they gained verbal consent to display this confidential information; there was also a section in the patient pathway to obtain their consent.
- Nursing staff documented on the front of the patient care pathway if there was a do not attempt resuscitation order in place or an advanced decision to refuse treatment and that they had seen the relevant document. This ensured staff respected the patients' wishes should they collapse and need emergency treatment.
- Training on mental capacity and deprivation of liberty safeguards (DoLs) was included in the mandatory safeguarding adults training. Compliance rate for adults safeguarding training was; level one 91.85%, level two 95.54% and level three 100%.
- Staff we spoke with were able to describe how DoLS might be required and that would contact the director of clinical services and involve the consultant and relatives as appropriate. They also said that in actuality this was not something that they were likely experience due to the limitations of the admission criteria.

Are surgery services caring?

Good

Our rating of caring stayed the same. We rated it as **good.**

Compassionate care

- **Staff cared for patients with compassion.** Feedback from patients confirmed that staff treated them well and with kindness.
- Throughout our inspection, we saw staff treating patients with compassion, dignity and respect. They told us they felt they were kept well informed about their care and were involved in making decisions about their treatment at each stage.
- Patients told us staff were kind and attentive. We saw staff took the time to interact with people who used the service and those close to them in a respectful and considerate way.
- Staff understood and respected the personal, cultural, social and religious needs of people and how these may related to care needs. For example, they checked how patients preferred to be addressed and recorded this in the care pathway.
- We observed patients were spoken to in a polite and courteous manner and staff sought permission before providing treatment.

Good

Surgery

- The Patient Led Assessment of the Clinical Environment (PLACE) privacy and dignity score was 91.7% which was higher that the BMI Healthcare average of 86%.
- We saw notices on display on the wards advising patients to let staff know if they wished for a chaperone.
- The hospital monitored patient feedback from their Patient Satisfaction Survey and the NHS Friends and Family Test (FFT). Between February and July 2018, the FFT inpatient scores were consistently above the England average with an average of 97%.
- Staff at the hospital encouraged patients to complete patient satisfaction questionnaires to review and improve patient experience. The results of the questionnaire were collated by an external company and a monthly report provided to the hospital for view and analysis and cascade to the hospital team. The monthly report showed patient response rates, rating within categories and ranking against all BMI hospitals. At the time of inspection the hospital was rated 44 out of 55 BMI hospitals nationally.

Emotional support

- **Staff provided emotional support to patients to minimise their distress.**
- Staff had a good understanding of the impact that a person's care, treatment or condition had on their wellbeing and on those close to them, both emotionally and socially.
- Staff in all areas showed sensitivity and support to patients and understood the emotional impact of them having to be admitted for surgery. We observed a theatre team providing additional reassurance for a patient who was anxious about their surgery.
- People were given appropriate and timely support and information to cope emotionally with their care, treatment or condition. Additional information was provided at pre-assessment and they were signposted to other support services.
- Staff told us they had time to spend with patients and their families to provide whatever emotional support they needed.
- The hospital had open visiting hours on the ward so relatives and carers could visit at any time to offer support.
- Patients told us staff regularly checked on their wellbeing and to ensure their comfort.
- The hospital did not have its own chaplaincy service but had links with local services who attended if requested.
- Patients were able to telephone the ward after discharge, for further help and advice on their return home.
- Patients had access to counselling services if needed and staff would liaise with the GP as necessary.

Understanding and involvement of patients and those close to them

- **Staff involved patients and those close to them in decisions about their care and treatment.**
- Patients told us that they were involved in their care planning and that they were given the opportunity to ask questions about care and treatment. Staff gave leaflets to support the verbal information provided.
- Patients told us they were given clear explanations about the risks and benefits of the planned treatment and patients understood how their recovery would progress. This happened through discussion with their consultant and pre-assessment nurses. They also had been made aware of any costs they may incur.
- Patients told us they felt comfortable asking questions and said that staff took time to explain and answer their queries.
- The ward staff performed follow up telephone calls 48 hours post discharge. A nurse was rostered to call patients to check that they had no problems or complications. Staff said that patients were appreciative of the service and that it enabled patients to ask questions that they had not thought about during their admission.

Are surgery services responsive?

Good

Our rating of responsive stayed the same. We rated it as **good.**

Service delivery to meet the needs of local people

Good

Surgery

The service planned and provided services in a way that met the needs of local people. The services provided reflected the needs of the local population served and ensured flexibility, choice and continuity of care.

- The service was registered with various insurance companies, providing access to treatment for patients who had private healthcare insurance. Additionally, patients could opt to pay for treatment themselves. BMI Healthcare had introduced a BMI card, allowing patients to spread the cost of their treatment over 12 months.
- In addition, the hospital worked with local commissioning groups to support NHS patients treated with a number of procedures including but not limited to cataract eye surgery, joint replacement, hernia repair and endoscopy.
- The hospital participated in the NHS e-Referral Service, allowing local people to receive timely access to treatment. Through this service, NHS patients who require an outpatient appointment or surgical procedure are able to choose both the hospital they attend and the time and date of their treatment.
- Between August 2017 and July 2018 86% of patients who stayed overnight were non- NHS funded and 14% NHS funded.
- The service admission criteria ensured GPs only referred patients whom the hospital had facilities to care for. For patients needing critical care, the hospital had a contract with the trust to use their facilities, with them transferring patients back to the hospital once well enough.
- There were no facilities for emergency admissions; commissioners and the local NHS trust were aware of this.
- The hospital held weekly bed management meetings where they reviewed admissions for surgery for the following two weeks. The senior clinical and administration teams attended, ensuring a collaborative team approach. This enabled staff to ensure they were prepared and equipped for the patient pathway, discussing staffing, equipment, skill mix, and concerns.
- Theatre lists for elective surgery were planned with the theatre manager and bookings team. This ensured all aspects of patients' requirements were checked and considered before booking a patient on to the list and ensured that operating lists were utilised effectively.
- Patients and relatives attending the hospital had access to limited free car parking within the hospital grounds.

Meeting people's individual needs

The service took account of patients' individual needs.

- Admissions were pre-planned so staff could assess patient needs prior to treatment. This allowed staff to arrange how to meet patients' specific needs, including their cultural, language, mental or physical needs.
- The hospital had an open visiting policy and encouraged contact with family and friends for support and assistance.
- There was a variety of hoists and pressure relieving equipment for the safe management of patients.
- Pre-assessment nurses at The Chiltern Hospital gave patients information leaflets about their planned procedure or treatment during their pre-assessment appointment, or the hospital sent the leaflets to patients with their outpatient appointment letter. The patient information leaflets were written in English but could be provided in other languages or formats.
- The catering arrangements were outsourced to an external provider and there was a variety of meals provided for patients which they said met their needs. Facilities were available for special diets including cultural dietary needs as required. Patients expressed a high degree of satisfaction with the food and drinks and said they were offered choices. The staff provided support with meals as needed and hot and cold drinks and snacks were readily available.
- The hospital used care pathways for surgical patients. These pathways promoted effective patient care based on evidence based practice and ensured that individual patient's needs were recognised. They also provided flexibility to enable patients the option to stay an additional night according to need. This was evidenced in the way they reviewed the needs of older self-funding

patients who may not feel safe to return home after two nights and, dependent on individual assessment, offered a third night at no additional charge to the patient.

- The layout of the hospital meant that most areas were accessible for people in a wheelchair, however the entrance to the pre-assessment clinic was only just wide enough to get a wheelchair through.
- On Chalfont ward, patients had to access three patient rooms via a slope. The service risk assessed patients and would not allocate anyone to these rooms if they had difficulty with mobility.

Access and flow

People could access the service when they needed it. Waiting times from referral to treatment and arrangements to admit, treat and discharge patients were in line with good practice.

- The hospital offered a flexible service that included variable appointment times and choices regarding when patients would like their surgery, subject to consultant availability.
- The hospital admitted both private and NHS patients on a planned basis for elective surgery, and staff provided care in a timely manner.
- The hospital followed corporate and local policies and procedures for the management of the patient's journey, from the time of booking the appointment until discharge and after care. Staff we spoke with were aware of these policies and procedures.
- The hospital had established a clear booking process for appointments and hospital admissions. Patients we spoke with told us the hospital had a good and efficient booking process.
- Patients were added by the booking team to the hospital's patient information management system (PIMs). This meant that patient details and appointments could be tracked by staff working throughout the hospital.
- The hospital had a written inclusion and exclusion criteria for patients. This meant the hospital only admitted patients they had the facilities and expertise to care for.
- Once the patients had been admitted into the hospital for surgery, there was no monitoring about how long they waited for their surgery. Therefore, the service could not identify if there were problems relating to theatre delays and the reasons for them.
- Patients had access to assessment, diagnosis and treatment; the hospital had no waiting lists for surgery for private patients. A cooling off period between booking and surgery allowed patients to cancel or postpone their surgery, if they changed their mind.
- All patients having a general anaesthetic were assessed in a pre-assessment clinic at The Chiltern Hospital prior to their surgery. The hospital used telephone pre-admission clinics for ambulatory local anaesthetic procedures. This ensured that they met strict admission/exclusion criteria as the hospital did not admit patients with complex co-morbidity or bariatric patients.
- Patients' discharge planning began at the pre-admission assessment stage with involvement of allied health professionals as needed including but not limited to pharmacy and physiotherapy
- The operating department followed a planned programme of activity from Monday to Friday, with Saturday operating sessions available on request from clinicians. The hospital assigned consultants theatre time on a sessional basis unless there was a clinical necessity to provide an unplanned session, such as a return to theatre.
- Staff communicated planned changes to the surgical lists via the administration team. The hospital required consultants to give five days notice of any changes to the list so the hospital could ensure enough staff were working. Senior managers discussed, with consultants who regularly did not comply with this standard.
- There were morning, afternoon and evening operating sessions. The evening session ran from 6pm to 8pm and included both inpatients and day cases. Theatre and ward staff told us the evening surgery session sometimes overran, with patients returning to the ward after 9pm. Occupancy rates on both wards meant that any day case patient who required an overnight stay could do so. If a patient required or requested an overnight stay, staff recorded this as an incident.

Good

Surgery

- From January 2018 to December 2018, the hospital cancelled four procedures for non-clinical reasons. When procedures were cancelled or were delayed, this was recorded as a clinical incident and appropriate actions taken. Cancellations were explained to people, and they were offered alternative date within 28 days.
- The hospital provided an on-call theatre team however, in the event of a patient deteriorating and requiring further intervention there was a service level agreement (SLA) in place with the local NHS trust and ambulance service to transfer patients for more complex care and treatment.
- Consultants, or if unavailable the resident medical officer (RMO), authorised the discharge of patients from the hospital. This meant patients could be discharged out of hours if they wished.

Learning from complaints and concerns

The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with all staff.

- There was a corporate BMI complaints policy (August 2018). The complaints policy followed a three-stage process in dealing with complaints, with clear timeframes.
- From August 2017 to July 2018, the hospital received 132 complaints. Complaint content varied from costings to attitude of staff.
- The responsibility for all complaints rested with the executive director (ED) in liaison with their executive assistant (EA). On receipt of a new complaint the ED involved the head of the relevant department in the investigation of a complaint. Corporate protocols required that complaints were acknowledged in writing within two working days.
- The EA monitored the response process internally to ensure that timescales were being adhered to. If a response was not able to be provided within 20 working days a holding letter was sent to the complainant to keep them fully informed of the progress of their complaint.
- All complaints and their accompanying documents were loaded on to the hospitals incident/risk reporting system. Dependent on the nature of the concern, complainants were invited into the hospital for a meeting with the ED and associated manager to discuss the investigation findings. Following the meeting a response was prepared and sent to the complainant.
- If the hospital received a complaint, the executive director aimed to speak directly with the patient to address the concerns promptly. At the same time the executive director spoke with patients and asked them how satisfied they were with the nurses, doctors, food and environment. Using this approach the hospital endeavoured to correct any issues the patients had before they developed into complaints.
- Patient rooms had Patient Information Guides which included a section outlining the formal complaints procedure. However, patients we spoke withtold us they did not know how to make a complaint but would be happy to raise concerns if they had any. We saw comment boxes on the ward for patients to leave feedback cards but did not see specific leaflets on how a patient could make a complaint. The senior staff told us leaflets were available.
- NHS patients who were unhappy with the complaint response had the option of Parliamentary and Health Service Ombudsman, private patients were signposted to the Independent Sector Complaints Adjudication Service (ISCAS). During the reporting period August 2017 to July 2018 two complaints were referred to ICAS.
- Complaints were reviewed at the hospital governance meeting, heads of department (HODS) meeting, medical advisory committee (MAC) and department meetings. They were also discussed at the daily comms cell meeting to ensure that any learning identified was shared.

Are surgery services well-led?

Good

Our rating of well-led improved. We rated it as **good.**

Leadership

Managers at all levels in the service had the right skills and abilities to run a service providing high-quality sustainable care.

- An executive director (ED) had overall accountability for this hospital and one other location, which was part of the same area group. The ED had overall responsibility for the clinical and operational management of both hospitals, escalating concerns as needed.
- The ED was supported by senior management team members, which included an executive assistant (EA), quality and risk manager, patient liaison officer, director of clinical services (DCS), director of operations (DO) and the medical advisory committee (MAC) chair.
- The senior management team were supported by heads of department (HoDs) or managers for theatres, outpatients, pharmacy, diagnostic imaging, physiotherapy, oncology and the wards.
- The clinical HoDs reported directly to the DCS, and non-clinical HoDs to the DO.
- The leaders had the skills, knowledge, experience and integrity they needed for their roles.
- The department managers that we spoke with had a good understanding of the challenges to quality and sustainability, and were able to identify the actions needed to address them.
- Staff we spoke with felt the organisation supported them to deliver the patients' care. They told us that the director of clinical services promoted a positive culture and valued staff.
- Consultant medical staff told us they had a good working relationship with the staff and senior management to deliver care and meet patients' needs.

Vision and strategy

The service had a vision for what it wanted to achieve and workable plans to turn it into action, which it developed with staff and patients.

- The hospital used the BMI Healthcare corporate vision, which was to offer "the best patient experience and best outcomes in the most cost-effective way". The vision had been translated into eight strategic priorities, which were entitled:
  - Governance framework
  - Superior patient care
  - People, performance and culture
  - Business growth
  - Maximising efficiency and cost management
  - Facilities and sustainability
  - Internal and external communications
  - Information management
- The vision was cascaded to teams through departmental meetings, staff forums and notice boards. All staff we spoke with knew of the vision but not all were knowledgeable about their role in achieving it.
- There was a hospital business plan in place to support the achievement of the corporate vision. This included aims and objectives and any challenges to achieving the aims, particularly the financial impact.
- The hospital strategy included plans for the redesign and development of the recovery area within the theatre suite. We saw plans for this and the hospital were awaiting approval and funds before commencing with the work.

Culture

Managers across the service promoted a positive culture that supported and valued staff, creating a sense of common purpose based on shared values.

- The service had a caring culture. Staff told us that they enjoyed working on the wards and in the theatre department and felt well supported by their departmental managers.
- Department managers told us that they had an open door policy and that they were proud of their staff and their departments.
- Staff told us that they felt departmental managers were approachable. The theatre manager and the ward manager worked clinically and would provide clinical cover for sickness as appropriate.
- The executive director and clinical service director were well respected, visible and supportive.
- Staff told us they enjoyed coming to work. They commented on the strong team work and how the positive feedback from patients had helped during all the management changes.

- Staff were flexible in the hours they worked to meet the needs of the service and patients. They felt valued and well supported by the senior staff at the hospital.
- The hospital was working towards a more open culture and there was a focus on the needs and experiences of patients and staff. BMI had a corporate Freedom to Speak Up Guardian and each hospital had local champions.
- Most staff told us they felt comfortable raising concerns and felt the hospital had a "learning culture, not blame culture". Processes and procedures were in place to meet the duty of candour. Where incidents had caused harm, the duty of candour was applied in accordance with the regulation.
- However, some staff told us they found it difficult to whistle blow due to the small number of staff at the hospital. They felt there was a risk of identification if they raised a concern, even though they could raise this anonymously via an online form or to a central BMI Healthcare email address. Not all staff had confidence in the process and told us they had chosen not to raise concerns.
- All staff we met were welcoming, friendly and helpful. It was evident that staff cared about the services they provided and told us they were proud to work at the hospital. Staff were committed to providing the best possible care for their patients.
- Once a week the hospital held 'Free cake Friday' to encourage staff to meet and acknowledge the work staff had completed that week.

Governance

There were structures, processes and systems of accountability to support the delivery of the strategy and good quality, and sustainable services.

- There was a governance structure in place. Hospital sub-committees reported to the clinical governance committee and medical advisory committee (MAC), these meetings were all held jointly with The Chiltern Hospital. Meeting minutes showed there was representation from all surgical disciplines at the MAC meetings. Senior leaders then reported to the corporate BMI Healthcare regional and national clinical governance structure.
- Outcomes from the clinical governance meetings were shared at the heads of department meetings; although, minutes from departmental meetings did not show this information always being shared with frontline staff.
- Agendas and minutes for meetings followed a standardised format, with actions listed, who was accountable for the action and by when. We saw from minutes of the clinical governance meetings that staff discussed complaints and incidents, including any learning and trends related to these events. They also discussed audits, policy reviews, updates from clinical committees and any external guidance or new legislation.
- The clinical governance committee (CGC), met every month and discussed complaints and incidents, patient safety issues such as safeguarding and infection control, risk register review. There was also a standing agenda item to review external and national guidance and new legislation, such as National Institute of Health and Care Excellence (NICE) guidance. This ensured the hospital implemented and maintained best practice, and any issues affecting safety and quality of patient care were known, disseminated managed and monitored.
- We reviewed three sets of clinical governance meeting minutes and saw they were well attended by the senior management team, HoDs and clinical leads. Standard agenda items for discussion included clinical incidents, complaints, audits and risks.
- The role of the MAC chair included ensuring that all consultants were skilled, competent, and experienced to perform the treatments undertaken. Practising privileges were granted for consultants to carry out specified procedures using a scope of practice document, these were reviewed bi annually. Registration with the General Medical Council (GMC), the consultants' registration on the relevant specialist register, Disclosure and Barring Service check and indemnity insurance were all checked by the hospital and ratified by the MAC.

Managing risks, issues and performance

The service had systems in place to identify risks, plan to eliminate or reduce them, and cope with both the expected and unexpected.

- The hospital had a corporate risk register across both hospital sites which contained 58 risks and was regularly reviewed and updated to ensure that risks were monitored and appropriately managed.
- There were arrangements for identifying, recording and managing risks. Heads of departments had ownership, and managed departmental risk registers which fed into the hospital's risk register. The ward and theatre documented risks reflected what staff had told us. Risk performance was discussed through the committee meeting structure and there was good engagement from department leaders. It was hospital policy to display risk register in each department. This was an improvement since our last inspection.
- There was a systematic corporate programme of clinical and internal audit to monitor quality, operational and financial processes, and systems to identify where action should be taken.
- The daily comms cell meetings were held at 9am, Monday to Friday, and were attended by representatives for each department across both hospital sites (including managers and staff). The meeting covered a range of subjects including risk review, recent incidents, health and safety update, training compliance review, and any concerns that affected the hospital. This enabled staff to gain a wider view of risk, issues and general performance within the hospital.
- The hospital manager had built relationships with the different services that the hospital has service level agreements (SLAs) with, particularly the local NHS Trust who provided the critical care, pharmacy, pathology and some diagnostic imaging services. The manager had reviewed the terms of the SLAs and monitored performance of these services to ensure they met the agreed standards.

Managing information

The service collected, analysed, managed and used information well to support all its activities, using secure electronic systems with security safeguards.

- Managers had a good understanding of performance monitoring, with information on quality, operations and finances used to measure improvement, not just assurance.
- The hospital and service had clear service performance measures, which were reported and monitored by the parent BMI organisation and the local commissioners. These included data and notifications that required submission to external bodies.
- Staff had access to a range of policies, procedures and guidance which was available on the service's electronic system
- All designated staff had access to patients' medical records which included assessments, tests results, current medicines, referral letters, consent forms, clinic notes, pre and post-operative records.
- Medical records storage had improved since our last inspection with the addition of tracking of notes for traceability. The hospital had set up a tracking system for notes leaving and returning to the secure note storage area.
- Information technology systems were used effectively to monitor and improve the quality of care. For example the corporate risk and incident recording system had been updatedand provided the hospital with a platform to monitor and assess risks and assess trends.
- The BMI Group had policies and processes in place governing Information Governance, Security and Personal Data Protection. All data controller registrations for the processing of personal data were maintained in accordance with the requirements of the UK Information Commissioners Office and information security and governance policies were compliant with ISO/IEC27002 the Code of Practice for Information Security Management.
- The hospital had a 'Consultant App' which allowed remote login to clinics and theatre lists on a smartphone. The app enabled consultants to access clinic and operating theatre data. The application was downloaded using BMI credentials. No data was stored on the phone and a time out was applied for security.

Engagement

The service engaged well with patients, staff, the public and local organisations to plan and manage appropriate services, and collaborated with partner organisations effectively.

Good

Surgery

- The hospital actively gathered people's views and experiences through questionnaires. As a result of feedback regarding pain control the hospital had introduced an MDT ward for all inpatients.
- The hospital told us that before any change was implemented they would speak with staff about the benefits. They would discuss reasons for the proposed change and would seek staff feedback. This engagement happened through departmental and staff meetings and information was provided in the hospital weekly newsletters.
- Staff told us that managers at all levels were approachable and that they felt comfortable to raise any concerns with them.
- We observed that the corporate BMI 'Reward and Recognition' scheme had been introduced, and that each month an employee was nominated to receive a reward in recognition for going above and beyond their normal duties.
- Information was cascaded to staff through newsletters, emails and staff noticeboards.

Learning, continuous improvement and innovation

The service was committed to improving services by learning from when things went well or wrong, promoting training and innovation.

- There were systems and processes for learning, continuous improvement and innovation. We heard about support for staff to develop extended practice and management courses. For example in pre-assessment nurses were supported to attend external courses and seminars for professional development.
- Within the theatre environment staff regularly took time out to work together to both for personal and professional development and review team objectives, processes and performance. Staff told us this had greatly improved morale and the team culture within theatres.
- The hospital had an ongoing refurbishment programme. Staff commented on the hospital looking more presentable for patient and visitors.

Requires improvement

Services for children and young people

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

Information about the service

Children and young people (0-18 years) are seen at BMI The Chiltern hospital in outpatients, diagnostics and are admitted for surgery to the three-bedded day case unit. The children's nursing team consists of a lead children's nurse supported by two other permanent nurses, one who is a children's nurse. This team is supported by five bank children's nurses.

The team are responsible for supporting paediatrician out-patient clinics, physiotherapy, imaging, pre-assessment of children undergoing surgery, children's phlebotomy services, the admission of children for surgery and minor procedures, including, ENT, orthopaedics, urology, and plastic surgery.

Children are seen within outpatients, physiotherapy and imaging and can be seen from birth upwards. Phlebotomy services for under 16's is managed by the children's nursing team. Apart from phlebotomy, no invasive procedures are carried out on children under three. Children aged three and over are admitted for surgical day case procedures.

In the last 12 months;

The hospital saw;

- 360 children aged 0-2 years in outpatient.
- 172 in-patients and 2666 outpatients aged 3-15 years
- 46 in-patients and 558 outpatients aged 16-17 years.

Are services for children and young people safe?

Requires improvement

This was the first inspection of the children and young people service at the Chiltern Hospital. We rated safe as **requires improvement.**

Mandatory training

The service provided mandatory training in key skills to all staff, but not all staff had completed this training.

- The service identified key mandatory training subjects in accordance with relevant professional bodies regulations and in line with professional standards of practice. Staff received training through the BMI online learning package (BMI Learn) and in face to face practical sessions.
- Mandatory training for medical staff, consultants and resident medical officers included, anti-bribery and corruption, equality and diversity, record keeping, information governance, manual handling, prevention radicalisation and safeguarding, for example.
- Mandatory training for all other staff, other than medical staff, included, adult basic life support, paediatric basic life support, equality diversity and human rights, infection prevention and control, safeguarding and moving and handling, for example.
- Nurses working in the children and young people service had identified mandatory training which related

specifically to the appropriate age group of patients. This included safeguarding children, levels 1, 2 and 3, care and communication of the deteriorating patient, consent and paediatric immediate life support.

- Data provided by the hospital following the inspection demonstrated, at the time of the inspection, only one of the eight bank and permanent nurses had completed their 27 core mandatory training subjects.
- Of the remaining seven nurses working in the children and young people's ward on either a full time or bank basis, were not in date with between one and 10 mandatory training subjects. This included training in a range of subjects including, adult basic life support, care and communication of the deteriorating patient, medical gasses (practical and registered practitioner training) and safeguarding vulnerable adults level 3. This data did not identify when the training period had expired.
- The service stated training had not always been completed in line with the hospitals 90% completion rate. This was due to staff waiting for new courses to be available, long term absence and a new starter to the service who was in the process of completing all training.
- A children and young people services audit completed in September 2018 had identified 12 consultants had not produced evidence they had completed safeguarding children level three training. As a result, they had been suspended from seeing patients under the age of 16 until they could evidence successful completion.
- The service lead, a senior registered children's nurse, regularly reviewed staff training and maintained an oversight of completion against mandatory training subjects during three monthly team meetings, staff supervision, appraisals and team meetings. We were told rotas were planned to allow staff sufficient training time. However, we found that action had not always been taken to address non-compliance.

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report child abuse and knew how to apply it.

- Staff who cared for children and young people had completed safeguarding children level three training. Following the inspection the hospital told us Safeguarding Adults Level 3 training was introduced in January 2019 for all staff therefore not all staff had completed this training at the time of the inspection. The service lead had completed safeguarding children to level four.
- The safeguarding lead for children was the director of clinical services. They were supported by the service lead, children's nursing team, associate director of clinical services, lead paediatrician and lead anaesthetist. Staff knew the named safeguarding leads. Safeguarding flowcharts and resource folders were in all departments giving further information on how to contact the local authority's children's safeguarding board if a concern was identified.
  Safeguarding children training included all forms of abuse including female genital mutilation and PREVENT training. PREVENT training is a form of safeguarding training to help identify individuals at risk of being exposed to risks of radicalisation. Hospital data confirmed staff had a 100% compliance with completion of safeguarding children training.
- Staff had access to the provider's 'Safeguarding children policy'. This policy was within its review date and had version control, although was due to expire the month of the inspection and we were not informed of the timescales for the review to ensure it remained in date. The policy set out staff responsibilities and guided staff through the process of raising concerns to the local authority. The policy was supplemented with a flow chart of the process and contact details for the local authority. Staff we spoke with knew how to recognise and the process to raise a safeguarding concern.
- Safe recruitment procedures were not always followed. The recruitment processes had not ensured patients were assisted by staff with the appropriate qualifications. There were documented recruitment checks which all staff were expected to complete. These included pre-employment checks such as written references with regards the applicant's previous work experiences, their personal character and checks they held the necessary qualifications for the post applied for. Recruitment checks also included a Disclosure and Barring Service (DBS) check and these were repeated

annually. The DBS helps employers make safer recruitment decisions and helps prevent the employment of staff who may be unsuitable to work with patient who use care services.

- The service did not ensure staff met the requirements of their recruited role. A member of staff had been recruited into the position of a 'registered children's nurse', however were a registered adults nurse with children's experience. This had not been identified during their recruitment process therefore the service could not offer assurance this process was always safe.
- The risk of child abduction and actions to take to minimise this risk was documented in the hospital's 'Safeguarding children policy'. This identified the definition of a child abduction. Staff told us there was a missing persons policy in place which covered what to do in the event of a missing child. The service lead told us they had created a new abduction process guidance document titled, 'Safety and Security of CYP in outpatients' which was currently in draft form awaiting formal sign off. Staff were aware of making sure children were not left alone, knew what children were wearing when they entered the ward and controlled access to and from the ward.
- Supervision notices were clearly displayed in the outpatient waiting area and within the ward. These advised parents/guardians to ensure children were supervised at all times. CCTV was present in the outpatient waiting area, which was adjacent to the front door to the hospital, to offer additional security to patients and parents/guardians.
- During pre-assessment procedures staff identified any safeguarding concerns surrounding children and their ongoing care and treatment. This included identifying visitors who did not have legal authority to visit or remove the child from the hospital.
- During the inspection we saw nursing staff refuse to allow a consultant to book a young patient to their theatre list until they had provided evidence of their completion of this safeguarding training. This ensured the ongoing welfare needs of patients were met.

Cleanliness, infection control and hygiene

The service controlled infection risk well. Staff kept themselves, equipment and the premises clean. They used control measures to prevent the spread of infection.

- Six of the eight nursing staff had received training on infection prevention and control in healthcare and infection prevention and control in high impact interventions. The remaining two members of staff had yet to complete this however, were due to as part of their new induction and return to work process.
- The child inpatient ward area of the hospital and the children's waiting area within the hospital's main reception area were visibly clean and free from clutter.
- Children and young people staff were responsible for cleaning the allocated children's waiting area within the hospital's outpatient department. They were also responsible for cleaning equipment within the ward. The on onsite housekeeping team were responsible for cleaning floors and bed areas within the ward and elsewhere throughout the hospital.
- Cleaning was completed daily with schedules visible in the ward and children's waiting area in outpatients, these were signed as up-to-date. Staff said they were happy with the level of service they received from the housekeeping team. The housekeeping team were available until 10pm and would not enter the ward or treatment room whilst children and young people were present to preserve their dignity.
- During working hours staff were responsible for cleaning equipment between use such as chairs and cleaning equipment, staff told us this was done using three-in-one disinfectant wipes.
- The service provided appropriate and adequate quantities of personal protective equipment for staff including gloves and aprons in a range of sizes. These were available across the hospital for easy access. There was also easy and constant access to hand washing facilities throughout the hospital which were used by staff.
- We observed safe hand hygiene practices were followed to minimise the risk of cross infection between patients. Hand sanitiser gel units were located throughout the

hospital and staff were seen to consistently use them. Staff were observed to be 'bare below the elbow' in accordance with the national institute for health and care excellence (NICE) guidance.

- The hospital had no reported cases of healthcare associated infections in services for children and young people. No cases of Methicillin-resistant Staphylococcus Aureus (MRSA), Methicillin-sensitive Staphylococcus aureus (MSSA) or Clostridium difficile (C.Diff) were reported by the hospital from January 2018 to August 2018.
- Infection prevention and control (IPC) practices were audited on a bi-monthly basis. We reviewed the results of two patient IPC equipment audits and the last three completed hand hygiene audits completed between July 2018 and November 2018. These evidenced consistently high compliance with 100% noted on four of the audits.
- Where areas for improvement had been identified from these audits actions had been allocated and acted upon. For example, in July 2018 an audit identified there was no cleaning schedule in place for children's play equipment. This was documented on an action plan and steps put in place to ensure completion. This resulted in a 100% compliance rating when the audit was repeated in November 2018.

Environment and equipment

Most equipment used by the service was suitable and staff looked after it well. However, not all areas where children received care and treatment were fit for purpose and some did not meet national guidance.

- Staff told us the engineer and maintenance team were responsible for ensuring equipment had up-to-date safety testing and servicing in line with manufacturers recommendations. These items included scales used for weighing children and young people, monitoring equipment and resuscitation equipment
- We observed a number of pieces of equipment including weighing scales, resuscitation and breathing apparatus which was marked as available for use. This equipment had stickers clearly indicating they had been serviced and subjected to the required testing to remain appropriate for use.
- Suitable resuscitation equipment for children of all age ranges was readily available within the ward and outpatient areas. Records showed these were checked daily with more detailed checks completed weekly.
- Staff used the 'Weight, Electricity for defibrillation, Tube size, Fluid dosing, Lorazepam dosing, Adrenaline dosing, Glucose dosing' (WETFLAG) system for the use of child resuscitation equipment. WETFLAG outlines the approach to managing a deteriorating child patient and is used to safely calculate the appropriate weight-based drugs and equipment to be used in an emergency.
- WETFLAG information was recorded on the back of the pathway documentation for all admissions prior to the day of surgery. Staff told us the pathway was being updated corporately so the information would be moved to the front of the patient's documentation, so it was more visually obvious to staff in the event of an emergency.
- The service did not have a dedicated child recovery or anaesthetist area. Children were treated immediately post-operatively in the adult recovery and anaesthetic area. A green removable screen was available and used to separate children and young people from other patients within the room. This did not, however, prevent children being seen, seeing other adult patients or equipment which could cause distress.
- The area identified for paediatric patients to recover was overlooked, through a window, by the theatre suite office. This presented a safeguarding, privacy and dignity risk as staff and non-hospital staff visiting the office could see the child or young people.
- Staff mitigated this risk of children being cared for in a recovery area shared with adults by ensuring children and young people were seen first or second on the theatre lists in the morning and afternoon. This reduced the risk, but children could still possibly meet with adult patients.
- Following the inspection, we requested the risk assessments in place for all areas where children and young people were cared for. This information was not provided therefore we could not be assured all available risks had been identified, documented with all the risks mitigated wherever possible.

Requires improvement

Services for children and young people

- 'Treetops', the three bedded, purpose designed children and young people ward was based in the adult inpatient and day case Chalfont Ward. Treetops was secured by an appropriate electronic security-controlled access. Only staff with the correct level of permissions could access the ward. Patients, their parents/guardians, any visitors and other staff could only access the ward by alerting staff within who would afford access. We saw children and young people were not alone at any time and were unable to leave the department without being accompanied by a known and identified parents/ guardians, known visitor or member of staff.
- Treetops was designed to make it appropriate for any age of child. For example, the beds for children and young people had age appropriate bed linen and activities were provided to entertain and distract children of all ages.
- Treetops however, did not have a toilet built into the secure environment. This meant children and young people had to leave the ward and use an en-suite toilet of one of the adult patient rooms in the Chalfont Ward. Staff told us, and we saw, no children were able to leave the ward without being accompanied. This minimised the risk of children interacting with unknown persons or leaving the hospital whilst accessing toileting facilities.
- Staff told us, and we saw, staff on the Chalfont Ward ensured a patient room and toilet was always made available towards the end of the ward nearest Treetops. This minimised the length of time and travel for children and their parents/guardians between the ward and toilet facilities. Staff told us the lack of toilet in the ward was the top concern on their risk register however, they were awaiting funding to be made available to allow for the further development of the environment. No timescale could be provided regarding when this would be completed.
- We saw children and young people accessing outpatient services were accompanied at all times by their parent or guardian.
- The hospital participated in the Patient-Led Assessments of the Care Environment (PLACE) assessments. PLACE assessments provide a framework for assessing quality against common guidelines and standards to quantify the environment's cleanliness, food and hydration provision, the extent to which the provision of care with privacy and dignity is supported, and whether the premises are equipped to meet the needs of people with dementia or with a disability. The hospitals PLACE scores for 2018 were better than the England average and the BMI corporate score in all but two domains, the condition, appearance and maintenance of the hospital and ward food which was better than the national average but not as good as the BMI corporate score.
- The service had an effective system to manage waste disposal. There was a BMI healthcare corporate waste management policy which the hospital staff followed. Across the service sharps bins were correctly assembled and labelled to ensure traceability. This was in accordance with the Health and Safety (Sharp Instruments in Healthcare) Regulations 2013 (the Sharps Regulations).
- During the inspection we saw the correct management of waste and the use of coloured bags to correctly segregate of hazardous and non-hazardous waste. This was in line with the Health Technical Memorandum 07-01: Safe management of healthcare waste. Staff on the CYP ward had easy access to a biohazard spill kit to immediately manage any potentially hazardous material.

Assessing and responding to patient risk

Risk assessment and, screening tools were available. However, risks were not always identified and assessed to ensure these were effectively mitigated. Training for child related emergencies did not take place in line with the service's policy.

- Training data provided by the hospital demonstrated seven of the eight nurses on the ward had completed paediatric intermediate life support (PILS). The remaining nurse was new to the service and due to complete the training shortly following the inspection. They had, however, worked independently within the service prior to this training being completed. This placed children at risk of being cared for by staff who may not have had the necessary skills to respond to an emergency.
- To mitigate this risk, the service lead for children and young people, a registered children's nurse, one bank registered children's nurse and the hospital's resident medical officer (RMO) had completed European

Paediatric Advanced Life Support training (EPALS). An anaesthetist with current Advanced Paediatric Life Support (APLS) skills was on duty when children were present in the ward however, which minimised patient risk.

- Due to the small numbers and low complexity of children and young people seen during the inspection we only saw one risk assessment in use.
- The service however, did have access to a range of risk assessments, screening tools and record charts available to identify, record and document mitigating actions required to keep patients safe according to their individual needs.
- Patients observations were used to calculate a Paediatric Early Warning Score (PEWS). This is a nationally recognised system of using key observations such as a patient's blood pressure and pulse to help staff recognise changes in their condition which would indicate a deterioration in their health. The service used four different PEWS charts, one for patients aged zero to eleven months, patients one to four years, one for patients aged five to twelve and one for young people aged 13 to 18 years and staff were aware of the need to complete these if required.
- We saw one use of the PEWS during the inspection and this was used appropriately in recovery. Staff identified and discussed the appropriate actions to take if a patient's health deteriorating which included following the hospital's transfer policy if required.
- Effective guidance and procedures were in place and clearly displayed in patient areas to manage a child and young person's health in an emergency.
- The service had a 'Emergency transfer of patients Policy' which was known by staff however, this policy was no longer in date. The policy had been issued in August 2015 and was due to be reviewed in July 2018 however, this had not been completed. The children and young people service had been developed since October 2016 and the policy had not been reviewed in line with hospital timelines to ensure it still contained the most appropriate guidance.
- This policy however, did set out the procedures for the escalation and transfer of a seriously unwell child. This was necessary if a child's condition deteriorated after surgery. Staff had access to a specialised children's acute transport service which would provide an emergency transfer for children. There was a service level agreement with a neighbouring counties NHS trust to support this policy. Staff confirmed that there had been no transfers of children and young people due to deterioration in the year prior to the inspection.
- The children and young people service had a 'Children's Resuscitation Policy' which was issued in August 2017 and valid for three years. This provided guidance for staff to support them in recognising an 'at risk of critically ill child(ren)'. It stated the hospital should complete simulation exercises to ensure staff had the opportunity to practice the skills necessary to deliver the highest standard of paediatric emergency care. The policy stated 'Resuscitation skills and training should be undertaken every four months as a minimum for those hospitals who admit children as inpatients, day cases and outpatients. These will focus on children's emergency management'.
- Following the inspection, we asked the hospital to provide the dates of the last completed children resuscitation simulations. The hospital provided evidence they had completed two unannounced resuscitation simulations in April 2018 and August 2018. They were unable however, unable to provide evidence they had completed three in a year as identified as necessary in their policy. We viewed an assessment by an independent training body however, which evidenced an improvement in the children and young people services performance in these scenarios between April and August 2018.
- We saw, and records confirmed, the 'World Health Organisation (WHO) Surgical Checklist, Five Steps to Safer Surgery' was used. This had been completed thoroughly in the relevant patient record reviewed.
- The children and young people service had a sepsis screening tool in place to identify, document and provide guidance on how to manage a patient's potential risk of sepsis. This information was readily available on the resuscitation trolleys and within care documentation. The 'Inpatients paediatric sepsis screening and action tool' was different for the varying age groups seen to ensure accurate documentation and recognition of a deteriorating patient.

- Sepsis training was part of the mandatory training Care and Communication of the Deteriorating Patient module. Figures supplied following the inspection identified four nurses were overdue its completion. The service advised this was an adult based training module which did not cover children and young people. The service advised the course was added to all nurses training requirements in January 2019.
- Staff informed us that all children attending outpatients or who were in patients were cared for by a member of the children's nursing team. There was no standard operating process or risk assessment with mitigating actions which informed staff of this arrangement and the corporate policy of having an on-call children's nurse had not been implemented. This meant children and young people were not always supported by a staff with the appropriate qualification and registration.
- We brought this to senior managers attention and a risk assessment was put in place at the time of the inspection which identified a registered children's nurse would be available on call to offer assistance when required.

Nurse staffing

The service had enough nursing staff however, did not ensure they always had the right qualifications and training to keep people safe from avoidable harm and to provide the right care and treatment.

- Treetops was staffed by a full time lead registered children's nurse, two full time nurses (one of whom was a registered children's nurse) and five bank registered children's nurses.
- The service identified staffing levels and skill mix on a patient needs basis. Staff told us they worked flexible shifts to meet patient demand. Shifts could commence from 06:30am dependent on patient need and finish at 9pm when the last child had been discharged from the ward or, the last child patient had been seen in the outpatient department.
- Records confirmed the service did not use agency staff, it had support from regular bank staff who could work at short notice if required. This ensured patients were supported by staff with a working knowledge of the service policies and procedures and were familiar with the environment and equipment used.
- There was a process in place to identify staffing requirements when children were admitted. When the referrals team accepted an admission booking, they would only provide the service on the days two nurses available. The service however, had not ensured they were always two registered children's nurses with the appropriate skills and registration present. To support the nursing team bookings would only be accepted if there were sufficient theatre staff with appropriate children's training and skills in Paediatric Immediate Life Support (PILS) working. Staff told us the anaesthetist would not book children for surgery without ensuring suitable numbers of nurses were on site.
- The outpatient department was staffed by adult registered nurses; however, children and young people staff knew the appointment details for all patients due to be seen by the outpatient department. Staff said that they felt well supported by the children's nurses and worked with them as needed.
- Staff told us, and rotas confirmed, two registered nurses, but not always both registered children's nurses, were on duty for booked surgeries for children and young people. There were no on-call registered children nurses arrangements in place at the time of the inspection to ensure a member of nursing team with the appropriate qualifications, experience and registration were always available to offer advice and support in an emergency situation.
- The hospital always had a resident medical officer on duty 24 hours a day, seven days a week which ensured access to an appropriate clinician should a parent/ guardian or member of staff need advice.
- The service had not always ensured, two registered children's nurses were always deployed to provide treatment, guidance and support. The provider's, in date, 'Children and Young People's' policy stated, 'For inpatient staffing, a minimum of two registered children's nurses is required at all times'. The children and young people service were not meeting the requirements of their policy.
- During the inspection we identified one registered nurse was due to complete lone working in the afternoon and into the evening. They were responsible for monitoring a day case patient and providing support if required to the

outpatient department. This nurse was a registered nurse with 30 years' experience of working with children however, had not undertaken the formalised training and registration to become a registered children's nurse.

- We brought this to the attention of the nominated individual who took immediate action to ensure a registered children's nurse would be onsite.
- BMI Healthcare limited had produced a provider wide risk assessment which stated an on-call system would be in place to ensure a registered children's nurse was always available to staff when needed. This information however, was unknown to the children and young people service we inspected, and a registered children's nurse was not always available to provide advice, guidance and support to staff when required.
- During the inspection the nominated individual drafted a new risk assessment for the hospital which was in line with the provider's guidance. This identified the risk of having a non-children's registered nurse working within the children and young people service with identified actions to minimise this risk. This also included the implementation of an on-call service, as per the provider's risk assessment. This meant there was always a registered children's nurse available to staff when support was required.
- Handovers between teams were an efficient process to ensure all staff involved in a patient's care were aware of actions taken and those required to keep a patient safe. We observed a handover between the surgical team and the children and young people staff in the recovery area. This was detailed in its completion and identified actions taken during surgery and ongoing care required.
- Patients were supported during their recovery by a nurse from the children and young people service. Theatre staff called one of the children's nurses prior to the patient entering recovery so that they were in attendance during the recovery phase. This provided a familiar face to the patient and ongoing continuous care.
- The children's activity data provided by the hospital during our inspection for the period August 2018 and 16 January 2019, demonstrated that children and young people had either been seen in out-patients or were in patients on 230 occasions and their care had been delivered by a registered nurse without on call children's nurse cover.This meant there was no registered children's nurse on site or on call to support and provide advice if necessary and not in line with BMI policy.

Medical staffing

The service had enough medical staff with the right qualifications, skills, training and experience to keep people safe from avoidable harm and to provide the right care and treatment.

- The hospital had a medical lead for children and young people's services. This was a consultant paediatrician who had been granted practicing privileges.
- Medical staff were predominantly employed by other organisations (NHS organisations) in substantive posts and had practising privileges to work at BMI The Chiltern. A practising privilege is, "Permission to practise as a medical practitioner in that hospital" (Health and Social Act, 2008).
- 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. BMI Healthcare's practising privileges policy required consultants to remain available both by telephone and, if required, in person, or to arrange appropriate alternative named cover if they were unavailable. This was to ensure a consultant was available to provide advice or review patients at all times when there were inpatients in the hospital. Staff we spoke with confirmed this happened.
- Consultant surgeons were responsible for their patients whilst they were inpatients at the service. There was also a resident medical officer (RMO) on site and available 24 hours a day, seven days per week for immediate medical advice. The RMO was accessible to patients and their parents/guardians if they had concerns about a patient's wellbeing following their discharge from the hospital. We saw their contact details were provided to patients in their discharge pack.

Records

Requires improvement

Services for children and young people

Staff kept detailed records of patients' care and treatment. Records were clear, up-to-date and easily available to all staff providing care. Records, however, were not always securely stored to maintain patient confidentiality.

- We reviewed 12 patient records and found documentation was clear, accurate and legible. Where a concern had been identified, for example an allergy, action was taken to make this clear so all staff involved in the patient's care were aware.
- Patient records were organised and contained all relevant patient information. Patients medical notes however, were not always securely stored and were accessible to people with no necessity to view.
- During the inspection we arrived in the children and young people ward and spoke with two parents who were waiting for a patient to return from surgery. On the counter in the ward was the 'Paediatrician outpatient's folder' which was readily accessible. This contained patient's names, dates of birth, treating consultant, their medical speciality and length of appointment for the children and young people attending the outpatient's clinic.
- We also found the 'Expected paediatrician patient's' folder readily accessible. This contained the future booking forms for patients with their names, dates of birth, surgeon and the type of surgery they were due to receive. We were unable to bring this to the services attention during the inspection.
- Following the inspection, we asked for evidence of audits being completed to ensure patient records complied with services standards, were completed correctly and appropriately stored. The service provided evidence of health documentation audits which identified, during the reviews in July 2018 and October 2018 records had been appropriately stored. This however, had not been the practice observed during the inspection.
- It had been identified in a 'Children's nursing team meeting' in January 2019 the children and young people service were not auditing inpatient records to identify where improvements could be made in the completion, which would include storage and handling. An action was put in place for these document audits to start from January 2019. This had not commenced at the time of the inspection.
- Children's discharge was nurse led. Patients and parents/guardians were provided with leaflets containing details about postoperative care for different procedures, pain medication, and the telephone number of the ward to call with any questions or concerns. This also included information on how to contact the RMO outside of the ward opening hours for advice and support if required.

Medicines

The service followed best practice when administering, recording and storing medicines. Patients received the right medication at the right dose.

- Medicines were stored securely and stores of controlled drugs were regularly checked. Controlled drugs are those which require a greater degree of security regarding storage and administration. Documents showed these were regularly checked by named staff. We selected two controlled drugs and found their numbers matched the documented stock levels.
- Staff kept medicines for children in a secure, lockable cabinet in the ward. We saw paediatric medicines were stored appropriately. Staff said if items required refrigeration it would be placed in the medicines fridge on the Chalfont ward.
- Nurses safely administered medicines. We observed nursing staff had the use of an up-to-date version of the "British National Formulary for Children" to double check medicine calculations, administering medicine safely based on these calculations. We observed staff follow this guidance and identify when it was not appropriate to deliver additional pain medication to a patient.
- We reviewed one medicine prescription record and found it accurately completed with allergies, date of birth, age, weight and height of the patient clearly recorded. This meant staff administering medicines had

all the information to ensure the medication dose was appropriate for the patient. In addition, we found no omissions of medicines and the records demonstrated staff administered medicines as they were prescribed.

- A controlled drugs (CD) audit completed December 2018 identified there had been no regular three-monthly pharmacy checks of CDs stored within the children and young people ward. At the time of the inspection we saw this process had recently been implemented
- **For our detailed findings on medicines please see the 'Safe 'section in the surgery report.**

Incidents

The service managed patient safety incidents well. Staff recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learned with the team and wider service.

- Staff understood their responsibilities to raise concerns regarding safety incidents and near misses. Staff knew how to report incidents correctly on the hospital's electronic incident reporting system and described what constituted an incident.
- The service reported 18 incidents from January 2018 to January 2019. These incidents were identified as low or no harm incidents. Three main themes of the incidents reported by the service were identified, these included, two incidences of a post-operative bleed within 28 days of surgery, patient pack being sent to the wrong address and two operations being cancelled due to staff last minute non-availability.
- These incidents were investigated thoroughly with action taken to minimise and lessons shared to minimise the risk of a reoccurrence. For example, following an incident where a patient's information pack had been sent to the wrong address learning was disseminated to teams across the service to ensure this was not repeated.
- Incidents were discussed at team meetings, heads of department meetings and cross service children and young people meetings. The cross-service children and young people meetings involved heads of nursing, clinical service manager and lead paediatric staff from the provider's other hospitals which provided children and young people's services. Meeting minutes confirmed incident reviews and lessons learned were permanent agenda items for discussion. This ensured all services learned from incidents and were aware to take action to prevent a recurrence.
- The service had no serious incidents or never events reported which involved children and young people from January 2018 to January 2019. Never events are serious incidents which are entirely preventable because guidance, or safety recommendations providing strong systemic protective barriers, are available at a national level, and should have been implemented by all healthcare providers.
- The service had no incidents which had required the duty of candour to be carried out. Managerial staff we spoke with understood their responsibilities in relation to duty of candour. The duty of candour is a regulatory duty which 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 provided reasonable support to that person.

Safety Thermometer

The service did not have a system to monitor safety results. Staff did not collect safety information to share with people using the service and to drive service performance.

- The children and young people service did not have access to an electronic dashboard or other monitoring system which enabled them to continuously review key areas to ensure 'harm free' care was being delivered.
- Staff said the children and young people service did not fit the criteria for the requirement of this monitoring as they only saw day case patients who were at a low risk of adverse reactions to surgery and treatment.
- The children and young people service could not evidence the delivery of 'harm free' care as a result

Requires improvement

Services for children and young people

Are services for children and young people effective?

Requires improvement

This was the first inspection of the children and young people service at the Chiltern Hospital. We rated it as **requires improvement.**

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence of its effectiveness.

- The hospital used policies developed by BMI Healthcare which referenced relevant guidelines and legislation. Most policies viewed were up-to-date with identified review dates to ensure regular review.
- We reviewed eight policies relating to the care of children and young people and saw they contained reference to national best policy and guidelines. For example, the 'Safeguarding children policy' contained guidance from BMI Healthcare corporate policies and guidance, it also made references to Department of Health and other governmental departments best practice publications for children's care.
- The hospital had a BMI 'Children and young people manual' (September 2017) which provided guidance in line with the Department of Health's guidance on the National Service Framework for Children. This meant the hospital had taken steps to ensure children and young people were cared for in line with best practice. For example, the use of Gillick competency. This is a term that is used to assess whether a child (16 years or younger) can consent to their own medical treatment.
- Staff in the children and young people service had a good understanding of, and had read, local policies and were able to access them using the hospital's intranet. We observed new legislation and corporate policies were a regular agenda item on the heads of department meetings. This enabled all managers to be aware of new working practices which would require implementation within their teams.
- We saw the hospital used the 'World Health Organisation (WHO) safe surgery checklist, Five Steps to Safer Surgery' tool. This reflected evidence-based practice to ensure safety for surgical procedures. We saw this guidance was followed.
- During our inspection we saw patients having a pre-assessment, general anaesthetic and post assessment prior to surgery. The National Institute of Health and Care Excellence (NICE) guidelines were used to assess patient's anaesthetic risk at pre-assessment. The service had strict admission criteria and did not admit patients with complex health needs. We reviewed the notes of 12 patients and saw patients had a completed pre-assessment checklist.
- The paediatric day case care pathway was evidence based. The pathway was underpinned throughout by national guidance including from the Resuscitation Council and The Marsden Manual 2015. The pathway included checks of paediatric early warning scoring and relevant risk assessments throughout. This guidance was followed by staff throughout the patient care observed.
- Cross service children and young people meetings staff working across the provider's children and young people services were held where updated knowledge and guidance could be shared. This ensured a consistent and evidence-based practice was being delivered. We saw evidence of this with the introduction of new fasting guidelines for children and young people which was discussed and shared in the September 2018 meeting.
- Staff told us, and meeting minutes confirmed, they met with other children and young people service leads from the provider's other hospitals to discuss working practices and share information. At the time of the inspection staff were in the process of reviewing the processes and guidance regarding allergies, rewriting their standard operating procedures to share with other children and young people services within BMI Healthcare to ensure consistency.
- Staff were encouraged to participate in reviewing best practice and national guidance to ensure policies and procedures were updated as necessary and shared with

the providers other children and young people services. This included the introduction of new fasting guidelines. This had had been work between services at the hospital to ensure practices followed national guidance.

Nutrition and hydration

Staff gave patients enough food and drink to meet their needs and improve their health. The service could accommodate patients' food choices in line with their preferences.

- Patient's dietary needs were assed upon admission and the kitchen informed accordingly. The service provided a separate menu for children, with age appropriate meal choices. Patients' feedback was all positive regarding meals served. Written feedback received included, 'The food was great' and when asked what was great about their hospital experience patients commented positively on the food which was provided.
- Day case patients received meals which met their needs whilst present on the ward. Children could choose from a varied child menu and an adult menu for older children. If a child had missed a meal due to pre-operative starving a meal would be requested prior to surgery so was available when they were able to eat. Staff told us patients could request something and the kitchen would prepare food different to the menu choice if the kitchen had the ingredients available.
- Staff said patient's dietary needs could be accommodated according to their preferences and gluten free and vegetation diets for example, were available if required. The children and young people service also had access to cereals, biscuits and bread for patients who were in the ward into the evening following treatment.
- Throughout the inspection we saw patients and their families were offered choices of food and drink. A patient returning from recovery was encouraged to eat and drink post-surgery to ensure they were appropriately hydrated and able to return home safely.
- Patients, where they could consent, or their parents/guardians if not, were provided with information regarding fasting prior to procedures in their pre-assessment consultation.We saw staff followed BMI Healthcare guidelines on pre-operative starvation and shared this information appropriately.
- Staff told us they followed a blanket starving policy for children and young people services. This was due to only having one or two children or young people as a surgery day case who would be first and second on the theatre list. In the event more children or young people were due to be seen or there was a delay in surgery due to an acutely unwell patient staff would liaise with the anaesthetist to identify what food and drink the child or young person could be given.
- The hospital did not monitor pre-operative starvation times as part of any paediatric score card or monitoring system. Senior staff told us a recent children and young people's meeting with the paediatric lead, anaesthetist and risk and governance lead had been held to discuss the monitoring of theatre starve times. This was to ensure patients fasted within day surgery information guidelines set out by the Royal College of Nursing. Senior staff said this was something they were going to do moving forward however no timelines for implementation could be given.

Pain relief

Staff assessed and monitored patients regularly to see if they were in pain. They supported those unable to communicate using suitable assessment tools and gave additional pain relief as required.

- The service used nationally recognised pain assessment tools to determine and continually assess patient's pain levels. These included the Baker-Wong pain assessment tool for patients.
- The Baker-Wong pain assessment scale shows a series of cartoon faces ranging from a happy face or a score of one for 'no hurt' to a crying face and score of 10 which represents 'hurts like the worst pain imaginable'. Patients were asked to choose the face which best described their level or pain. The scale is appropriate for the use in children from the age of three which was the minimum age for surgery and treatment in the children and young people service. The meant patients of all ages could communicate their level of pain and have these needs met.
- We saw patients' levels of pain were continually reviewed to determine whether they were appropriately controlled. This ensured patient wellbeing was being maintained and supported them with their recovery.

- The service had access to paediatric pharmacy advice and support, between 08:00am and 17:00pm Monday to Friday and Saturday mornings. Out of hours the resident medical officer was available to prescribe and dispense medicines to alleviate patient pain and manage associated distress.

Patient outcomes

There was no patient outcome monitoring in place to monitor the effectiveness of care and treatment and use the findings to improve them. The service could not evidence they compared local results with those of other services to learn.

- There were no patient outcome measures used to calculate the health gains after surgical treatment using pre and post-operative measures. Therefore, it was not possible to demonstrate the effectiveness of surgery.
- The hospital had no unplanned transfers to local NHS trust in the period January 2018 to December 2018 for children and young people.
- The service does not participate in any audit programmes to benchmark outcomes with other similar services either within the BMI group or externally.
- The service could not evidence they routinely monitored patient outcomes to ensure treatment delivered was effective met patient need.

Competent staff

The service did not always make sure staff were competent for their roles.

- Staff told us the children and young people service had officially opened in October 2017 and at that time, the induction had been self-led without a formalised structure in place. As a result, the service lead had introduced an induction package to be delivered to all staff working within the children and young people service. This included checklist of children's competencies for registered children's nurses which required observing and signing off before the member of staff could be deemed competent to complete their role.
- Nursing staff told us they were clinical mentors and able to observe and sign off their colleague's competency areas. The provider's 'BMI acute care competencies, (registered children's' nurse) Competences assessment log books' ensured consistent knowledge and evidence of identified and required skills were documented. We asked to review the competency books for staff in the children and young people services but only received these for five of the eight members of staff.
- For the three permanent contracted members of staff we noted their competences assessment log books had not been completed until September 2018, 11 months after the children and young people service had officially opened. Therefore, between October 2017 and September 2018 staff had not been assessed as competent for their role.
- New staff were allocated a buddy to support them throughout their induction period. Staff spoke positively of this induction process and said they could seek additional support from staff and managers if they had felt it necessary.
- The lead children's nurse stated children and young people with known complex needs were not accepted at this service. This assured us the service ensured staff were not expected to provide care for children with complex needs outside of their competency.
- Data provided by the hospital showed all medical staff with practicing privileges were appropriately registered with their professional body. This meant the hospital conducted checks to make sure the doctors were registered with the General Medical Council.
- Medical staff had their competencies checked by the Medical Advisory Committee, as a condition of their practicing privileges. This ensured that they undertook procedures that they were competent to undertake and which they did in their substantive NHS roles.
- Practising privileges (PP) were reviewed formally every year, consultants had to demonstrate competence and only undertake procedures they performed in their NHS role. Medical practitioners annually provided the hospital with up to date evidence of adequate insurance or indemnity cover; GMC registration; participation in annual whole scope of practice appraisal. Conditions of consultants PPs meant that cover arrangements were in place in the event they were not available due to annual leave, or other commitments.

- Staff spoke positively of the appraisal and supervision in place to support them. Appraisals and supervisions were timetabled in with protected time to allow staff to participate fully. These were used to identify if staff were happy in their role, identify areas for improvement and ensure ongoing learning needs were discussed and met where possible.

Multidisciplinary working

Staff of different kinds worked together as a team to benefit patients. Doctors, nurses and other healthcare professionals supported each other to provide good care.

- Patient admissions were arranged between the consultants and members of the nursing staff on duty at that time. This meant patients had the same named nurse who was able to determine admission numbers. This ensured the patient to staff ratio were kept within safe limits.
- The hospital took part in multidisciplinary team (MDT) meetings for children and young people services and met weekly with the lead anaesthetist to review children booked for surgery the following week. This ensured all members of the team were aware of the children and young people's needs and staffing levels were planned to meet these.
- A bi-annual meeting between the children and young people service, lead anaesthetist and lead consultant was held to review services and standard operating procedures to ensure they met the needs of the service.
- A daily morning communications meeting was held between lead staff from all departments and services. This covered a number of operational areas including reviewing incidents and allowed staff to share concerns or offer support to other services if required.
- Physiotherapists stated they felt there was good MDT working and support between outpatients and staff from the children and young people service. We observed there was a good rapport between staff and specialties.
- The service had identified links with local safeguarding networks. One of the permanent children and young people nurses liaised with the local NHS organisations and clinical commissioning groups when required. A senior manager within the hospital attended the local NHS safeguarding meetings which focused on adult safeguarding issues however, disseminated information and newsletters produces to all services included the children and young people service.

Health promotion

The service did not actively disseminate and promote healthy lifestyle advice to children and young people.

- The services did not actively offer health promotion to children and young people or their parents/guardians during consultations or the admission process. If necessary or requested staff, however, could provide advice on patient's health and wellbeing.
- Children and young people staff said they were planning to work with the outpatient's department to develop a children and young people specific health and safety notice board. This would be reviewed weekly and would contain advice including the safe use of car seats and sun safety. No timescales could be provided regarding when this work would be completed.
- One of the nurses on the children and young people ward had an interest in nutrition and childhood obesity and had provided guidance and advice to parents/guardians when concerns had been raised. All children and young people staff could offer reassurance where needed and guide parents/guardians to local support groups if felt necessary.
- Another nurse on the children and young people ward was a breastfeeding advisor and could offer guidance and support to parents/guardians within the ward and outpatient area if required.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. They followed the service's policy and procedures when a patient could not give consent.

- The services admission criteria meant that children or young people with known mental health issues were not admitted to the service. Staff, however understood their responsibilities under the Mental Capacity Act 2005 and knew how to support patients who lacked the capacity to make decisions about their care.

Requires improvement

Services for children and young people

- Guidance was provided to staff, and they knew how to access, the local NHS trust's Child and Adolescent Mental Health Service if they had concerns regarding a patient's mental health, prior, during and post interaction with the children and young people service.
- The service had an up-to-date consent policy based on best practice and legal guidelines which included guidance for staff on consent issues. This policy outlined the process for gaining valid consent from patients for examination and treatment and included information regarding the 'Gillick Competency'. This is legal requirement used to determine whether a patient has sufficient understanding and intelligence to enable them to fully understand a proposed procedure.
- Staff could demonstrate a working knowledge of the Gillick Competency when gaining consent and records documented when this consent had been obtained and signed by both patient and parent/guardian.
- Staff discussed the ability of children and young people to withdraw their consent at any time which was respected. An example was given where a patient decided, during their procedure, to no longer continue. The patient's parent/guardian expressed a wish for the procedure to continue however, staff did not allow this to happen. They demonstrated the patient could understand the outcome of stopping the procedure and was therefore able to make the fully informed decision about their treatment and care.

Are services for children and young people caring?

Good

This was the first inspection of the children and young people service at the Chiltern Hospital. We rated it as **good.**

Compassionate care

Staff cared for patients with compassion. Feedback from patients confirmed that staff treated them well and with kindness.

- Staff were motivated to deliver compassionate care throughout the patient's treatment at the hospital.

During the inspection we saw positive, caring, friendly and encouraging engagement between staff and parents/guardians. Staff were kind in their approach to children but remained professional.

- During the inspection we saw parents/guardians being treated with compassion and clearly enjoying their interaction with staff and other people present at the service. Interactions were respectful and considerate, and staff demonstrated genuine warmth and interest in patients, and parents/guardians, wellbeing. Care and therapy were delivered by staff in a way which evidenced it was focused on the patient's wellbeing.
- Staff used appropriate language to ensure patients understood treatments, procedures and ongoing care to build trust with the patient and their parents/guardians. We observed a post-operative discussion with children and young people and surgery staff with a patient, during which explained what had happened, why and what the overall outcome would be for the patient. They explained this using language the patient could understand easily and offered them the opportunity to ask questions throughout their meeting.
- We saw the privacy and dignity of patients were maintained on most occasions, staff knocked on doors before entering consultation rooms and ensured doors were closed when consultations were occurring.
- Between January 2018 and December 2018, 411 pieces of feedback had been received for across the children and young people service, all of which had been positive in its completion and praised staff for being kind and compassionate to them throughout their care pathway.
- Positive verbal feedback was provided by patients and their parents/guardians during the inspection and we saw written positive feedback on the quality of the children and young people service offered. Written feedback for services provided across children and young people included, 'Both nurses were friendly, they explained how the procedure was going to happen and did it efficiently', 'Very friendly, helpful, support staff, quick and efficient' and '(Nurses) really kind and walked us through it, kept us both as calm and happy as

possible'. A guardian had written about their family member being a day case patient, 'Everyone was extremely helpful, friendly and informative, they really helped our relative to feel as comfortable as possible'.

- People we spoke with during the inspection spoke positively of the caring nature of staff they interacted with within the children and young people service. One patient due to attend an outpatient appointment told us, "Staff have always been really friendly" and described the staff as "Amazing". Parents/guardians we spoke with in the ward confirmed staff's ability to deliver compassionate care telling us, "The staff having been excellent in reassuring (family member)".

Emotional support

Staff provided emotional support to patients to minimise their distress.

- We saw children and young people and their parents/guardians were supported emotionally throughout their hospital journey from pre-assessment to follow up after treatment
- The children's nursing team supported children and young people undergoing surgical procedures by offering a face-to-face pre-assessment to ensure they were emotional prepared for admission. This allowed patients to familiarise themselves with the environment, it also afforded patients and their parents/guardians to meet the nurses and ask questions to alleviate fears and anxieties.
- Staff took the needs of children and young people into account and had found an innovative way to reduce the stress of their patients. For example, patients who were attending theatre were able to drive an electronic toy car from the ward to the theatre to minimise feelings of anxiety and distress. Positive written feedback from patients showed they had enjoyed this part of the process immensely.
- Staff encouraged parents/guardians to accompany their child to theatre and support the patient's emotional needs whilst in the anaesthetic room. The children's nursing team escorted parents/guardians to the recovery room when the patient was transferred from theatre. This provided reassurance for both patient and parents/guardians in times of stress.
- Staff recognised the stress placed upon parents/guardians when their family members were in surgery and acted to minimise this wherever possible. When a patient was taken to theatre their parent/guardian was provided with a voucher to attend the hospitals restaurant, this allowed them time away from the ward environment and ensured they had something to eat and drink. Staff said often parents/guardians would not have had anything to eat and drink prior to their family members surgery either due to stress or not having the time to get themselves ready. As a result, the voucher system had been introduced to ensure their needs were also met.
- Children and young people requiring day surgery were accompanied by a parent/guardian to the anaesthetic room and stayed with them until they were asleep. This ensured parents/guardians could continue to provide emotional support for the patient. A guardian we spoke with during the inspection told us, "Staff had been excellent in reassuring (the patient)" and said the anaesthetists had been able to distract the patient whilst the cannula had been placed which had caused them, and their parents/guardians some concern pre-procedure.
- Staff within the children and young people service had access to a psychologist to offer support to patients if they expressed a need pre- or post-procedure. The psychologist ran a clinic which was accessible to young people from the age of 14 if needed.
- Children and young people were given a hospital teddy bear (if they wished) which would be waiting for them on admission to the ward. These were also made available to children and young people who were being seen in outpatient departments to minimise distress. For example, children going to use the MRI machine which was an unfamiliar situation for them.

Understanding and involvement of patients and those close to them

Staff involved patients and those close to them in decisions about their care and treatment.

- Staff were committed to working in partnership with children and young people and their parents/guardians to ensure they were actively involved in planning care and treatment. Patient feedback demonstrated staff

Requires improvement

Services for children and young people

used pre-assessment meetings to allow patients and their parents/guardians to acclimatise to the hospital environment, involve them in discussions about their planned care and explain proposed procedures clearly.

- Children and young people met the ward nursing team during their pre-assessment. During these meetings the process of what to expect during their treatment was fully explained to the patient and their parents/guardians. This was also the opportunity for questions to be asked of staff.
- Children and young people and their parents/guardians were involved in making decisions about the care provided. Patients said staff spoke to them directly and in a way, they could understand. Parents/guardians spoke positively saying all staff involved them and their family member in decisions about the care options available.
- Children and young people and their parents/guardians we spoke with felt well informed about their care and treatment and were kept informed of changes to the patient's care by the multidisciplinary team involved in their care. For example, we saw doctors (surgeon and anaesthetist) enter the ward and tell the patient and their parents/guardians what happened during the patient's surgery.
- Children and young people attending for day surgery received information in a clear and simple format before admission. It detailed what they should expect at their admission and facilities available for them to use. It also included information about anaesthesia and their hospital stay and discharge arrangements.

Are services for children and young people responsive?

Requires improvement

This was the first inspection of the children and young people service at the Chiltern Hospital. We rated it as **requires improvement.**

Service delivery to meet the needs of local people

The service planned and considered the need of young people accessing the service, but did not always provide facilities in a way that met their needs.

- The service did not undertake acute or emergency surgical admissions for children and young people.All surgical interventions were undertaken as day cases. The hospital had no critical care facilities and children and young people were screened at pre-assessment to ensure the hospital had suitable facilities to treat them. A service level agreement was in place with the children's acute transport service (CATS), if the condition of a children and young people deteriorated and they required an urgent transfer to an NHS acute hospital.
- All children and young people attending the hospital were overseen by the service lead and referrals team. This ensured all aspects of a patient's requirements were assessed and considered before booking a patient onto a surgical list or into an outpatient clinic.
- Treatment delivered at the service was for self-funded patients. This meant services were planned according to patient demand.
- Patients and their parents/guardians had been actively involved in the designing of the service. As the ward was being developed potential patients and their families were involved in reviewing the building work and to comment on if it would suit their needs.
- The children and young people service was unable to accommodate single sex areas in the children's ward however, were always aware of patient numbers and bookings. If identified two female patients and an older male patient were due to attend on the same day staff had the ability to place the older male patient in a more private space on the adult ward. Staff told us this was discussed in pre-assessments however the parents/guardians we spoke with were not aware of this option being available. During the inspection however, only one patient at a time was in the ward meaning this discussion would have not been necessary.
- The hospital had a separate waiting area for children within the outpatient department waiting room however, did not always provide facilities for older children whilst they waited. During the inspection we saw one patient was kept waiting 20 minutes for their appointment. This patient told us they enjoyed reading magazines and books however, no age appropriate magazines were available for them to read whilst they waited.

- The small child waiting area was appropriate for toddler aged children with games and low seating area however, there were no activities for older children to distract them whilst they waited to be seen. We spoke to another patient who told us they enjoyed reading sports magazines however nothing age appropriate was available for them in the waiting area. Staff in the children and young people ward had access to magazines available for older children however, these were not available to children in the outpatient waiting area.
- Facilities were available for patients and relatives in the restaurant of the hospital including nappy changing facilities where required. Ward staff also had access to drinks and snacks if the main restaurant was closed prior to a late discharge.

Meeting people's individual needs

The service took account of patients' individual needs

- All children and young people using the service were low risk on admission and did not have complex needs which required additional support and therefore the service could meet their needs.
- Staff told us they had access to language line if required however, despite treating patients from non-English-speaking EU countries they had not had to use the service, however, it was available for use.
- Staff told us that they did treat children with a mild learning disability or exhibiting autistic behaviour traits. If patients required additional time to process their surroundings however outpatient appointments were booked in length according to the needs of the patient.
- Patients and their parents/guardians told us they were given detailed explanations about their admission and treatment. Parents said age appropriate language was used by doctors and nurses to explain procedures to their child.
- Staff could refer children and young people to local child and adolescent mental health services if they had concerns regarding their mental health and wellbeing. Staff we spoke with however said the situation where this was required had not arisen.
- The three bedded children and young people ward was decorated in a child friendly way. Age appropriate bed linen was on the beds and child friendly curtains were available for each bay which had pictures of sea creatures on. The walls were decorated with animal and nature related stickers. A TV was available for use which had access to child friendly channels and radio channels for older patients. There was also a seating area with a toy box, games, building blocks and colouring in books for younger children. Children and young people were encouraged to take the favourite toys into hospital and older children were able to access WIFI during their hospital stay.

Access and flow

People could access the service when they needed it. Waiting times from referral to treatment and arrangements to admit, treat and discharge patients were not monitored to ensure it met patient's needs.

- The outpatient children and young people children and young people service assessed children from early infancy to 18 years of age with symptoms across the general paediatric spectrum. Commonly managed problems included, respiratory complaints such as asthma, urology and orthopaedic issues.
- A number of surgical treatments were offered for children and young people over three years of age. These included those associated with ear, nose and throat (ENT), urological problems, audiology and general paediatric surgery. Children and young people were seen from the age of three to 18 years unless assessed to be treated on the adult pathway (between the ages of 16 and 18 years) by the children and young people's team.
- Patient's had timely access to initial assessment and treatment through a children and young people referral pathway at the hospital. The booking system was conducive to meeting patient's needs. Parents/ guardians could select times and dates for appointments to suit their child's school commitments or the child's family. Appointments could be before or after school and between school terms.
- All children were prioritised for theatre to be first or second on the list either on the morning or afternoon list. This ensured that there were staff and equipment set up and readily available to meet the needs of the child minimising any wait they experienced.

Requires improvement

Services for children and young people

- All admissions for children and young people were agreed with admitting consultant and the children and young people service lead. All children had a pre-admission assessment with a registered nurse by telephone for minor procedures which would involve a local anaesthetic if the patient preferred and face-to-face for more complex procedures or those requiring a general anaesthetic.
- When procedures had to be cancelled or were delayed, this was recorded as a clinical incident and appropriate actions taken. In the period from January 2018 to January 2019, two procedures were cancelled due to staff related issues, one due to illness and the other a family emergency. Cancellations were rescheduled for as soon as possible, (the following week in both cases) after discussion with the patient, their parents/ guardians, children and young people nursing and surgery teams.
- Patients and their parents/guardians were provided with a hospital discharge folder when discharged from the day case ward. Discharge information was also sent to the patient's GP detailing the surgery completed and medicines prescribed during and post-surgery.
- Within the discharge folder information was provided to support patients with their recovery including questions to reminding patients to ask how long it was anticipated their discomfort would last, the name and use of their discharge medicines and contact details for the children and young people ward and resident medical officer. This was to ensure patients had all the information available to them on what to expect following their discharge from the hospital.
- The service could not evidence they monitored patient referral and treatment times to ensure treatment was delivered in line with patient's needs. However, the majority of patients were self-funded or insured and there were choices of dates and times available which was dependent on the consultant's clinic times or theatre lists.

Learning from complaints and concerns

The service could not evidence that it treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with all staff.

- Following the inspection, we asked the children and young people service to provide the last three completed complaints and investigations which had occurred in the 12 months prior to the inspection. The service was unable to supply this information stating they had not received any complaints. Further contact from the hospital identified there had been no concerns or complaints raised within the 12 months prior to the inspection. As none had been received we are unable to comment on the efficiency and overall complaints process to ensure it met patient's needs.
- We saw leaflets throughout the hospital informing patients how to make a complaint or raise a concern about their treatment. These were, however, aimed towards adult patients or patient's parents/guardians. There were no child friendly leaflets available to enable children and young people patients to raise their concerns independently.
- The service had an in-date complaint's policy which provided guidance on how to follow the complaints process and explained how complaints could be resolved via resolution or escalated through independent complaint reviews.
- The hospital's website identified they were aligned to the Independent Healthcare Sector Complaints Adjudication Service (ICAS) complaint handling guidance. This service provides an independent adjudication on complaints about ICAS subscribers and investigated complaints once they had been investigated via the hospital's own complaints process.
- The hospital's website also directed complainants to an email where they could raise their concerns with the Executive Director of the Hospital.
- Parents/guardians we spoke with told us they were unaware of the formal route to raise a complaint but had not had cause to do so. They told us they would speak to the staff, telephone the hospital's reception or view the hospital's website if they felt they had a concern or complaint they wished to raise.

Are services for children and young people well-led?

Requires improvement

Services for children and young people

Inadequate

This was the first inspection of the children and young people service at the Chiltern Hospital. We rated it as **inadequate.**

Leadership

Not all managers within the service had the right skills and abilities to run a service providing high-quality sustainable care. The services senior management team were unaware of the serious concerns identified during the inspection in relation to the organisation and operation of the children and young people's service.

- Processes were in place for line management support of managers. Staff spoke positively of the ability of their immediate and senior management team to support and lead the service. Despite this positive feedback however, the providers management team were unaware of the serious issues identified during the inspection with the organisation and operation of the service. Once these issues were raised to the senior management team, immediate action was taken in response.
- The children and young people service was led by the lead registered children's nurse who had experience and knowledge of operating and leading a children and young person's service. However, their leadership of the service had not been appropriately monitored and reviewed by the provider's senior management team. This was required to ensure work undertaken met the providers policies procedures and national standards. The provider could not evidence this took place and we were not assured a safe, effective and responsive service was always delivered.
- The lead for children and young people services reported directly to the director of clinical services and executive director. Staff told us the senior management team (SMT) demonstrated they supported the children and young people services lead and were engaged with the plans to do develop the service. We did not see however, senior leaders had suitable oversight of the leadership of the service. They had not identified there were serious concerns relating to recruitment, environment and the monitoring of service delivery.
- The hospital had an established SMT in place at the hospital. The children and young people ward, theatres, and the outpatient department had managers in post who received support directly from the SMT. The service had medical representation on the medical advisory committee (MAC) for children's services from the lead consultant paediatrician.
- Staff spoke positively of the SMT and told us they were visible, approachable and supported them well. A schedule of regular meetings including monthly heads of department meetings, monthly clinical governance meetings, weekly incident meetings and daily communication cell meetings, this meant leaders were immediately accessible to staff. We observed a daily communication cell meeting which involved staff from all services within the hospital and sister hospital the Shelburne, this was well attended with leaders actively encouraging open communication and offering support where required.

Vision and strategy

The service had a vision for what it wanted to achieve. However, there were no effective processes in place to ensure the monitoring, reviewing and progress of care delivery against these visions.

- There was a vision to deliver high quality sustainable care within the children and young people service. The provider had developed a vision for the hospital and staff to work towards which included prioritising patients and staff ensuring a safe environment for example. This had been further developed by the children and young people team to create their own vision and philosophy of care, this focused on placing the children and young people at the heart of all the work completed within the service. This work identified how the children and young people would work towards achieving the provider's overall vision for the delivery of a quality service.
- The vision for the children and young people service was set out in the 'Children's Services – Our Visions 2018-2019' document. This document set out the vision to deliver the 'best children's services in the best way

possible'. This included the improvements needed to improve, which included, ensure all areas within the children and young people service were child friendly, children and parents to be provided with health education and advice as required and ensuring local guidance/standard operating procedures were current and reflect best practice.

- It was identified during this inspection areas which required additional work had been identified as areas for improvement. Staff had developed and supported the strategy speaking positively of their desire to deliver high quality safe care to children and young people.
- However, there was no effective approach to monitoring, reviewing or providing evidence of progress against the delivery of the vision's values. The visions had not been translated into meaningful and measurable plans at all levels of the service. The service could not actively demonstrate these values in the work completed by the children and young people staff.

Culture

Managers across the service promoted a positive culture which supported and valued staff, creating a sense of common purpose based on shared values

- Children and their parents were at the heart of the patient centred approach to care, which was visible during our inspection. Staff at all levels throughout the hospital, were committed about delivering high quality patient care.
- Staff spoke positively about working for the children and young people service and organisation. Staff in departments throughout the hospital who worked with children and young people services spoke positively about working at the hospital, and the priority that children's services was given.
- The children and young people service fostered an open and honest culture. We saw there was an open approach to incident reporting with all staff stating they were comfortable to do so without fear of reprisal. Staff described the service lead as approachable and took their concerns seriously.
- The provider worked to promote staff wellbeing. This included initiatives such as the physiotherapist team opening the gym for staff at weekends, prior to patient appointments. Occupational health services were also available to support staff mental health and wellbeing.

Governance

The service did not maintain an overview of all aspects of care delivery to ensure the continual improvement in service quality. The hospital's governance processes were not effective in ensuring appropriate safeguards were in place.

- There was a governance structure in place for children and young people's service, with a pathway of escalation to the paediatric lead and the Medical Advisory Committee (MAC).
- The service had a regular meeting structure in place which included governance related discussions. These included clinical governance meetings, MAC, heads of department meetings, children's nursing team meetings and children and young people committee meetings. All meetings had representation from children and young people services to ensure they were given equal representation.
- Whilst governance arrangements were clear there was a lack of systematic performance management of individual managerial staff and sufficient oversight of the services operation.
- The service had not ensured recruited staff held the essential qualifications for the role they were employed for. The processes did not always screen out candidates who did not hold the necessary children's nurse qualifications at application stage. During their recruitment, managers interviewed and appointed an individual without challenging they did not hold the necessary qualification for this role. During our inspection we identified this risk and alerted the executive director who took action to keep the service safe.
- There were systems and processes in place to monitor compliance with mandatory training. Despite these however, it had not been effective in identifying staff who had not completed training, identified as necessary by the provider and required for their role.

Requires improvement

Services for children and young people

- We found auditing and assurance processes had not always been effective in identifying when the children's and young people's services had failed to act in accordance with corporate policies. For example, operating the service with sufficiently trained staff to protect and maintain patient safety.
- There was a children's nursing team meeting which met quarterly. This meeting fed into the hospital's clinical governance committee to advise them on the performance and safety of the children and young people's service. Representation at this meeting included the children and young people registered nurse lead, theatres, pharmacy, quality and risk manager, director of clinical services and leads from other services within the hospital. We saw minutes which showed issues such as the review of actions from previous meetings, incidents, infection prevention and control, safeguarding were covered in these meetings.
- Service level agreements were in place with local NHS trusts and the Children's Acute Transport Service, for advice and support. These were known by staff who said they could use without hesitation if required.
- The service had a formal annual audit plan in place. This plan included a range of audits including infection, prevention and control observational audits, medicines management and overall 'children and young people' audits. These audits reviewed the services safeguarding processes, training, staffing, risk assessments and successful use of operating lists for children and young people.
- **For our detailed findings on governance please see the 'Well led 'section in the surgery report.**

Managing risks, issues and performance

The service had systems in place to identify risks. However, these were inadequate and had not identified the patient safety and recruitment concerns identified during this inspection.

- Whilst the service had processes in place to manage and identify risks we were not assured risks were identified, mitigated and managed appropriately.
- Senior managers had not maintained an overview of the children and young people service to ensure delivery was in line with the hospital's policy and provider's guidance. Systems and processes had not recognised recruitment procedures were not always safe and had not identified risks to the services staffing levels were known. As a result no action had been taken to mitigate these wherever possible. Risk systems had not identified the services environment did not always met patients' needs. They had also not identified the staffing of the service had not met the provider's own policy regarding staffing and availability of on-call nurse provision.
- The service could not evidence, and we were not assured, senior managers were aware of the risks within the service and had appropriate plans in place to mitigate these. We asked the service to provide evidence including risk assessments completed for the operation of the service. These should have included a risk assessment for patients being treated in predominately adult areas such as outpatients and the recovery room for example. This evidence was not provided; therefore, we were not assured the risks had been recognised, action taken to mitigate and reviewed regularly to identify where improvements could be made.
- During the inspection the provided produced data which demonstrated, for the period August 2018 and 16 January 2019, children and young people had either been seen in the outpatients or as inpatients on the ward on 230 occasions without a registered children's nurse being present or available on call to provide advice and guidance. This was not in line with BMI policy and had not been identified by risk management processes or placed on the services risk register.
- We brought this to the attention of the nominated individual during the inspection who took immediate action to ensure a registered children's nurse would always be available to offer support whilst children were present. This included both as an inpatient on the ward following surgery and receiving treatment without the outpatients department.
- The children and young people service identified their two top departmental risks which were included on the hospitals risk register. This included the lack of toilet facilities in the Treetops ward and the risk of clinical staff not completing their appropriate paediatric immediate life support training. We saw this has been reviewed and updated the month of the inspection. Controls were in

place and actions identified to minimise these identified risks, however, not all risks to service delivery had been identified so appropriate mitigating action could be taken.

- Staff could raise concerns to the risk register by completing an electronic incident report. This would be discussed with the hospitals risk and clinical governance manager and added to the hospital's risk register if felt the issues required additional resources to address.
- We requested and were provided with the children's nurse staffing rotas and the activity for both the paediatric inpatients and outpatient department for the period August 2018 to January 2019. On review of this evidence we noted that at times the information provided conflicted, which meant there was a lack of accurate information available.
- **For our detailed findings on managing risks, issues and performance please see the 'Well led 'section in the surgery report**.

Managing information

The service did not always collect, analyse and use information to support activities. However, where used, secure electronic systems with security safeguards were in place.

- Staff had access to national best practice guidance, providers policies and standard operating procedures via the hospital's intranet system. When new policies were introduced staff were alerted via their e-learning system, BMI Learn, and had to check the online system to say they were aware and had read the information otherwise they could not continue to access all available content.
- Clinical governance bulletins and weekly news briefings were sent to all staff which included information regarding new policies staff needed to be aware of during the course of their work.
- There were clinical and non-clinical systems in place which captured areas such as incident reporting for example. This directly contributed to the quality of patient care through the identification of themes and trends which helped in the development of safer working practices.
- The service collected and collated limited information through regular audits for quality, safety and assurance to inform improvements to the service. The information collected included the review of medicines storage and pharmacist review, to inform patients' pain management through the use of appropriate medicines. This however, did not include patient outcome data to ensure care delivered met patient need or routine safety information to evidence the delivery of harm free care.
- The hospital had systems and process in place to manage electronic information securely. Staff used electronic records for the patient discharge process which required a security log in to access. Patient records, however, were not always kept secure on the ward when staff were not present and were accessible to the inspection team during the inspection.
- Staff did not have access to an electronic dashboard or other monitoring system to enable them to review key safety areas to see where improvements could be made if required.
- **For our detailed findings on managing information please see the 'Well led 'section in the surgery report**.

Engagement

The service engaged with patients and staff to plan and manage appropriate services.

- The service sought feedback from patients and staff to identify areas for improvement. This was gathered from patients and their parents/guardians by means of feedback forms handed to patients following their treatment from the children and young people service. All feedback was dealt with by the service lead and discussed at head of department meetings and daily communication cell meetings.
- Feedback forms asked patients and their parents/ guardians questions to identify if they were happy with the care and treatment provided. This included asking; if they knew the names of the nurses who were delivering their care and if things were explained in a way they could understand. The forms asked for narrative feedback about the most important thing staff did to make patients feel better and if there was anything which could have been done differently to make their experience better.

Requires improvement

Services for children and young people

- We saw a number of completed feedback forms which were all positive in their completion. Positive comments included, 'reassuring and calming presence from nurses and doctors', 'all the care delivered was first class, everybody was brilliant, thank you', 'everyone was really nice and caring' everyone was kind to me'. Other children and young people services such as the paediatric blood service had cartoon smiley faces which allowed patients to tick the cartoon face which identified how happy they were and whether they would recommend the hospital to others. These were also all positive in their completion.
- Staff surveys were completed annually to allow staff the opportunity to share their experiences of working for the service. The results from the last survey completed in December 2018 had not yet been published so we were unable to identify how the hospital was performing in line with the provider's average responses. Staff said following the December 2017 staff survey the hospitals executive direct and the SMT set up forums for staff to openly discuss concerns which had been welcomed by staff.
- There were regular staff meetings to share information with staff, we saw minutes from these meetings were detailed. These were used to review risks such as toilet facilities, discuss updates to previously identified actions, outpatients, inpatients, audits, safeguarding, policies, changes in health and safety and any new or emerging risks.
- The service was actively engaged staff in learning when incidents occurred to encourage shared learning. The provider group encouraged hospitals within the group to share learning with staff to prevent similar incidents occurring in other hospitals.
- **For our detailed findings on engagement please see the 'Well led 'section in the surgery report.**

Learning, continuous improvement and innovation

The service was not always committed to improving services by promoting training and innovation.

- The children and young people service told us they had worked with the lead anaesthetist to develop a new protocol for fasting prior to anaesthesia. This had resulted in new guidance being created regarding the timing of the last fluid intake, and type, prior to anaesthesia. A new provider policy 'Fasting before Anaesthesia' had been created and disseminated to the provider's hospitals to ensure a consistent approach to patient care. This was not innovative practice however, this change in protocol meant the service was working in line with the Royal College of Anaesthetist guidance published in May 2018.
- The service could not demonstrate innovative practices and staff could not evidence reflective practice to ensure ongoing learning to improve the quality of service provision.
- **For our detailed findings on learning, continuous improvement and innovation please see the 'Well led 'section in the surgery report.**

Requires improvement

Outpatients

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

Information about the service

Outpatient services at The BMI Chiltern Hospital includes orthopaedics, dermatology, ophthalmology and cardiology. The Chiltern Hospital is part of the BMI South Buckinghamshire Hospitals group. The senior management is shared between this hospital and The Shelburne Hospital, which we inspected at the same time.

The outpatient department has 12 consulting rooms including dedicated ear, nose and throat (ENT) and ophthalmology rooms. All clinics are consultants led with support from registered nurses and health care assistants. Minor operations such as removal of facial skin lesions are performed in a dedicated treatment room in the outpatient department. The majority of patients were seen in outpatient clinics Monday to Friday, with some evening and weekend clinics.

Between August 2017 and July 2018, the outpatient department saw 48398 patients in total of which 44814 were adult appointments. The outpatient area at The BMI Chiltern Hospital was shared between adults and children and 3584 were appointments for children 0-17 years. Out of these (both adult and child) appointments, 19438 were first attendances and 28960 were follow-up appointments. The majority of patients 93% were privately funded patients and 7% were NHS patients. Both NHS and private patients had an overall ratio of new appointments to follow up (a NICE measurement of efficiency and effectiveness) of 1 to 1.5.

During our inspection, we visited the outpatient department. We spoke with seven patients. We spoke to a range of staff including: administrative staff (4); clinical nurse specialist (1); clinical services manager (1) consultants (2); healthcare assistants (3); deputy clinical services manager (1); medical records manager (1) medical records administrator (1); nurses (2); physiotherapists (3); physiotherapy assistants (1); physiotherapy manager (1) and administrators/ receptionists (2). We observed staff providing care to patients and reviewed 10 patient records.

Are outpatients services safe?

Requires improvement

Our rating of safe stayed the same. We rated it as **requires improvement.**

Mandatory training

The service provided mandatory training in key skills to all staff and made sure everyone completed it.

- At our last inspection report (January 2017) we said that the provider should ensure all staff were up-to-date with all their mandatory training. At this inspection they had made improvements and ensured staff were up to date with their mandatory training. Mandatory training for all staff groups was made up of modules accessed through an on-line learning system. Staff told us it was easy to access but the face to face sessions were harder as they had to be available and had to have enough staffing in the department on the day to attend.
- Nursing staff logged onto their online learning and we saw those individuals were 100% compliant (this was indicated by colour per module and the future date it

was due). If members of staff could not fit training into their normal working day, they were encouraged by their managers to do their training at home and the service would pay them overtime.

- Consultants completed their mandatory training online, failure to complete training resulted in practising privileges. Practising privileges give medical staff the right to work in an independent hospital following approval from the Medical Advisory Committee (MAC). being suspended. The system sent an email when their training was due. Consultants found it difficult to attend the face to face components of mandatory training due to their clinic schedules and therefore the online training was completed before the face to face.
- The resident medical officer was trained in Advanced Life Support (ALS) and would support the outpatient staff if a cardiac arrest situation arose. All Resident Medical Officers were trained in adult and paediatric life support (basic and intermediate levels).

Safeguarding

Staff understood how to protect patients from abuse and the service worked with other agencies to do so. However, not all staff had completed the required level of safeguarding training.

- Staff in outpatients understood their role in identifying and protecting patients from risk of abuse and when abuse had occurred. Staff had training on how to recognise and report abuse and they knew how to make referrals appropriately in line with intercollegiate guidance.
- The BMI corporate mandatory training policy set a standard of 100% compliance rate to mandatory training and new staff 90% compliance within the first three months. All administrative staff were expected to complete level 1 safeguarding adults, compliance with this training was 91.85% and for level 1 safeguarding children it was 90.37%. Clinical staff had to completed level 2 safeguarding adults which 95.54% of staff had done and 94.64% were compliant with level 2 children's safeguarding. The managers and consultants were expected to complete Level 3 safeguarding adults and children, they were all compliant with this training.
- The director of clinical services was the location lead for Adult and Child Safeguarding. All consultants had level three adult and paediatric safeguarding which was in line with the recommendations from the intercollegiate document.
- Staff were trained in recognition of female genital mutilation and would know how to escalate a situation if they needed. Staff were also provided with Prevent training and 89% of staff at The BMI Chiltern had completed it. Prevent works to stop individuals from getting involved or supporting terrorism or extremist activity. Radicalisation is a psychological process where vulnerable and/or susceptible individuals are groomed to engage into criminal, terrorist activity.

Cleanliness, infection control and hygiene

The service controlled infection risk well. Staff kept equipment and the premises visibly clean. They used control measures to prevent the spread of infection.

- The patient areas in physiotherapy and outpatients, including waiting areas, treatment rooms and toilets were visibly clean and hygienic. Infection control audits were regularly completed every month and the joint outpatients had shown 100% for standard precautions hand hygiene and patient equipment (November 2018).
- Managers and staff told us that any urgent cleaning was completed quickly.
- Staff did not know if patients had infections before they came to clinic with the exception of the dressings clinic in which case they followed the advice of the infection control lead nurse. If it was apparent that a patient had an infection they would be isolated in a clinic room.
- Cleaning and decontamination of surgical instruments was subcontracted to an offsite provider. However, staff were trained to use an approved trio wipes system for naso pharyngeal scope but we did not see any audits of this process.
- We saw the staff cleaning rota in the outpatient departments. It had recently been changed to allocate

staff to specific rooms to ensure cleaning was done and we saw the completed check lists which demonstrated the staff were cleaning their delegated areas every day.

- Hand hygiene, aseptic non- touch technique (ANTT®) and infection control audits were undertaken monthly. The audits for infection prevention and control in November 2018 (most recent result) were 100% for patient equipment, hand hygiene and standard precautions. Standard precautions are the minimum infection prevention practices that are stipulated by the World Health Organisation (WHO 2017).
- Maintaining a clean hydrotherapy pool had been identified on the risk register due to problems with liquid based chorine but this issue had been resolved and the water samples had been clear every day for the last two months.

Environment and equipment

The service generally had suitable premises. However, there were plans for the existing floor plan to be reconfigured and for some of the specialist services to move to the BMI Shelburne.

- The environment was appropriate and patient centred. The chairs were comfortable and there was sufficient and varied seating. Toilets were clearly signposted and there adapted toilets for people with disability.
- The waiting area was visibly clean and tidy and included a water dispenser and magazines available for patients
- On our last inspection (January 2017) we told the provider the chairs in the outpatient department should be clean and in good repair, with sufficient numbers and types. At this inspection we noted the chairs were wipe-clean and in a good state of repair. There was a good range of seating including chairs for bariatric patients.
- Staff undertook a monthly health and safety audit and sent the audits to the health and safety officer. The sinks in the department were being replaced to meet the Department of Health Technical Memorandum (HTM 64), that specified the requirement of a horizontal waste outlet with no plug to prevent contamination from splashing.
- All patient equipment was visibly clean and in good working order although there was some inconsistency in the use of 'I am clean labels' (some of them had fallen off) but all the equipment cleaning checklists we saw were completed.
- The equipment had bar codes and servicing and calibration was managed centrally. The service contracts for equipment were in place to test all equipment six monthly and staff reported Portable Appliance Tests (PAT) were done at the same time.
- The resuscitation trolley was dust-free and visibly clean and we saw staff completed daily and weekly checklists, to ensure equipment was in date and fit for use.
- A new call bell system had been installed and there was a further plan of adding lights above the doors to indicated who was ringing across outpatients and the pre-assessment area. This would ensure staff could obtain timely support and assistance when necessary.
- We observed that there was limited space for staff to write notes, make phone calls and talk with patients without being interrupted. The central reception area where staff worked had two computers and a reception desk opening onto the corridor which could impact on patient confidentiality. However, the provider had considered the layout of all the outpatient rooms and costed for reconfiguration. The reconfiguration was scheduled to start this year the with a sluice area to be identified as priority.
- The patient waiting area had a small children's play area. A 'Daily Children and Young People's Risk Assessment' was completed as they shared the same waiting area as adults.
- Children were always accompanied by a parent or responsible adult. We noted window restrictors were in place on the windows. Equipment was secured to the walls and sharps boxes were closed and out of reach.

Assessing and responding to patient risk.

Staff completed an updated risk assessment if needed for an individual patient.

- We were given an example of a patient who had deteriorated and transferred from the outpatient

department at BMI Chiltern Hospital to the acute NHS trust. Staff had been trained to identify and respond to deteriorating patients using the National Early Warning Score (NEWS). This situation was recorded on the incident reporting system and discussed at the daily 'Comms Cell' (the organisations daily communication meeting) to ensure learning was shared across the hospital.

- We were told by staff patients occasionally walked in seeking urgent medical attention. The service had tried to mitigate this situation by placing notices outside to say that there was no A&E. However, in the event a patient presented at reception, staff told us that an outpatient nurse would assess the patient before call 999 for assistance.
- Staff we spoke with who used the hydrotherapy pool, had a good understanding of emergency protocols. The senior physiotherapist explained the emergency evacuation procedure using the emergency button in the pool area (or one around their neck if they were in the pool with the patient) to summons immediate help. The emergency evacuation was practiced twice a year to ensure all staff knew exactly what to do.
- The department team meeting minutes showed that the World Health Organisation surgical checklist and a swab count board, had been introduced to the outpatient department in December 2018. However, no audit of the checklist was available. Therefore, we were not assured that it was being used correctly.
- Staff were not aware of any formal arrangements with the local mental health services as the criteria for patients accessing the services meant that staff did not see people with severe mental illness.

Nurse staffing

Nurse staffing levels did not always meet the needs of the patients. Due to the service often having minimal staffing levels, it was difficult to cover sickness or vacancies and ensure patients were kept safe and provided with the right care and treatment. Staff had competency development to ensure they had the right mix of qualifications and skills.

- At our last inspection (January 2017) The BMI Chiltern Hospital was asked to ensure all outpatient clinics had sufficient numbers of staff to meet patients' needs. The establishment was 4.4 registered nurses and 3.2 nursing assistants, however they had a vacancy for 0.6 WTE registered nurse and were recruiting to this post. They had recently recruited to 1.0 WTE healthcare assistant. Staff in outpatients reported that in the event of staff sickness it was difficult to meet the demands of chaperoning, minor operations and clinics. Therefore, we were not assured sufficient action had been taken to resolve the findings of our January 2017 inspection in relation to sufficient numbers of staff to meet patients' needs.
- We were told children's nurses from the children's ward cared for children attending outpatient clinics that ran alongside the adult clinics. The adult nurses did not cover these clinics, they told us the most they would have to do would be to show a child and their parent the right clinic room to go to. At our inspection we identified not all nurses caring for children in outpatients were registered children's nurses and a registered children's nurse was not always available on site or on call to provide support. This arrangement was not compliant with BMI policy.
- As the outpatient department was not staffed to full establishment they sometimes used bank staff on their rota but avoided the use of agency. The department would try and use their own staff or the same bank staff each time to ensure continuity. Bank staff had the same mandatory training modules to complete as permanent staff which was dependent on their role.
- A staffing utilisation tool was used to plan the rota. The tool took into account the need for variable amounts of time for different appointments. Staff were aware the system needed updating to calculate the staff needed for chaperoning and breast clinic appointments and were waiting for these changes on the system.
- The deputy manager in outpatients reported providing adequate staffing was concerning them the most and that the lack of staff made any advanced planning very difficult. Staff also reported they were dissatisfied with the rota coming out at very short notice.

- We observed the pathology department was short staffed and the clinical service manager and charge nurse from outpatients, covered the absence.

Physiotherapy staffing

The service had enough physiotherapists and physiotherapy assistants, with the right specialities to keep patients safe and provide the right care and treatment.

- We were told that staffing the physiotherapy team was a constant challenge. The physiotherapists had participated in recruitment days, conferences and offered flexible working to attract staff.
- The physiotherapists worked flexibly across The BMI Shelburne Hospital and The BMI Chiltern Hospitals and across the different sub-specialties offered. This ensured patients had the specialty they needed while allowing staff to increase their knowledge, skills and experience.

Medical staffing

The service had enough consultants, with the right specialities to keep patients safe and provide the right care and treatment.

- There were 241 consultants who had been granted practicing privileges to worked at The BMI Shelburne Hospital and The BMI Chiltern Hospital. Consultants worked at the hospital under practising privileges. Practising privileges give medical staff the right to work in an independent hospital following approval from the Medical Advisory Committee (MAC). All applications for new posts since 2017, had been through the MAC.
- The BMI Chiltern and Shelburne Hospital had undertaken considerable work to improve the processes around practising privileges from the last report January 2017. A completed application pack and supporting documents including; disclosure and barring service (DBS) checks; curriculum vitae; certificates of qualification; annual appraisal; General Medical Council (GMC) registration and revalidation; medical indemnity and Information Commissioners Office (ICO) certificate evidencing registration was now required for all consultants. Since the introduction of this system, all consultants had been required to provide updated documentation annually and failure to provide or renew documentation prior to expiry lead to temporary suspension or withdrawal of practising privileges.
- Outpatient clinics were planned around consultant availability and would only be cancelled if the consultant was not available. The medical staff supported the nurses and other healthcare professionals when clinical advice was needed.
- The hospital contracted Residential Medical Officers who rotated to provide medical support to the outpatient department as well as covering the inpatient wards.

Records

Staff kept detailed records of patient's care and treatment

- The hospital used paper patient records and were planning on introducing electronic records in the near future. To manage the storage of paper records 30,000 sets of patient records of patients not seen in the last 12 months had been scanned following the recently closure of BMI The Paddocks hospital.
- Patient records were held securely onsite in the medical records department. Records for clinics were collated 24 hours in advance, with clinic lists printed and cross checked to ensure the correct records were available and last-minute patient additions to the list were added. The clinic nurse would sign out the notes and sign them back in to medical records at the end of each clinic.
- During clinic the patient records were placed in the individual consultant's room and this was constantly manned with no opportunity for patients to view the patient records of others. If the consultant left the room we saw the nurse locking the room.
- The consultants wrote in the patient records when they saw the patient then dictated a letter immediately after each consultation. Outpatient nursing staff entered details in the records by exception, if they were changing a dressing or to document they had chaperoned.

- Clinic notes were typed up within 24 hours of the clinic by the administration team and the hospital had a service level agreement with local GPs that they received the letters within two days of being typed.
- Of the 10 sets of patient records we reviewed, eight were complete. These patient records documented: the NEWS score, pain management care plan, minor procedure health questionnaire (completed by patient), consent form, World Health Organisation check list and care pathway were present. In one patient record the consent form was missing and with another, the World Health Organisation checklist was missing.
- The service had employed a new director of operations whose remit included medical records and the process for managing patient records had significantly improved since our last inspection. The manager had converted bank administrative staff to permanent as the manager acknowledged the importance of medical records management. Staff reported on a single day there maybe one or two sets of notes missing out of an average of 300 per day. However, patients were never seen without their records as the last clinic letter, pathology and radiology results could be accessed from the electronic systems.
- Staff used a labour-intensive system of coloured folders to pass on cheques (yellow), letters (blue) and messages (red) which they gave to the consultant running the clinic.
- There was no mechanism for flagging people with specific needs such as learning disability. However staff reported they did not see patients with specific or complex needs as they would not meet the criteria for accessing the service.

Medicines

The service followed best practice when prescribing, giving, recording and storing medication.

- Medicines were stored safely across all outpatient services. Staff kept all medicine cupboards locked and the nurse in charge held the key. Staff kept medicine fridges locked, checked and recorded temperatures daily to ensure the medicines were kept at the correct temperature and they knew how to escalate and the actions to take if the temperature went out of range.
- Staff placed medicines required by consultants in clinic in a sealed blue bag, this was handed to the consultant at the start of the clinic. Current practice was for the clinic nurse to hold the medicine key but there were plans to replace this system with one that would allow consultants to access the medicine cupboards via a swipe card.
- There was a system for recording every FP10 prescription written in the department. The prescription pads were kept securely in a locked cupboard and a paper and electronic log was kept of the number of prescriptions and consultant signatures. The pharmacist monitored the use of FP10 prescriptions per consultant.
- Medicines management compliance was audited on an annual rolling programme and 100% compliance was attained in October 2018.
- The BMI Chiltern participated in the European Antibiotic Awareness Day/World Antibiotic Awareness Week annually to raise awareness amongst staff and service users of the issues around antimicrobial usage and resistance.

Incidents

The service managed safety incidents well. Staff recognised incidents and reported them appropriately.

- Managers investigated incidents and shared lessons learnt with the whole team and the wider service. Staff reported incidents on an online system. Incidents were reviewed as a standard agenda item at departmental meetings.
- When things went wrong that affected patients, staff apologised and gave patients honest information and suitable support.
- Staff understood their responsibilities under Duty of Candour, but stated they had not had any safety incident that resulted in moderate, severe harm or death and therefore had not invoked this. 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, under Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- The outpatient department had 14 incidents between July 2018 - December 2018 that ranged from a patient fainting in the consulting room to a cancelled procedure when the urine results were received but not actioned. There were no overarching themes although two were related to the labelling of samples and the outpatient manager was changing this process to reduce the possibility of error.
- Clinical staff gave examples of how they raised incidents for trips and falls in the department. One example we were given was an incident when a patient fell in the outpatient department, staff followed up the patient at home and found that the patient had subsequently developed a severe headache. The BMI staff member called an ambulance with the patient's permission, to transfer the patient to A&E. The learning from this incident was that, all patients who fall in the department should have an ECG (electrocardiogram) as well as a blood sugar test and a full set of observations before they leave the department as there may be an underlying cause to the fall.
- However, some clinical and administration staff said that they did not get feedback from incidents reported or issues raised and this deterred them from raising issues in the first place.
- The physiotherapists analysed the trends in the incidents they reported and reported the main theme for physiotherapy incidents were wound dressings beginning to peel off in the hydrotherapy pool. Staff had done significant work in reducing the risk of this, for example in conjunction with the infection control lead physiotherapists had developed competencies for the physiotherapy assistants and physiotherapists in changing dressings.

Are outpatients services effective?

We do not rate effective for this core service.

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence of effectiveness. Managers checked to make sure staff followed guidance.

- The BMI Chiltern Hospital did not have a tissue viability nurse and staff told us they had difficulties accessing NHS tissue viability advice from the acute trust as they did not have a SLA for this service. Staff told us that they relied on their training as a nurse to decide what dressings should be applied to a wound. Staff did not demonstrate an awareness of the link that was available to them to access The Marsden Manual (this online reference guide provides up-to-date, evidence based information on over 200 nursing procedures).
- There were arrangements in place such as training courses, feedback, in-service training and accredited courses to ensure staff use evidence based guidance for extended roles such as acupuncture (Acupuncture Association of Chartered Physiotherapists and BMI standards for Acupuncture).
- The breast care service followed 'Early and locally advanced breast cancer guidelines (NICE 2018)' and used Breast Cancer Care publications and the BMI Chiltern was recognised with a Macmillan Kite mark for excellence.
- Different specialities within outpatients participated in national audits such as: The National Joint Registry (NJR) which reports on outcomes of joint replacement surgery; Patient Reportable Outcome Measures (PROMs) measurement of a patient's health status before and after a procedure; CQUINs set by the Commissioners to promote improvement in patient care; Public Health England (PHE) national Mandatory Orthopaedic Surgical Site Infection (SSI)Patient Led Assessment of the Clinical Environment (PLACE) assessing the quality of the hospital environment.

Nutrition and hydration

Staff gave patients enough food and drink to meet their needs.

- There was a water dispenser, coffee and tea available in the outpatient department.

- We saw the physiotherapy assistants frequently topped up the water jugs, to ensure patients undergoing hydrotherapy were kept well hydrated.

Pain relief

Staff assessed and monitored patients to see if they were in pain.

- In our last inspection report we asked the provider to ensure there were clear protocols and guidance for pain management in the outpatient department. We did not observe nursing staff using protocols for pain management and they were not aware of any pain assessment tool. Therefore, we were not assured they had acted on this finding.
- The nursing staff did not routinely assess the patient's pain but the consultants always explored this during the patient's consultation. The consultants were observed asking the nature, location, duration, pattern, aggravating factors and associated symptoms of the pain using a visual analogue pain scale. We observed consultants giving advice to the patient on managing their pain with their current medication.
- We observed the physiotherapists giving advice to patient about their pain control and how and when they should take their medicine in relation to when they were having hydrotherapy or physiotherapy as an outpatient.

Patient outcomes

Managers monitored the effectiveness of care and treatment and used the findings to improve them. They compared local results with those of other services to learn from them.

- The physiotherapy service reported on the patient reported outcome measures (PROMs) using the national quality of life questionnaire (EQ-5D-5L). The results showed that patients received effective treatment as the majority of patients' health outcomes improved.
- The BMI Chiltern Hospital had inputted into Private Healthcare Information Network (PHIN) since 2017. This information provides information on which patients can base their choices on where to have their privately funded healthcare. PHIN states in regard to outcomes, there was 'Good Participation' by the service (this is not meant to be a quality score itself but provides a useful indicator of the extent the hospital is actively engaged in measuring and improving clinical care).

Competent staff

The service made sure that staff were competent for their roles.

- There was a Band 4 development programme for HCAs and we spoke to one member of staff who had completed the programme who was very complimentary of the whole experience and the skills they had gained.
- We saw seven completed HCA minor procedures competency documents. These HCAs had successfully completed competencies for additional roles such as suture removal. We saw seven completed HCA induction and competencies documents. This demonstrated that there was an induction and competencies for the HCA role that all post holders were expected to complete.
- We saw 11 completed registered nurse induction and competencies documents and eightcompleted registered nurse minor procedures competencies. However, these were written in 2014 with no review date and only one date (the completion date), therefore it was not possible to tell if the staff member acquired these competencies within their probation period.
- The induction of staff was variable one staff member told us that the mentor allocated to them was unhappy in their job and therefore not at all helpful, there was no-one to assess their competencies and they were only given an induction information pack one month after starting. Staff told us that the training for assisting in specific procedures in minor operations was not formalised and therefore stressful for the individual trying to learn on the job.
- Some senior nursing staff worked flexibly between roles in outpatients and pathology utilising their phlebotomy skills.
- The physiotherapy assistants worked flexibly between clinical aspects of their role and covered administrative tasks in the department. The whole

team worked flexibly across The BMI Chiltern and The BMI Shelburne and we saw the completed competencies for all the physiotherapists and physiotherapy assistants.

- All staff had competency folders and were responsible for keeping these up-to-date. We were shown one example that was 92% complete containing competencies for: suture removal; clip removal; dressings; chaperoning and visual field testing. Staff told us that the service incentivised 100% compliance with a pay rise.

Multidisciplinary working

Staff in different roles worked together as a team to benefit patients.

- We observed the outpatient staff working seamlessly with X-ray and diagnostics to ensure a smooth pathway for patients who were primarily seeing their consultant but needed an X-ray the same day. The X-ray was reviewed there and then by the consultant and a plan of care discussed with the patient.
- The breast care nurse attended the weekly MDT at the acute NHS trust and liaised with their pathway co-ordinator, oncology, surgery, radiology and clinical nurse specialists.
- There was a daily handover and a communication book for staff to write messages between shifts. This promoted the sharing of information.

Seven-day services

Staff in the general outpatients worked in the evenings and six days a week to provide a responsive service to patients.

- The BMI Chiltern Hospital held the majority of clinics from 08.00-21.00 Monday to Friday but the department worked flexibly as a team to provide clinics such as the 'dressings clinic' on Saturdays. The outpatient department was open 08:00-14:00 on Saturdays.
- The physiotherapy department was open in the evenings four days a week and hydrotherapy was open for an hour on Saturday and Sunday mornings to ensure an equitable service for all patients to access hydrotherapy on day three of their post-operative pathway.
- The breast clinics did not run at weekends but finished at 20.00 on some evenings to provide flexibility and choice for the patient.

Health promotion

- We saw limited evidence of health promotion although there was a poster for the cardiovascular disease prevention service and a poster for BMI health checks.

Consent and Mental Capacity Act

Most staff understood their roles and responsibilities under The Mental Health Act 1983 and the Mental Capacity Act 2005.

- There were online mental capacity and the deprivation of liberty policies which were accessible to all staff, these were version controlled and in date. Staff told us they were aware of these policies and could access them.
- Staff were aware of their responsibilities regarding The Mental Capacity Act (2005) and Deprivation of Liberty Safeguards (DOLs). The patient's capacity was not formally assessed as all patients were assumed to have capacity and staff could not recollect any patients attending the department who had issues regarding capacity.
- Staff had received training on mental capacity although could not give examples of situations they had applied the principles at work. Staff explained they would not be likely to see patients with mental capacity issues in their service, as they would be seen in the elderly care services at the local NHS trust. However, should they have concerns about a patient's mental health or capacity to consent verbally to investigations they would discuss this with the outpatient manager and if necessary contact the patient's GP.

Are outpatients services caring?

Good

Compassionate care

Requires improvement

Outpatients

Staff cared for patient with compassion. Staff displayed understanding and a non-judgemental attitude towards the patients.

- We saw comment cards filled in by service users. Feedback from patients confirmed the staff treated them well, with kindness. One patient told us they were "always treated well by staff".
- The overall friends and family patient satisfaction survey had improved since the last CQC inspection from 78% to the current 98.5% of patients who said they were likely, or extremely likely to recommend the service to their friends and family.
- We observed when intimate personal care and support was being given by a member of the opposite sex they were offered a chaperone. We observed notices in every clinic room offering a chaperone and observed consultants offer this before they examined a patient.
- Another patient told us that a registered nurse was "brilliant" at taking clips out of his wound…she was "so skilful I didn't even realise she had taken them (the clips) out".

Emotional support

Staff provided emotional support to patients to minimise their distress.

- However, staff told us if a patient became distressed in the open environment it was difficult to maintain their privacy and dignity as there was limited availability of spare rooms. It was also difficult to maintain confidentiality in the open reception area.
- There were a limited amount of information leaflets available in the outpatient waiting area, available in English only. In specific clinics we saw a mix of information leaflets, BMI consultants' information sheets (no review dates) and from national organisations such as British Association of Dermatology (BAD) Cryotherapy advice sheet, March 2018. The BAD information and that of other national organisations did meet the information standard certification however staff were unsure of the processes around the governance of BMI consultants' information sheets.
- We observed consultants in clinic giving patients their business card and added a disease specific website address for the patient to look up relevant and up to date information and support. They also gave an open invitation for the patient to telephone them if they had any further questions.
- The BMI Chiltern Hospital employed a breast nurse specialist who provided patients and their families with a life-changing diagnosis appropriate emotional support and help in accessing further services.

Understanding and involvement of patients and those close to them

Staff involved patients and those close to them in decisions about their care and treatment.

- We heard staff at reception dealing with all enquiries with in a friendly manner. They did their best to be flexible and provide the next appointment when the patient asked for it.
- Patients told us that "physiotherapist was excellent", the staff in the physiotherapy department have been "lovely" and "they are excellent" in the work they do and they "understand the need to be sociable." We saw patients talking to physiotherapists and they were giving the patients time to talk and establish therapeutic conversations.

Are outpatients services responsive?

Good

Our rating of responsive stayed the same. We rated it as **good.**

Service delivery to meet the needs of local people

The service planned and provided services in a way that met the needs of local people

- There was sufficient car parking and clearly marked disabled spaces. The outpatient department was clearly signposted and staff greeted patients at the general reception desk. There were appropriate clean toys for children within the adult waiting area.

- In addition to the normal Monday to Friday outpatient service 'dressings clinics' were provided on a Saturday morning so that wounds could be assessed and dressings renewed.
- The physiotherapy department offered evening clinics until 20.00 Monday to Friday and hydrotherapy on Saturday and Sunday mornings. This flexibility offered by the physiotherapists, facilitated the patient (day three on post-operative pathway) to access hydrotherapy and achieve the best possible outcomes.
- Patients could access services easily as there were 200-300 outpatient appointments were available each day the majority of these at The BMI Chiltern Hospital. On one day that we visited there were 223 appointments for this site.
- The BMI Chiltern Hospital had a service level agreement with the NHS acute trust, and saw NHS outpatients when the trust lacked capacity. They also accepted 'spot' contracts from the NHS acute hospital to assist with waiting list initiatives

Meeting people's individual needs

The service took account of patients' individual needs.

- All patients received a pack prior to their first appointment that was tailored to the treatment or procedure they are going to receive. This ensured patients were aware of what to expect and could consider any questions they may have prior to the appointment.
- Staff could not give many examples of meeting the need of individuals. This was mainly due to the patients using the service who had mostly chosen the hospital and the hospital admission criteria was not inclusive and this meant those with complex health needs did not use the service.
- The department had provided seating for bariatric patients as weight-loss surgery was a sub-specialty within surgery.
- The physiotherapists were trained and could offer speciality treatments that included acupuncture, chronic pain management; hand therapy; hydrotherapy muscle testing of the knee; gait analysis; pelvic health; sports injury vestibular rehabilitation; sports injury and respiratory physiotherapy in addition to post-operative clinics. The physiotherapists ensured that they were sufficiently trained to cross cover each other in periods of absence.
- We observed the consultants in clinic taking the time to explain their condition to patients, check their understanding and allowing the time needed to make decisions and consent to care and treatment.
- BMI Healthcare offered patients 'live support' on the BMI website. This is an encrypted online chat session into the BMI network via a secure encrypted connection. Patients could also request information via an online query tool.
- The department had access to a portable hearing loop to assist those patients who had hearing loss.
- Staff said an interpreter service was available and if they identified at the patient's first appointment that they needed assistance, they would arrange it for subsequent appointments. However, they had never been in a situation where they had to use it.
- Staff told us that they had not encountered any aggression from members of the public but they were not aware of any actions they should take if this were to arise.

Access and flow

People could access the service when they needed it. Waiting times from referral to treatment and arrangements to admit, treat and discharge patients were in line with good practice.

- Consultants sometimes added patients to the clinic list, which along with the national contact centre adding additional patients to lists during a day impacted on the flow through the department. If any patient waited more than 15 minutes they were informed of the reason why.
- We were told by the physiotherapy manager that the current waiting list for outpatient physiotherapy was 10 days with no breaches. The department also had a 48-hour contract where they would see patient for a

30-minute appointment within 48 hours for another private healthcare provider. All inpatients would be booked into hydrotherapy and their outpatient appointments planned before discharge.

- NHS patients told us that they booked their appointment on the national choose and book portal, this gave them a choice of appointment time and they chose BMI Chiltern for the shorter waiting times. Self-funding or those with health insurance booked appointments by telephoning the hospital or through the centralised team in Scotland or via the BMI website, the website included a 'live chat' support to patients. This approach ensured patients were able to book an appointment that met their individual needs
- The referral to treatment times were monitored for the NHS patients, these ranged from 17 for orthopaedics to 46 days for urology but this data was not collected for the self-funded or insured patients.

Learning from complaints and concerns

The service treated concerns and complaints seriously, investigated them and learned lessons from the results and shared these with staff.

- There had been improvement since the last CQC report (2017) when the service was asked to display information for the patients on how to make a formal complaint.
- Although leaflets were available on how to raise concerns and complaints they were not very prominent and we had to look for them. When a complaint is received the response, process is monitored by the personal assistant to the executive director to ensure that a response is provided within 20 working days otherwise a holding letter is sent to the complainant to keep them fully informed of the progress of their complaint. All complaints are uploaded to the incident reporting system and investigated, the findings are fed back to the complainant who is also offered the opportunity to come and discuss the complaint if they wish.
- Staff told us that they heard about complaints at the "daily comms cell" which was a meeting to communicate key messages and any concerns across the organisation. This meeting was attended by senior management and department representatives, senior management meetings and heads of departments meetings. The heads of departments then cascaded any concerns or complaints information to the staff in their departments. Staff gave us examples of some complaints that related to outpatients such as a patient being given an appointment for The BMI Chiltern Hospital rather than The BMI Shelburne Hospital as the two departments were run as one.
- We saw patients filling in feedback cards and posting them into the collection boxes. We attended the 'daily comms cell' meeting where the feedback from service users was reported to the group on the same day as it was received. This approach ensured any issues raised could be resolved in a timely manner.
- Most complaints were about incorrect billing and during the last year the clinical staff had been made responsible for the correct coding for appointments, treatments and medication, some of the staff told us how difficult this had been and had put extra pressure on their working day. However, now they were used to do the coding they felt it made sense as they were the staff closest to the patient and therefore knew what they had done.
- Compliments were also highlighted in the same way and any patient feedback attributable to individuals or teams triggered an 'Above and Beyond' nomination and in addition any member of staff could nominate another. The medical records staff had received this nomination for the improvement plan they had successfully delivered.

Are outpatients services well-led?

Requires improvement

Our rating of well-led stayed the same.. We rated it as **requires improvement.**

Leadership

Managers had the right attitudes, skills and abilities to run the outpatient service however they were a newly formed team and had just begun to address some of the challenges in the outpatient department.

- The deputy clinical services manager reported to the clinical services manager who reported to the director of clinical services who reported to the executive director. They managed The BMI Chiltern and The BMI Shelburne outpatient departments as one clinical unit, they also managed the pathology and phlebotomy services. The deputy clinical services manager reported to the clinical services director and the clinical services director who reported to the executive director.
- Some staff felt that they did not work with the outpatient managers as much as they would like to as the managers covered vacancies in pathology and that they 'felt sorry for them' as they had so much to do. Other staff said they would appreciate more supervision from the outpatient managers especially during the induction period, however they were working hard firefighting staffing issues.
- The two senior managers in the department were providing cover for phlebotomy and this impacted on the time they had to work with staff on the improvements they had planned to make.
- Staff in outpatients told us that the executive director was "very visible", "approachable" and had "an open-door policy" as well as being seen in the outpatient department to help with the daily cleaning. Staff told us that they appreciated free-cake-Friday, an initiative taken by the executive team to raise morale.
- The physiotherapists also told us that the executive team visited the department at 07:00 and 19:00 every weekday and felt supported by them. The physiotherapy manager had significantly improved the feedback from audits and the escalation of risk to the executive team.
- Some nursing staff felt there should be more investment from the executive leadership in training, development and upskilling of staff to improve retention in the department.

Vision and strategy

The service had a vision for what it wanted to achieve and had started to work on plans to implement change.

- The BMI corporate vision was to deliver the highest quality outcomes, the best patient care and the most convenient choice for patients. The senior management had implemented a local vision for the hospital based on a care, compassion, competence, communication, courage and commitment. This commitment was reflected in staff conversations with us and in the outpatient departmental meeting minutes.
- On a wall of the outpatient waiting area we saw the statement 'Coming together is a beginning, keeping together is progress, working together is success' displayed with service user feedback.
- Staff told us that the leaders of the organisation were committed to change and they had seen "dramatic changes in the last year", such as the computerisation of notes, access to pathology results online and the current project of digitalising X-ray results. Staff said they were committed to working alongside the executive leadership team to improve the service for all patients.
- The outpatient manager's priority (2019) was to look at clinic utilisation and to reconfigure the services and the available space accordingly and this would require significant resources, time and some capital expenditure.
- To achieve the vision major changes were required such as moving some specialist services to the BMI Shelburne. We were told this would required significant resource which had not been identified at the time of our inspection.

Culture

Managers across the department promoted positive culture that supported and valued staff. Most staff had a sense of common purpose based on shared values, however there were a few staff who expressed negative experiences.

- The physiotherapy staff told us that "there is a good ethos within the hospital that genuinely puts the patients' best interest at its heart."
- In the general outpatient department, there was a mixed culture. The nursing assistants were happy in their roles whereas some registered nurses and some administration staff felt the managers gave "a lot of

empty promises" and "no-one listens". There were several disgruntled members of staff who were in the minority but had well-reasoned evidence for their sense of injustice.

- The majority of staff we spoke with told us that the culture encouraged honesty at all levels of the organisation, including with people who used services, in response to incidents. When asked, the staff understood their responsibilities under duty of candour and had been trained in this. These comments supported the objectives of the strategy to promote an honest, open and blame-free culture where risks were identified and addressed at every level and escalated appropriately.
- Staff told us that there had been one situation in 2018 when a consultant did not adhere to the values of the organisation. BMI Healthcare removed their practising privileges due to behavioural issues and the consultant no longer worked there.

Governance

The department had systems to improve the quality of its services and safeguarding however they needed more time to embed this meaningfully at every level.

- There was an embedded structure of clinical governance. The hospital sub-committees fed into the clinical governance committee and this fed into the Medical Advisory Committee (MAC).
- Outcomes from the clinical governance meetings were shared at the heads of department meetings and then cascaded down to the outpatient department. Outpatient department meetings were held monthly, with a structured agenda and minutes. We saw between October and December 2018 there was a good attendance to these meetings and that discussion occurred although the content of the discussion was not recorded. However, clinical incidents were discussed but learning from these was not documented. There were no specific actions in the minutes delegated to specific team members or timescales.
- Staff undertook internal quality audits which assisted in driving improvement and gave all staff ownership of things that went well and that needed improvement. This ensured staff of all grades were involved in quality improvement.

Managing risks, issues and performance

The department had systems for identifying risks, planning to eliminate or reduce them

- The managers leading the outpatient's department understood the risks and had escalated these appropriately.
- The outpatient manager told us that the number one risk was staffing. On their risk register the lack of a sluice, urinalysis was undertaken in the staff toilet was documented. The need for a sluice had been acknowledged and the next reconfiguration of outpatients included a plan for a sluice. Staff had also escalated on the risk register, the need for a room for cleaning the naso-endoscope and this was part of the clinic utilisation project.
- The breast care service managed risks by recognising their limitations as a small independent provider and therefore patients with neutropenic sepsis or complex metastatic disease would be seen at the acute NHS trust.

Managing information

The department collected, analysed, managed and used information, using secure electronic systems with security safeguards.

- The BMI Chiltern Hospital had a good information security culture. BMI Healthcare was compliant to the international standard for best practice information management (ISO/IEC27001:2013). The site has a dedicated Information Security Officer, who conducted audits (which were reported locally and corporately). Staff were trained and confident their practices conformed to the required standards of General Data Protection Regulation and training had been updated accordingly.
- We were told by staff that fax machines were still in use to send patient information to The BMI Shelburne

Hospital. However, staff were aware this was not best practice and Department of Health guidance is for NHS organisations to phase out fax machines by the end of March 2020.

Engagement

The department engaged with staff, patients and relatives and used their feedback to plan and develop services.

- We saw patients filling in feedback cards and posting them into the collection boxes. We attended the 'daily comms cell' meeting where the feedback from service users was reported to the group the same day as it was received. This promoted the timely sharing of patient feedback.
- Staff were encouraged to make suggestions at any time. The minutes of the outpatient department stated that agenda items were discussed with staff but it was difficult to identify their suggestions and views.
- Patients were encouraged to come back for a walk around the department and suggest any improvements, however we were not given examples of changes brought about from direct patient feedback.
- Some staff were disgruntled due to lack of induction, training and considerations of shifts and the managers were aiming to improve this by putting out the off duty shifts one month ahead.

Learning, continuous improvement and innovation

The department was committed to improving services by learning from when things went well and when they went wrong.

- The outpatient manager's main project this year was reported to be the utilisation of the available space. We were told that there were plans to move specialist services for outpatients from the Chiltern Hospital to the Shelburne Hospital.
- The outpatient department was committed to working with the executive leadership to learn from things that did not go well and from listening to patients to continuously improve their services.
- The physiotherapy department had a plan for developing a wellbeing centre that had recently gained board approval and were passionate about this expansion of their service.
- The medical records department were committed to scanning all the current medical records of patients who had not used the service in the last 12 months so that transfer to an electronic patient record could happen as soon as BMI had rolled out the software.

Requires improvement

Diagnostic imaging

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

Information about the service

The Diagnostic Imaging Department at BMI The Chiltern Hospital provides general plain x-ray imaging, OPG (Orthopantomogram) dental Imaging, interventional and diagnostic ultrasound. On site there is a digital full field Mammography, limited interventional radiography, mobile X-ray, Computerised tomography (CT), Magnetic resonance imaging (MRI), Dual energy x-ray absorptiometry (DEXA) an X-ray that measures bone mineral density and radiographic imaging in theatre. Nuclear Medicine scans are organised through an agreement with a local NHS trust.

Services were delivered to adults and children from Monday to Friday with limited services on a Saturday. An on-call service was available for inpatients.

We spoke with four patients and two relatives. We interviewed seven members of staff which included, senior leads, a radiologists, radiographers and diagnostic imaging assistants.

Are diagnostic imaging services safe?

Requires improvement

We rated safe as **requires improvement.**

Mandatory training

The service provided mandatory training in key skills to all staff and made sure the majority of staff completed it.

- Staff received effective training in safety systems, processes and practices in line with schedule 3, Ionising Radiation (Medical Exposure) Regulations 2017 (IR(ME)R) The service ensured staff were appropriately trained to administer radiation. We reviewed staff competency booklets which confirmed this and included a sign off form confirming the local rules and policies had been read. This ensured staff could safely perform examinations involving radiation.
- Mandatory training rates for staff in the diagnostics department were 94.30%. this was above the hospital target of 85%. Staff completed training through the corporate learning system 'BMILearn'. This was an online resource of training modules where staff could also view their individual training needs and current compliance. The system also alerted staff when mandatory training was due to be completed.
- All radiology staff were expected to have completed paediatric basic life support (PBLS) and basic life support (BLS) training. However, at the time of our inspection only 60% of staff had completed their PBLS despite children attending the department for investigations.

Safeguarding

Staff understood how to protect patients from abuse. Staff had training on how to recognise and report abuse and they knew how to apply it.

- Staff could describe the escalation process if they had safeguarding concerns and were aware of the corporate safeguarding policy and where to locate it. The policy incorporated Mental Capacity, Deprivation of Liberty Safeguards and PREVENT advice. PREVENT aims to safeguard vulnerable people from being

radicalised to supporting terrorism or becoming terrorists themselves. The policy also included female genital mutilation (FGM) and the actions staff should take.

- Information was displayed across the department of who staff should contact if they had any safeguarding concerns. This ensured they could access timely advice and support from the person with lead responsibility for safeguarding.
- Staff in the department received level two children's safeguarding training which included child sexual exploitation training. This was in line with the safeguarding children and young people intercollegiate document (2019). We requested mandatory training data but this was not broken down into topics, at the time of our inspection 94.3% of staff had completed all their mandatory training which included safeguarding training. However, we were not assured that all staff had completed all the required safeguarding training.

Cleanliness, infection control and hygiene

The service controlled infection risk well. Staff kept equipment and the premises clean. They used control measures to prevent the spread of infection.

- Staff decontaminated their hands in line with the World Health Organisations five moments for hand hygiene and NICE guidance (QS 61 statement three). This standard states people should receive healthcare from healthcare workers who decontaminate their hands immediately before and after every episode of direct contact or care. All the patients we spoke with told us they saw staff decontaminate their hands before and after patient contact. Across the department we saw the service had fitted new handwashing sinks.
- The imaging department completed hand hygiene observational audits every two months. This included condition of skin, decontamination at the point of care, were staff bare below the elbows and if staff followed the six-step technique correctly. The results from March 2018 until September 2018 showed compliance was 100% with exception in May 2018 where the result showed 95% for skin condition.
- Hand gels were available at the entrance to every department and were easily accessible; we witnessed all staff using the gel on entry to and on leaving departments. Staff on the units adhered to the infection control policy and wore minimal jewellery; their hair was tied back and off the collar and were bare below the elbow. All staff in the department including reception staff wore clean and tidy uniforms. Personal protective equipment such as gloves and aprons were available to staff.
- Clinical and patient waiting areas were visibly clean and free from dust and debris. There were cleaning schedules in place, which housekeeping staff completed and included sign off by housekeeping supervisors.
- The process of cleaning equipment such as the ultrasound scanner was logged in a record book. Equipment was cleaned with a specific cleaning wipe prior to the days use and after contact with each patient. We reviewed three books and saw a record of the equipment cleaned was logged, alongside patient details and when the equipment had been cleaned post use. This meant cleaning could be monitored for compliance.
- Staff identified when equipment such as weighing scales had been cleaned by using 'I am clean' green stickers. We saw all equipment had green labels which indicated the date and by whom the item had been cleaned.

Environment and equipment

The service had suitable premises and equipment and looked after them well. However not all the paperwork was evident.

- The department had a range of equipment for the investigations they undertook. The diagnostic imaging service had one magnetic reasoning imaging (MRI) machine, one computerised tomography (CT), two ultrasound rooms, one x-ray machine and a dual energy x-ray absorptiometry (DEXA) bone scanning unit. All had equipment folders with information such as fault codes, telephone numbers of suppliers, and a fault record to ensure staff could access support in the event of a fault.

Requires improvement

Diagnostic imaging

- We saw evidence that before a piece of equipment was handed over for use the necessary tests had been completed to ensure it was safe for use. We saw evidence of regular servicing maintenance and fault repair on the x-ray, CT, MRI, DEXA and ultrasound equipment. The unit also had a fault record book, which we reviewed and all faults had been completed and closed. This demonstrated staff ensured equipment was safe and fit for use.
- However, whilst, service records were available they were not always complete. The MRI machine had an engineer visit on 14 October 2018 but no corresponding handover form and the MRI handover forms were not always completed by staff when they received the equipment back. This was discussed with senior teams at the time of our inspection.
- The service had risk assessments for all their rooms which housed scanning units, however not all of these were saved in the correct file, were difficult to locate and many were in draft versions, not finalised or signed off. Therefore, risks and their mitigations may not have been fully identified or actioned.
- The service carried out regular quench pipe inspections. Quench pipes are used to safely expel helium out of a building quickly if the magnet in the MRI accidently overheats. The MHRA recommend annual inspections of all ventilation piping, which should include, at least, a visual inspection of the external piping.
- Staff wore lead aprons where appropriate and new lead aprons had just been delivered to the unit as the old ones had frayed. Aprons were systematically tested and this meant staff were protected from the risk of radiation exposure.
- Staff radiation exposure was monitored by the radiation protection supervisor, and records of dose badges were kept on the internal drive. All staff wore radiation exposure devices to ensure staff were not over exposed. Results were shared if a reading was above zero.
- Patient doses were monitored however, during the radiation protection meeting it was identified that due to staffing changes and a new method of recording, staff were not always recording in the correct units on the clinical record interactive system (CRIS). Teaching on how to record on CRIS was in the process of being completed.
- We saw daily records and weekly checks of the x-ray and the ultrasound rooms which included oxygen checks, for adults and paediatrics. Staff had completed weekly anaphylaxis drug checks for the month so far, which assured staff that equipment as ready and safe to use.
- The service used a Picture Archiving and Communication System (PACS) which was a system used to store patient images. This enabled the service to eliminate the expense of film processing and storage and gave staff faster access to images. In case of internet and IT outage, the service had a business continuity policy. The service told us that PACS servers, and the BMI IT network was monitored 24 hours a day, seven days a week and in the event of a failure engineers would be alerted immediately. There were two main PACS servers – if one went down then the service would automatically switch to the other.
- Adult and paediatric resuscitation trollies were available and located close to the department.There was a rota of who was responsible for the daily and weekly checks. We reviewed January 2019 checks and all had been completed. The trolleys were tamper evident, sealed clean and had an 'I am clean' green sticker on them.
- All relevant MRI equipment was labelled in line with MHRA recommendations. Equipment stored for use in the MRI room had MRI safe stickers attached demonstrating it was safe for use.
- Equipment which was maintained by the hospital such as suction machines and the warming unit for intra venous contrast had a portable appliance test and next service due label, all of which were in date.
- The radiology departments had working radiation warning signs outside all rooms for safety and to prevent unauthorised access. There was a red barrier to stop unauthorised visitors from entering the MRI room, which was in use throughout our time in the department.

Assessing and responding to patient risk

Requires improvement

Diagnostic imaging

Staff completed and updated risk assessments for each patient.

- Staff told us what action they would take if a patient became unwell or distressed while waiting for, or during an investigation. All rooms were fitted with emergency bells to alert other staff of concerns and they would telephone 2222 and alert the emergency response team of the need for support. If an emergency happened in the MRI room, the table could be removed and wheeled into the waiting area. Oxygen with the correct masks was available for adults and children within the MRI/CT department.
- We observed processes in place to ensure the right person received the right scan at the right time. Staff completed a six-point check of name, date of birth, address, body part, clinical information and previous imaging checks in line with the legal requirements of IR(ME)R to safeguard patients against experiencing the wrong investigations
- The service had an advanced life support trained registered medical officers (RMO) on site 24 hours a day, seven days a week therefore was available when children were in the department.
- Staff told us and we saw posters displaying how to use a SKI sheet in the case of an emergency evacuation for example in a fire. TheSki Sheetenables care staff to quickly and safely move non-ambulant individuals to a place of safety in anemergency. The service was in the process of providing SKI sheet training to all staff and we saw discussions of this at the health and safety meeting. The service displayed posters with details of training sessions on how to evacuate patients safely.
- The service had the support of a radiation protection advisor (RPA) through an advice service contract with a radiation protection centre, we saw the contract to substantiate this. The service also had one radiation protection supervisor (RPS) who worked on the unit and provided guidance and support to staff in each area.
- As required by the Health and Safety Executive (HSE) who regulate the Ionising Radiations Regulations 2017 (IRR99), all areas where medical radiation is used in hospitals are required to have written and displayed local rules which set out a framework of work instructions for staff. These local rules were displayed throughout the department.
- In line with the National Institute of Health Care Excellence (NICE) Acute kidney injury guidelines and the Royal College of Radiologists standards for intravascular contrast agent administration patients were risk assessed to ensure they were suitable to receive contrast. A screening process performed by the radiographers and nurses enabled them to identify any pre-existing clinical conditions which could impact on the ability to perform scans with contrast. Contrast media is a substance used to increase the contrast of structures or fluids within the body and is used in certain types of radiological investigations. Staff asked patients who required intravenous contrast about their allergy status and kidney function. The service also used a machine which gave an instant creatinine level, an indication of kidney function status, which indicated if the procedure should go ahead.
- Staff asked patients admitted for an MRI pre-scan questions such as if they had a cardiac pacemaker or metal fragments in their eye or their body. These questions ensured that if the patient had certain metal fragments and pace makers which could cause the magnets in the scanner to malfunction these were identified and the MRI scan would not go ahead.
- There were reporting rooms for radiologists to report on findings on site. Referrers were contacted directly via email/letter or phone-call. This approach promoted the timely sharing of results.
- Relatives or staff who chaperoned/comforted patients had to sign a record to document they agreed and understood the risks and level of radiation exposure. For women there was a declaration to sign to establish if pregnant or not.
- The service was in the process of having a new digital x-ray suite fitted however in the interim had to use an old x-ray machine which had been serviced. Whilst this machine was assessed as fit for purpose the table did not always go low enough for some people to sit on. This had been risk assessed and the unit had hired an

electronic step to help patients gain access to the machine safely. This arrived on the day of our inspection therefore we were not able to assess if this action had mitigated this known risk.

- The service held daily team briefs to identify any issues that would impact on the service during the day, such as staffing, patients who required hoisting, patient complications and information/ updates relating to the alteration work to x-ray room two.
- The service had an agreed list of staff working at the hospital who could refer patients for investigations. This included medical and non-medical referrers. In February 2018 an audit was undertaken to identify how many request forms had been written by nurses on the ward who did not have referral privileges. Out of 50 request forms, nurses had written 14 without referral privileges. Following this audit staff were reminded of who was authorised to refer patients for investigations. A repeat audit undertaken in April 2018 showed two out of 55 referral forms were incorrectly written by nursing staff, demonstrating the action taken had resulted in improved compliance.
- There were posters and signs which informed patients who were or could be pregnant to let a member of staff know. Staff questioned all patients who were 12 to 55 years of age to identify if they could be pregnant. However, both the paper and electronic policy were out of date. The electronic version had expired in November 2018 and the paper copy held in the department's CT folder was dated 2010. Whilst we could not be sure which policy staff were following, both were out of date.
- All radiographers and radiology staff were expected to have completed training in paediatric basic life support (PBLS) and basic life support (BLS). At the time of our inspection only 60% of staff had completed their PBLS. While we were told the RMO had completed advanced life support training and was on site when children were in the department, there was a risk that in the event of a paediatric emergency a suitably trained staff member may not be in the department and readily available.

Staffing

The service had enough staff with the right qualifications, skills, training and experience to keep people safe from avoidable harm and to provide the right care and treatment.

- A new manager had been appointed in September 2018 who was supported by a new experienced deputy manager who had recently started following a long gap where the service did not have a deputy manager. At the time of our inspection the service had one fulltime radiographer vacancy and one 10-hour radiographer vacancy. The service was actively advertising using social media networks and the local radio station to recruit to these vacancies.
- The service had a total of 14 radiographers all with current HCPC registration.
- The service had a bank of staff and used regular agency radiographers who had completed a local induction who were employed to cover vacancies and sickness. This ensured there were always sufficient numbers of staff on duty.
- The hospital used a utilisation tool which helped them to understand how effectively they used their staffing in relation to their throughput of patients. Staff requirements were discussed at the daily communications cell meeting.During our inspection utilisation for the radiology service was at 102% which staff explained was due to short term sickness and the aim was 65% utilisation. From the month of December 2018 to January 2019 it had averaged at 85% and senior staff explained this was due to staff vacancies and sickness. To cover these shortfalls, managers and the deputy manager stepped in, but this impacted on their non-clinical time.
- Sickness in the diagnostic service was reported as 1.5% over the previous year which was below the BMI corporate target of 3%.

Medical staffing

The service had enough medical staff, with the right mix of qualification and skills, to keep patients safe and provide the right care and treatment.

- The service had 14 radiologists working under practicing privileges across the two hospital sites.

Diagnostic imaging

- Radiographers told us they had good access to radiologists for advice and they were contactable out of hours.

Records

Staff kept detailed records of patients' care and treatment. Records were clear, up-to-date and easily available to all staff providing care.

- Records were kept securely. All records for patients were stored in a locked cupboard behind the reception desk, which was not accessible to the public. Once a patient's scan had been completed the records went to the ward office and then to the administrative team for processing and billing.
- The service provided electronically encrypted reports within a picture archiving and communication system (PACS) system to store data and prevent unauthorised access. PACS is a medical imaging technology which provides economical storage and convenient access to images from multiple modalities. This enabled appropriate sharing of information should a patient be referred to another clinical team or to the local acute trust, to their GP for review or discharged. This arrangement was in line with NICE QS15 Statement 2.
- All computers observed were password protected and locked when not in use. We saw computers were generally out of view of patients, this reduced the risk of confidential patient information being seen by other patients or visitors.
- We reviewed 12 sets of paper patient records which included imaging requests, World health organisation (WHO) safety check lists and medicine prescriptions. We noted, seven of the 12 records had a WHO surgical safety checklist due to the invasive nature of the procedure. We saw staff had fully completed and signed each record. However out of the eleven sets of records where staff administered medicine, four sets of records did not include evidence that the medicines had been checked and signed for by staff.

Medicines

The service stored medicines safely and securely however did not always follow best practice when prescribing and recording.

- Staff used patient group directions (PGD), which allowed specific health care professionals to supply and/or administer a medicine directly to a patient with an identified clinical condition without the need for a prescription or instruction from a prescriber. This meant once trained and assessed as competent in the use of PGDs, radiographers could administer identified medicines, such as contrast medium for specific investigations.
- The service had three PGDs in use by staff. We reviewed the paper copies, all of which were in date and version controlled. The paper work provided showed clinical condition/ details which included inclusion and exclusion criteria. Strength, dose, duration of treatment, adverse effects and records and follow up. Each PGD had a list of senior staff who authorised the protocol, these were the lead doctor/ radiologist, lead pharmacist, lead nurse and an organisational authorisation which was the clinical director. We were provided with evidence to show which member of staff had received training in the PGDs in use in the department. All staff who were able to use the PGD had signed to say they agreed with the contents of the PGD and would work within it.However, there was no signature of the authorising manager to say they were aware the protocol had been read. As this applied to all three of the PGDs that staff were using we were not assured who the authorising manager was and if they had any oversight of who had read the protocol and who was using PGDs within the department.
- Staff used a pre-printed label for CT and MRI prescription and protocol. This label was stuck into the patients notes and identified what the scan protocol and/or medication would need to be administered.Medicine prescriptions included intra-venous and oral medicines such as, contrast, bowel preparation, diuretics and anti-spasmodic, some of which were administered using a PGD. The instructions on the sticker stated please tick, staff would tick but did not document the dose given. Some medicines such as contrast were calculated by a patient's weight and staff told us they would do this using the manufacturers guidelines, double check with another member of staff but not record the dose given. This was not in line with the Royal Pharmaceutical Society, Professional Guidance on the

Administration of Medicines in Healthcare Settings (January 2019), which stated when there had been a dose calculation and a specific dose given to a patient, it must be recorded in the patient record.

- We reviewed 11 sets of patient records who required medicines given prior to and during their procedures. Four of these records did not fully record if medicines had been given. For example, one MRI procedure with contrast had been ticked but not signed to say it had been given and one other had a local anaesthetic not signed for.
- After our inspection we were provided with an audit which had taken in place in October and December 2018. The audit checked ten sets of notes per month for doses recorded on the patient request record and if they were recorded on clinical record interactive system (CRIS). The audit showed that 90% of doses were recorded on CRIS and 93% of audited records showed drugs were recorded on the patient request form. However, the recording of contrast medium was not evident in any of the sets of notes we reviewed.
- A limited stock of controlled drugs (CDs) were kept in the department and were stored in a locked cupboard in the x-ray room. These were used for in-patients who were having intravenous port catheter systems for chemotherapy inserted. Staff explained that a trained ward nurse would attend the unit with the patients and check the CD with the radiologist. We reviewed the CD log book and saw that all CD's were checked and signed by two members of staff. The CD book was locked away along with the CD order book and CDs, which were checked weekly.
- Staff checked the dose and patient identity before administering medicines. We observed staff checking patients for their name, date of birth and address before they administered medicine.After cannulation of a patient, we observed the radiographer double check the contrast solution with a colleague.
- Medicines were stored securely. Staff had access to a medicines trolley in the CT room, this was lockable and tethered to the wall. We reviewed a selection of medicines all of which were in date and in sealed undamaged packages.

For our detailed findings on medicines please see the Safe section in the surgery report

Incidents

The service managed patient safety incidents well. Staff recognised incidents and reported them appropriately.

- Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support.
- From August 2017 to January 2019, the service had not reported any incidents classified as never events taking place in the diagnostics services. Never events are serious patient safety incidents which should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.
- Over the previous 12 months, the service reported three ionising radiation incidents. Due to the level of the dosage none required to be reported to the Health and Safety Executive or the Care Quality Commission. However, during the radiation protection committee meeting it was identified that patient doses had been incorrectly recorded on the CRIS reporting system. Therefore, it was not clear if the level of dosage had been recorded and actioned appropriately.
- The service responded to incidents by investigating and when necessary changed practice. A recent example of this was after a patient experienced an extravasation. This is when intravenously (IV) infused medications leak into the extravascular tissue around the site of infusion. In response to this staff changed the pre-checking procedure to include who cannulated, loaded the syringe and had patients received a leaflet. The leaflet explained the procedure, the possibility of extravasation and recommended to press emergency buzzer if any pain occurred at the site of injection. The CT questionnaire was changed to ensure that the process from start to finish could be traced.
- The service told us about incidents when incorrect patient identification stickers had been used over a period of July and August 2018 and again in January 2019. An investigation took place, the service shared an action plan which had been developed following

the investigation with us. We saw actions completed included individual staff had been written too, reminding them of their duty under IRMER (2017) regulations to perform identification checks.

- The service sought external professional advice as part of their investigations when necessary. We saw documented evidence of how the service had sought advice from the medical physics experts in relation to dose assessments for radiation incidents and magnetic substance queries.
- Staff discussed incidents and themes in the imaging departmental team meetings. We reviewed minutes of the meeting that took place in September 2018 and saw how the wrong patient sticker was discussed and the correct procedure reaffirmed. Other incidents were minuted and if the appropriate action had taken place, was documented.
- Incidents were identified in the quality and risk reports. Action plans and lessons learnt were documented along with themes and trends. We reviewed the minutes for three clinical governance meetings and saw how incidents and themes were discussed. External safety alerts and recalls of medications/ equipment were also discussed. The meeting was attended by the heads of all departments who were expected to share information with the individual departments. This approach promoted learning across the hospital.

Are diagnostic imaging services effective?

We currently do not rate effective for this core service.

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence of its effectiveness. Whilst managers checked to make sure staff followed guidance, this guidance was not always the most up to date.

- Staff in the MRI/CT department showed us a folder which contained 58 standard operating procedures (SOP). Astandard operatingprocedure (SOP) is a set of step-by-step instructions compiled to help staff carry out complex routineoperations for example with operating equipment. We reviewed a selection of these SOPs for example guidance on CT of the sinuses, orbits and temporal bones and found they all reflected national guidance. However, of the 58 SOPs, 33 had expired and needed renewing. There was no standard operating procedure for the mammography machine, the service told us a comprehensive SOP was being drafted at the time of our inspection. We were therefore not assured staff were using the most up to date guidance.
- Risk assessments were undertaken but not always fully completed. Whilst we saw radiation risk assessments were in place and dated 2018 they were saved as 2017 reports on internal drive, and some were incomplete and not indicated as being at draft level.
- In line with Ionising Radiations Regulations 2017 (IRR99), the service appointed a radiation protection supervisor (RPS) who ensured staff followed the services standard operating procedures and adhered to the radiation protection procedures. However, SOPs were not all in date and may not reflect the most up to date guidance.
- The service worked to the IR(ME)R and guidelines from the National Institute for Health and Care Excellence (NICE), the Royal College of Radiologists (RCR), the College of Radiographers and other national bodies. The service adopted and used the diagnostic reference levels (DRLs) as an aid to optimisation in medical exposure. Local DRLs were in place and referenced to national DRLs and were recorded on the hospitals PACs system and audited annually by the appointed radiation physics advisor.
- Senior management completed a number of checks prior to granting radiologists practising privileges at the hospital. The term ‘practising privileges’ refers to medical practitioners being granted the right to practice in a hospital. In order to maintain their practising privileges radiologists were required to supply copies of current insurance, a disclosure and barring scheme check, their registration, last appraisal for their main place of work and evidence of completion of the required mandatory training. The hospital was up-to-date with these annual checks and reviews of clinical performance which took place biennially with the Medical Advisory Committee (MAC),

in keeping with the BMI Healthcare 'Practising privileges policy' (2015). The policy contained a standard agenda the MAC should adopt which included biennial review of practising privileges.

Nutrition and hydration

Staff gave patients enough food and drink to meet their needs

- Staff provided hot drinks and biscuits to those patients having MRI/CT, a hot drinks machine was available for those patients waiting in main x-ray.
- Information leaflets were sent to patients which identified instructions for eating and drinking prior to procedures. For example, those patients who were having ultrasound of their pelvis were instructed not to eat for six hours prior to the scan. Patients having a scan of their gall bladder were required to have a fat free diet for 24 hours prior to the scan.
- Special booklets were given to children and their families to explain sedation, should this be an option. The booklets also highlighted children may be required to fast prior to the procedure.
- Staff told us, they placed patients who had diabetes and required fasting on the morning lists to reduce any upset to their dietary intake and normal routine.

Pain relief

Staff assessed and monitored patients regularly to see if they were in pain.

- We observed staff asking patients having an MRI if they were comfortable and let them know how much longer they would be in the scanner.
- Radiology staff did not routinely use pain relief in diagnostic imaging except for when patients were attending for procedures such as port insertion. If in-patients required pain relief before or during an investigation the patient's consultant or resident medical officer on call would prescribe pain relief for the ward nurse to administer. For those patients who were having ports inserted there was a stock of controlled drugs kept securely in the department and administered by the radiologist and a ward nurse. Staff said patients would stay in the department until they were comfortable enough to return to the ward.

Patient outcomes

Although managers monitored the effectiveness of care and treatment and used the findings to improve them there was not always a consistent approach to audit.

- The service monitored safety via an electronic database, which enabled the hospital to compare its performance against other BMI hospitals. The monthly quality dashboard included patient incidents, the type of incident (such as a fall) and its contributing factors, and medication errors. The hospital used the results to improve practice and we saw evidence in minutes that incident discussions were a standard agenda item at meeting such as management team meetings, the clinical governance committee and if relevant, medical advisory committee.
- The radiology department submitted audit results such as infection control alongside other departments across the hospital and this was added to the monthly quality dashboard. This enabled the service to benchmark those areas that were generic across the departments and other hospitals.
- Local audits for the diagnostic department included health and safety, reject analysis, equipment checks, visual and quality assurance checks of the department, staff checks, for example were all radiographers HCPC registered and was there a nominated lead radiologist. Results from July, September, and December 2018 were all consistently above 90% however, we did not see evidence of any WHO observational audits taking place.
- The service benchmarked with other services at local level to compare practice and outcomes, for example the service had a magnet safety officer who compared the safety of the MRIs magnets across other BMI sites to ensure all were within safe parameters.
- Some of the audit information provided to us was unclear and not presented consistently. Information was presented in different formats such as the six-point check audit and the WHO form compliance check. These were presented in a different format to the general radiation safety audit and it was unclear where these results were stored therefore who had oversight of the results. The diagnostic service had undergone a recent change in its local management

with a new manager starting in September 2018 and a new deputy manager in December 2018. The service planned to improve the effectiveness of its auditing programme and shared with us the new audit programme for 2019. Audits were allocated monthly to staff members and this had been shared with the team.

- The service did not participate in the imaging services accreditation scheme (ISAS) at the time of our inspection.

Competent staff

The service had not made sure all staff were competent for their roles.

- Radiographers had competency assessments for the equipment they used, which were completed and up to date. All competencies were paper based at the time of our inspection. We looked at a selection of these which included training records for x-ray, CT, MRI and DEXA. All competency booklets had been signed off for all members of staff. These were reviewed yearly during the appraisal process.
- The Shelburne and Chiltern hospitals shared a radiation protection supervisor who was responsible for the compliance of the service. It was identified in the radiation protection audit that due to staff changes RPS duties such as review of personal dosimetry, contribution to incident investigations, staff training and records of radiation protection supervision were not always being achieved. As identified in the RPA it was now a legal requirement under IRR17 for RPS to be given sufficient time to complete their duties. The action plan reflected this and administration time was allocated to the RPS every two weeks.
- The service's appraisal data showed an 85% completion rate at the time of our inspection. Those staff who had not had a recent appraisal either were not currently working or had a date booked in for completion.
- All consultant radiologists working at the hospital had practising privileges which gave them the authority to undertake private practice within the hospital.All consultant radiologists participated in an annual appraisal at their NHS and shared this with the provider's medical director.
- We saw audit evidence that radiographers had in date health and care professional council registration (HCPC). This was in line with the society of radiographers' recommendation that radiology service managers must ensure all staff were appropriately registered.
- The staff room displayed how to access local and corporate polices, patient satisfaction survey results, safeguarding and speak up guardian information and the on-call rotas. This meant all staff could access this information at one single point and all staff knew where this was.
- The department saw patients including those under 18 years of age. To assist staff, to meet their needs they had access to a children's and young people's manual which was version controlled and in date. This identified when a children's nurse was required to be present in the imaging department, and stated as there was a registered children's nurse trained to level three safeguarding on the children's ward, the radiographers in the imaging department did not require level three children's safeguarding training. During our inspection it was identified that a registered children's nurse was not always present on the ward. Therefore, there had been times when children were in the department and this agreed standard had not been met as the children's ward rota did not accurately identify those staff who were qualified children's nurses.
- Staff provided care to children but not all had the necessary training to deliver care in an emergency. Whilst mandatory training completion was above the hospital target, paediatric basic life support training was at 60% compliance in January 2019. Therefore, a competent member of staff may not be available in the event of a paediatric emergency.
- The unit had one agency member who worked regularly on the unit. We reviewed their induction check list which was fully completed, we saw competencies had been signed off for plain x-ray and the mobile image intensifier.

Requires improvement

Diagnostic imaging

Multidisciplinary working

Staff of different kinds worked together as a team to benefit patients

- We observed effective team working, between all staff groups. Staff representation from all departments attended the daily communications meeting (comms cell). This enabled staff to have a good understanding of any operational issues within the other departments that may affect the day's workflow. For example, building work had just commenced in the department and this had the potential to disrupt service.
- There was currently no requirement for a formal service level agreement for imaging services through the local NHS Trust Provider. On occasion the Chiltern Hospital may request specialist services for example, long leg x-rays, whole spine x-rays, from the local NHS Trust. Staff would liaise with the relevant department directly and all documentation would be marked for either the Chiltern or Shelburne hospitals.
- Staff told us radiologists had a good working relationship with consultants. Radiologists contacted the patient's consultant directly if they found abnormalities on scans or x-rays, this ensured information was shared in a timely manner.

Seven-day services

The service operated over a seven-day period with the availability of on call radiologists to perform emergency diagnostic scans.

- Radiographers provided an on-call service out of hours, between 1730 to 08.30, Monday to Friday and 08.30 to 08.30, Saturday to Sunday. On Saturday radiographers who had previously been on-call from home now worked in the department during the morning due to the increased workload. And one Saturday a month provided the MRI department ran a service.
- There was no official radiologist on call rota and we were told that this was in the process of being finalised.

Health promotion

- We saw information on health and health promotion for example there were leaflets on breast health available in the waiting area.

Consent and Mental Capacity Act

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care and staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005.

- Staff had received training on mental capacity although they stated they would not be likely to see patients with mental capacity issues in their service as they would be seen at the local NHS trust. However, should they have concerns about a patient's mental health or capacity to consent verbally to investigations they would discuss this with the unit manager, the radiologists and should it be necessary contact the patients GP.
- There were online policies which were accessible to all staff for example on mental capacity and the deprivation of liberty which were version controlled and in date. Staff told us they were aware of these policies and could access these.
- Staff asked children over the age of 16, accompanied by their parent or responsible adult and deemed competent, to consent for their treatment. This was in line with BMI policy, which was version controlled and in date.

Are diagnostic imaging services caring?

Good

We rated caring as **good.**

Compassionate care

Staff cared for patients with compassion.

- We observed how staff demonstrated a kind and caring attitude to patients and took time to speak with patients and their relatives in a respectful, patient and considerate way. This was evident from the

interactions we witnessed on inspection and the feedback provided by patients. All the patients we spoke with praised the staff highly for their caring and attentive manner.

- Patients and their relatives told us 'the staff could not do enough for you and explained everything very patiently'. One patient told us they were anxious about feeling claustrophobic during their MRI scan, however the radiologist had taken time to explain and the service had a wide bore machine which helped people to feel less enclosed.
- Staff introduced themselves and explained their role and went on to fully describe what would happen during the procedure. During the MRI procedure staff frequently checked if patients were comfortable and updated them on how long they had left in the scanner.
- Our last inspection report highlighted the changing rooms in the x-ray department were small and did not allow patients enough room to change comfortably. We observed during this inspection the changing rooms had been refurbished and were much larger. However, for those patents in wheelchairs access to the changing rooms would be challenging due to the narrowness of the corridor. Staff told us they would assist patients to change in an x-ray room should this be an issue.
- Staff ensured they maintained patients' privacy and dignity during their time in the department. Patient Led Assessments of the Care Environment (PLACE) for 2018 for privacy, dignity and wellbeing were 92.14% which was above the England average of 83.7%. The Patient-Led Assessments of the Care Environment (PLACE) are annual assessments of the non-clinical aspects of the patient environment, how it supports patients' privacy and dignity, and its suitability for patients with specific needs e.g. disability or dementia.
- The hospital had a patient satisfaction dashboard which showed an improvement in diagnostic imaging of patients being treated with dignity and respect, In November 2017 the department scored 86.8%, this had increased in November 2018 to 92.1%.
- The service ensured all patients who were having ultrasound scans were chaperoned by a diagnostic imaging assistant.

Emotional support

- Staff supported patients through their investigations, ensuring they were well informed and knew what to expect. Leaflets provided contained useful information and covered potential questions patients and their relatives might ask.
- Staff provided reassurance and support for nervous and anxious patients particularly for those patients who were concerned about feeling claustrophobic. We observed how staff provided reassurance for all patients throughout their scan regularly updating them with timescales.
- There were minimal waiting times for patients and they were updated should there be any delay. A relative told us that 'the department was smoothly run and staff were always ready to help' another told us 'I had not finished my drink before it was all finished'.

Understanding and involvement of patients and those close to them

Staff involved patients and those close to them in decisions about their care and treatment.

- The service allowed for a parent or family member or carer to remain with the patient for their scan if this was necessary. For those children who required an MRI their parent or carer could be present in the room after they had completed a radiological questionnaire.
- In line with NICE QS15 Statement four, patients had the opportunity to discuss any concerns and preferences prior to their scan. Patients who were concerned about feeling claustrophobic or lying still for long periods of time had the time to discuss their concerns and we saw how these were alleviated prior to their procedure.

Requires improvement

Diagnostic imaging

Are diagnostic imaging services responsive?

Good

We rated responsive as **good.**

Service delivery to meet the needs of local people

The service planned and provided services in a way that met the needs of local people.

- The department planned services around the needs and demands of patients. Appointments were available Monday to Friday and more recently on Saturday to accommodate patients with commitments during the working week.
- The hospital was well signposted and had ample parking for all patients. The diagnostics area was signposted and reception staff were available at main reception and in the diagnostic department to direct patients and their relatives if necessary.
- The weekend prior to our unannounced inspection the unit started building works to fit a new digital x-ray suite. During this period to maintain the service and minimise disruption a de-commissioned x-ray suite was being used.
- The environment was appropriate and patient centred for adults. The waiting areas were fresh and bright, visibly clean and welcoming. There was an adequate number of seating and a drinks machine was available in the main x-ray waiting room. However, there was no separate play area or waiting room for children.
- There were no separate rooms available for patients who found it difficult to wait in busy environments.
- When a child or young person attended the department a member of the children's nursing team could be contacted for advice. Staff showed us the rota which identified when a member of the children's team was available and children would only be booked in during these times. However, during our inspection we identified that a registered children's nurse was not always available when a child was present in the department. This was non- compliant with the provider's policy of always having a registered children's nurse on site or on call when a child was present in the department.

Meeting people's individual needs

The service took account of patients' individual needs.

- The service used a wide bore MRI scanner, this was less enclosed than other scanners and so reduced the symptoms of claustrophobia. The unit had a programme which enabled scans to cut through 'artefact' more efficiently decreasing the time spent in the scanner.
- The wide bore scanner could also accommodate larger patients and the table was suitable for patients up to 30 stone in weight.
- To reduce a patient's apprehension staff told us children, nervous, anxious, phobic patients or patients living with dementia or learning disabilities could come to the department prior to their appointment to look around and see the scanning equipment. For those children who required an MRI or CT could be accompanied by a guardian/parent in the scanning room after having completed the safety questionnaire.
- For those patients who had learning disabilities staff told us they would be alerted on the referral forms and would encourage carers or relatives to attend appointments to support the patient and ensure staff were aware of their specific needs.
- To support patients who are hard of hearing a loop recorder was available in the main reception.
- Patients with mobility issues could enter the MRI scanning room on a MRI safe trolley or wheelchair. All waiting areas across the department were large enough to accommodate wheelchairs and patients with mobility issues. However, access to the changing areas in the main x-ray department was through a narrow corridor and this would make it difficult for a wheelchair user to negotiate.
- Staff working on the unit were unclear about the access to translation services and we were told patients who needed interpreters would bring a relative with them. However, the hospital told us

specialist communication services were provided, for example interpreters where English was not a first language. This meant that relatives may be used as interpreters which is not in line with best practice.

- There were no separate waiting areas for children who were attending the department as a patient or with a relative.

Access and flow

People could access the service when they needed it.

- NHS patients attending the service could access NHS services via the national Choose and Book portal which the service stated gave patients a greater choice of appointment times. We asked relatives of patients in the department if this had been an easy system to use and relatives told us they had chosen their appointment to fit in with their work commitments.
- Private patients who were self- funding their investigation or insured patients could book appointments through the centralised team or the BMI website, which included a 'live chat' support function. This approach ensured they could book an appointment that met their individual needs.
- The service met the six-week diagnostic test national standard and told us waiting times were up to two weeks. The service told us they actively managed their clinic capacity to ensure they could maintain short wait times. We reviewed an audit where 20 examinations (MRI, CT and Ultrasound) were randomly chosen and audited in November and December 2018.
  - In 55% of the audit cases, the waiting time was between 1-3 working days
  - In 35% of the audit cases, the waiting time was 3-6 working days.
  - In 10% of the total cases, the waiting time was more than 6 working days.
- < > were usually reported on within four days and all reports were sent to the referring clinician. A reporting time audit taken over the first 6 months of 2018 showed that reporting time 0-2 days averaged at 88.7%.
  Any urgent requests such as cancer referrals were given an urgent appointment. If an appointment was not available at short notice then the radiographer in charge of the modality would be consulted to secure an appointment for the patient as soon as possible. This patient would then be highlighted for urgent reporting on the clinical record interactive system (CRIS) and given to the next radiologist to report. If a certain radiologist was requested they would be called by the radiographer and made aware of the need for an urgent report.
- The service monitored 'did not attend (DNA) rates. From July to December 2018 there were 2,834 appointments of which only nine were DNA. The service told us that they are contacted within 30 minutes of failure to attend. A standard operating procedure had been written the month of our inspection which outlined the actions staff should take when this happened.
- Waiting times in the department were short and this was corroborated by what patients and their relatives told us and what we witnessed during our inspection.

Learning from complaints and concerns

The service treated concerns and complaints seriously and investigated them.

- The hospital analysed and discussed complaints during the quality and risk meeting. Complaints at a department level were discussed during the imaging departmental meeting. We reviewed minutes of this meeting for November and December 2018 and saw discussions around issues with reception such as speaking quietly, meet and greet, gossiping and patient's perceptions. The minutes documented what investigations and actions had been taken
- Leaflets were available in the waiting areas to guide patients in how to make a complaint or comment. We did not see any leaflets that were available in any other languages.

Are diagnostic imaging services well-led?

Requires improvement

We rated well led as **requires improvement.**

Leadership

Requires improvement

Diagnostic imaging

Managers were developing the right skills and abilities to run a service providing high-quality sustainable care.

- Management of the diagnostic department was still in its infancy and was in the process of developing the right skills and abilities to run the service and had just begun to address some of the challenges in their area.
- The radiology manager worked with the hospital's director of clinical services to understand challenges the department faced and identify the actions required to overcome these. We saw the service's action plan along with timescales, which included priorities such as recruitment and retention, the new digital suite development and updating all radiation protection paperwork (local rules) which were due for completion at the end of January 2019.
- Staff told us they received support from other senior radiological managers from other BMI hospitals. At a corporate level, 'round robin' emails shared learning and information across hospitals.
- Staff told us local leaders in the department were highly visible and we saw managers working alongside colleagues to maintain a smooth pathway for patients through the department. Staff told us leaders had the skills and experience to appreciate the roles they completed and offered valuable support.
- Staff told us the executive teams often visited the department and were approachable, helpful and operated an open-door policy.

Vision and strategy

The provider had a vision for what it wanted to achieve and workable plans to turn it into action, which it developed with staff, patients, and local community groups.

- The BMI corporate vision was to deliver the highest quality outcomes, the best patient care and the most convenient choice for patients. The senior management team had implemented a local vision for the hospital based on a care, compassion, competence, communication, courage and commitment. The local BMI vision was displayed throughout the department and staff knew what this was.
- The department had a strategy which included the development of a new digital suite. The work for this had commenced the weekend prior to our inspection and was expected to be completed within two months. This new suite aimed to improve the quality of x-rays.
- The previous inspection highlighted part of the departments plans were to grow the service by opening at the weekends, this had been achieved and the service ran sessions on Saturdays. This not only increased capacity but increased patient choice regarding appointment times.
- The radiology department had sufficient plans for the replacement of high cost equipment through managed services.

Culture

Managers promoted a positive culture that supported and valued staff, creating a sense of common purpose based on shared values.

- Staff told us they had monthly team meetings. We saw many staff attended these meetings and minutes were available to all staff on notice boards and on line.
- The new manager reinstated monthly team meetings.We reviewed meeting minutes for September 2018 through to January 2019 and saw the meetings had a standard agenda which included incidents, complaints, clinical information and updates. This approach encouraged sharing of information.
- All staff spoke proudly about their work in their individual speciality and as a part of the diagnostic imaging service. Staff felt supported in their work and said there were opportunities to develop their skills and competencies, which senior staff encouraged. Staff told us they felt valued and supported by colleagues and senior managers. Some staff had been supported through study at master's level
- All staff placed the patient at the centre of their service and described the care they delivered was based around the patient's needs, promoting a patient focused culture.
- Staff spoke positively about working for BMI and told us their managers and the executive team

acknowledged their wellbeing needs. The hospital had an open no blame culture and we saw posters showing the name, photograph and contact details of the speak up guardian.

- Staff participated in the BMI annual staff satisfaction survey. Positive results included staff being committed to doing their very best for BMI Healthcare, they could rely on others in their team and found their jobs interesting and fulfilling. Least positive results included ineffective introduction to change, pay rates and the lack of recognition of achievement. However, these results were from 2017 as the 2018 results were not yet published. This may not reflect the views of staff currently as it was acknowledged there had been significant changes to leadership within the hospital and across the diagnostic department. From what staff told us within the diagnostic department they were happy to work for BMI and felt valued by their senior teams.
- Results from the survey relating to staff development were entered onto the hospital's risk register. An action plan was developed and implemented to address these concerns, actions included development opportunities and training for heads of departments to improve discussions around staff skill development.

Governance

The service had slowly but systematically improved its service and quality.

- The hospital had a governance and risk management structure to support their delivery of care. We saw how the flow of information from the senior management team cascaded through the departments. Hospital sub-committees reported to the clinical governance committee, which fed into the medical advisory committee (MAC). Directors reported to the corporate BMI Healthcare regional and national clinical governance structure. Heads of department shared the outcomes from the clinical governance meetings at the heads of department (HODs) meetings, which promoted learning and sharing across the hospital.
- We reviewed meeting minutes from the Clinical Governance Committee, Medical Advisory Committee, Radiation Protection Committee (RPC) and Head of Departments meeting. All minutes followed a standard agenda and were formatted in a clear and easy way, with incidents and risks featuring as standing agenda items across all meetings. It was clear how information flowed from senior level through to all departments.
- The radiation protection committee (RPC) had yearly meetings and we reviewed the minutes of the first meeting held by the new management team. Unfortunately, there were no previous recorded minutes available as these had not been stored on the shared drive for the hospital Therefore we could not confirm what discussions had taken place and if agreed actions had been completed. An action from the RPC meeting was all recorded minutes were to be stored on the shared drive to reduce the risk of this happening again.
- During the RPC the terms of reference were re-established and those staff integral to the meeting were to be invited, such as the director of clinical services, theatre and consultant representation. Moving forward all minutes would be shared with committee members to ensure all areas had oversight of any actions required or issues identified.
- The RPC had a standard agenda which included the annual radiological protection report, management arrangements for radiation protection and summary of actions.
- The hospital used assurance systems and service performance measures, which staff reported on and monitored. The hospital had an audit dashboard and compared their performance to other hospitals across BMI. Audit, results and action plans were discussed at the monthly clinical governance and heads of department meetings
- The hospital held a monthly health and safety meeting which was minuted and attended by all departments to ensure messages and actions were shared. We observed a meeting which followed a standardised agenda including review of actions from previous meetings, incident and risk management, asbestos management and diagnostic and radiation safety.
- Staff in the radiology department had access to important information and updates and these were displayed in the processing room/ office. Staff meeting

minutes were displayed alongside. Staff used a communications book to share messages across the team and the daily comm cell emails were added into this.

- Committees such as the Health and Safety Committee held monthly meetings and had subcommittee meetings for example, the Water Safety Sub Committee.
- The clinical governance team were involved in ensuring all policies and procedures were up to date and in line with current national guidance.New policy and SOPs were disseminated thorough the weekly news bulletin, for example a new sickness policy was due for launch in October 2018. The clinical governance meeting minutes were shared across all departments. We reviewed the clinical governance meeting minutes for October 2018 and saw a cardiac arrest SOP in the MRI suite had been updated. However, not all the paper SOPs stored in the department were in date and 33 out of 58 were out of date, many of which had expired in 2016. This meant staff may not have been using the most up to date procedures.

Managing risks, issues and performance

The provider had systems to identify risks, plan to eliminate or reduce them, and cope with both the expected and unexpected.

- Local risk registers fed into the hospital's risk register.Risk registers were displayed in staff areas and all staff were aware of what the top risks were for their area. For the radiology department the main risk was recruitment and frayed lead coats which had just been replaced and was in the process of being removed from the local risk register.
- Risk registers had current risk scores and acceptable risk score. However, the information we reviewed did not have dates when the risk was added or reviewed. Whilst all risks were marked as open we could not be sure when they were last reviewed.
- We reviewed the risk assessment for the temporary use of the de-commissioned x-ray room for general radiography during the building works. Main hazards were detailed alongside current controls and further controls that were planned. A risk matrix identified the level of risk and plans were in place to mitigate any issues that may have arisen.

Managing information

The provider collected, analysed, managed and used information well to support all its activities, using secure electronic systems with security safeguards.

- There was sufficient information technology equipment for staff to work with across the diagnostics service. The service had access to the hospital's computer systems. They could access policies and resource material from the BMI's hospital's intranet.
- Staff could access electronic patient records easily and we observed staff locked computers when they were not in use to prevent the risk of unauthorised access.

Engagement

The department engaged with patients and staff.

- The 2017 BMI staff survey (BMiSay) was carried out by an external agency. Overall measures were lower than the 2016 survey. The hospital analysed the results showing key strengths and areas for improvement, and shared plans for improvements with the staff.

Learning, continuous improvement and innovation

The department was committed to improving services

- The radiology department had recently expanded their services to include Saturday mornings.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

Action the provider MUST take to meet the regulations:

- Draft risk assessments in relation to service delivery including mitigating actions for all documented risks.
- Ensure the staffing of the children's and young people's ward and support to other departments that children and young people visit for investigations or consultations is compliant with the provider's polies and procedures.
- Ensure governance processes are effective in identifying areas for improvement in service delivery.
- The provider must ensure medicine doses are recorded and signed as given.
- The provider must check all Patient Group Directives are signed by the appropriate staff.

Action the provider SHOULD take to improve

- Consideration should be given to the layout and design of the recovery unit to meet the needs of children and young people patients.
- Facilitate the provision of appropriate toileting and wash facilities for children and young people on the Treetops ward.
- Review the storage of all patient records and documentation to facilitate secure storage at all times.
- Compliance with the completion of all mandatory training including sepsis training in line with identified timescales should be monitored and action taken to improve compliance.
- Outpatient nursing rosters meet the needs of the patients and have sufficient numbers of staff on duty to facilitate safe, effective care and treatment to be delivered.
- Address all aspects of the standard agenda at outpatient team meetings and include audit results, action plans and specific learning from incidents and complaints.
- Provide patient information leaflets in a variety of languages, that reflect the demographics of patients using the service and in large print.
- All leaflets should include review dates and references to ensure they reflect current best practice.
- Provide all new members with an induction pack and mentor on their first day.
- Consider the implementation of a formal arrangement to access to tissue viability advice.
- Consider planning the off-duty rota for nursing staff at least one month in advance.
- Increase staff awareness of the availability of the portable hearing loop.
- Implement a process that identifies the need for an interpreter before the patient attends their first appointment.
- Consider completion of observational audits of the World Health Organisations safety check list alongside audit of completion of paperwork.
- Implement a local action plan or procedure for how staff should manage situations when a member of the public becomes aggressive.
- Providing a sluice in the outpatient department.
- Identify a designated room for distressed relatives/ quiet space in the outpatient department.
- That all Standard Operating Procedures and policies in use are the most up to date and remove out of date paper copies.
- Consider the introduction of a monitoring system, to assist track the condition of lead aprons.
- The provider should check only those staff who are deemed competent to order investigations do so.

Outstanding practice and areas for improvement

- Take action to address staff non-compliance with paediatric basic life support training.
- The provider should consider separate waiting areas for children in outpatients and diagnostics.
- Provide training in recording patient radiation doses and monitor compliance with recording.
- The endoscopy and oncology departments should consider producing a detailed competency framework for each role working in the department.
- The hospital should consider additional training for staff on the inpatient sepsis screening and action tool taken from the UK Sepsis Trust.
- The provider should consider accelerating plans to install sinks on wards to improve accessibility of handwashing.
- The provider should consider the sustainability of the oncology on call service as currently the service is split between two registered oncology nurses.
- All patient chairs in the surgical areas should have a wipeable surface to facilitate appropriately cleaning.
- The provider should consider promoting the role of the Freedom to Speak Up champions to give staff the confidence to utilise their expertise should they wish to do so.
- Review the storage of all risk assessments and documents relating to the servicing of equipment to facilitate easy access should these be requested to demonstrate assurance that the equipment is fit for purpose.
- Consider the development and implementation of a competency framework for each role working in the endoscopy and oncology departments.
- Consider implementing processes for recording when departments or areas are closed or not in use, due to operational reasons, to provide an audit trail of equipment and medicines checks which reflects which when areas are operational.
- The children's service should consider monitoring patient outcomes to audit if the care delivered met patient needs.

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 Care and treatment must be provided in a safe way for service users. The registered person must ensure risks to the health and safety of services users receiving care and treatment are identified with documentation actions in place to mitigate such risks.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Care and treatment must be provided in a safe way for service users. The proper and safe management of medicines.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing Sufficient numbers of suitably qualified, competent skilled and experienced persons must be deployed to provide care, treatment and support.

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

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

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance Systems and processes in place to monitor the delivery of safe care must be effective in identifying areas of concern and be used to improve the quality of the service provided.