BMI Healthcare Limited

BMI Bishops Wood Hospital

Inspection report

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This report describes our judgement of the quality of care at this service. It is based on a combination of what we found when we inspected, information from our ongoing monitoring of data about services and information given to us from the provider, patients, the public and other organisations.

Ratings

Overall rating for this location	Good
Are services safe?	Requires Improvement
Are services effective?	Good
Are services caring?	Good
Are services responsive to people's needs?	Good
Are services well-led?	Good

Summary of findings

Overall summary

Our rating of this location improved. We rated it as good because:

- 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 abuse and they knew how to apply it.
- The Hospital controlled infection risk effectively and introduced enhanced precautions since the beginning of the COVID-19 pandemic.
- Staff provided good care and treatment and gave patients pain relief when they needed it.
- Managers monitored the effectiveness of the service and made sure staff were competent.
- Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs. Staff provided emotional support to patients and their families.
- The service was inclusive and took account of patients' individual needs and preferences. Staff made reasonable adjustments to help patients access services. They coordinated care with other services and providers and people could access services when they needed them.
- Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff. They supported staff to develop their skills and take on more senior roles.
- Leaders operated effective governance processes, throughout the service and with partner organisations. Staff at all levels were clear about their roles and accountabilities. The hospital engaged well with patients to plan and manage services and all staff were committed to improving services continually.

However:

- The service was not doing all it could to remove or minimise risks to patients. Nationally recognised tools and guidance were not always used in a way that minimised risk. The World Health Organisation (WHO) safety checklist for surgery was not always completed in a way that kept people safe. When changes were made in the order of the theatre list, it was not always updated in line with best practice. Staff did not always complete the anaesthetic machine logbook.
- Patient notes were not always comprehensive, and information was not always easy to locate.
- National early warning scores (NEWS) were not always calculated accurately and there was a risk, patients might not be escalated appropriately.
- Medicines were not always stored securely in theatres.
- There was variable understanding and learning from never events and incidents, that occurred both within the service and in other organisations. Not all staff were able to articulate what had been learnt from incidents they described or how processes had changed to prevent incidents from happening again.
- Staff across surgical services thought multidisciplinary team working could improve in pre-operative assessment. Staff did not always agree nor feel supported on admission criteria and there was room for improvement in learning from patient cancellations.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Medical care (Including older people's care)	Good	Our rating of this service improved. We rated it as good because: • The service had enough staff to care for patients and keep them safe. Staff had training in key skills and understood how to protect patients from abuse. The service controlled infection risk effectively and managed medicines well. Staff collected safety information and used it to improve the service. • Staff provided good care and treatment and gave patients pain relief when they needed it. Managers monitored the effectiveness of the service and made sure staff were competent. Staff worked well together for the benefit of patients, advised them on how to lead healthier lives and supported them to make decisions about their care. • Staff treated patients with compassion and kindness, respected their privacy and dignity, took account of their individual needs, and helped them understand their conditions. They provided emotional support to patients, families and carers. • The service planned care to meet the needs of patients, took account of patients' individual needs, and made it easy for people to give feedback. People could access the service when they needed it. • Leaders ran services well using reliable information systems and supported staff to develop their skills. Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. Staff were clear about their roles and accountabilities. The service engaged well with patients to plan and manage services and all staff were committed to improving services continually. However: • Patient notes were not always comprehensive, and information was not always easy to locate in the paper notes.

- National early warning scores (NEWS) were not always calculated accurately and there was a risk patients might not be escalated appropriately.
- Not all staff could articulate shared learning from incidents and complaints.

End of life care is a small proportion of hospital activity. The main service was medical care. We have reported end of life care in the medical care section of the report as staff, leadership and governance fall within the medical care service.

Surgery

Good

Our rating of this service stayed the same. We rated it as good because:

- 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 abuse and they knew how to apply it.
- Staff provided good care and treatment and gave patients pain relief when they needed it.
- Managers monitored the effectiveness of the service and made sure staff were competent.
- Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs. Staff provided emotional support to patients and their families.
- The service was inclusive and took account of patients' individual needs and preferences. Staff made reasonable adjustments to help patients access services. They coordinated care with other services and providers.
- It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learnt with all staff. The service included patients in the investigation of their complaint.
- Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff. They supported staff to develop their skills and take on more senior roles.
- Leaders operated effective governance processes, throughout the service and with partner

Summary of findings

organisations. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.

However:

- The service was not doing all it could to remove or minimise risks to patients. Nationally recognised tools and guidance were not always used in a way that minimised risk. The World Health Organisation (WHO) safety checklist for surgery was not always completed in a way that kept people safe.
- When changes were made in the order of the theatre list, it was not always updated and re-printed in line with best practice.
- Staff did not always complete the anaesthetic machine logbook to record checks that had been completed.
- Medicines were not always stored securely in theatres.
- There was variable understanding and learning from never events and incidents, that occurred both within the service and in other organisations. Not all staff were able to articulate what had been learnt from incidents they described or how processes had changed to prevent incidents from happening again.
- Staff across surgical services thought multidisciplinary team working could improve in pre-operative assessment. Staff did not always agree nor feel supported on admission criteria and there was room for improvement in learning from patient cancellations.

We rated this service as good because it was effective, caring, responsive, and well led although safe requires improvement.

Summary of findings

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Summary of this inspection

Background to BMI Bishops Wood Hospital

BMI Bishops Wood is operated by BMI Healthcare Limited which is owned by Circle Health Group. It is a private hospital in Northwest London with 42 beds. Facilities include two operating theatres, a minor procedures theatre, a recovery area, a medical and surgical ward as well as outpatient and diagnostic imaging facilities. The hospital serves patients aged 18 years and over with private insurance or self-funding. The hospital also served NHS patients for a variety of surgical procedures, including orthopaedic, ear, nose and throat (ENT), gynaecology, urology, pain management and other general surgical procedures.

At the time of the inspection, there was a registered manager and a nominated individual.

The hospital provides surgery, medical care, outpatients and diagnostic imaging. The hospital is registered to provide the following regulated activities:

- Diagnostic and screening procedures
- Family planning
- Surgical procedures
- Treatment of disease, disorder or injury

The hospital has been inspected five times since it registered with CQC in May 2011, with the most recent inspection taking place in October 2017.

On this occasion, we inspected surgery and medical care using our comprehensive inspection methodology. The hospital provides day case surgery, inpatient surgery and cancer treatment services. The service offered a range of different surgical specialties, including orthopaedic, ophthalmology, urology, gynaecology, and ear, nose, and throat (ENT). The in-patient and day case facilities were located on the first floor of the hospital and were comprised of the surgical ward (Northwood) and the medical ward (Pinner) where oncology patients are treated.

Activity (July 2020 to June 2021):

- There were 2,700 day and inpatient visits to theatre at the hospital; of these, 43% were NHS-funded and 57% were privately funded.
- The top three surgical specialities were orthopaedic (34.5%), ophthalmology (16.7%) and gynaecology (11.8%).
- There were 269 inpatient medical episodes, 1423-day case chemotherapy episodes and 1923 outpatient treatments under medical care.

How we carried out this inspection

We inspected this service using our comprehensive inspection methodology. We carried out an unannounced inspection on 12 August and 19 August 2021.

During the inspection we visited Pinner Ward where they had inpatient beds and day beds for chemotherapy treatments. We spoke with nine staff, including registered nurses, a dietician, medical staff, and senior managers. We spoke with three patients, reviewed seven patient records and attended one daily management meeting and one daily staff huddle.

Summary of this inspection

You can find information about how we carry out our inspections on our website: https://www.cqc.org.uk/what-we-do/how-we-do-our-job/what-we-do-inspection.

Areas for improvement

Action the service MUST take is necessary to comply with its legal obligations. Action a trust SHOULD take is because it was not doing something required by a regulation but it would be disproportionate to find a breach of the regulation overall, to prevent it failing to comply with legal requirements in future, or to improve services.

Action the service MUST take to improve:

Core service Medical Care

- The service must ensure that national early warning score (NEWS) are calculated accurately Regulations 12 (2)(a)(b)
- The service must ensure escalation is clearly documented in patient notes. 12 (2)(a)(b)

Core service Surgery

- The service must ensure the anaesthetic machine is checked in line with the provider's policy and there is evidence recorded in the logbook of these checks. Regulation 12 (2)(a)(b)
- The service must ensure the surgical safety checklist (WHO) is documented as each stage is completed and not before steps have been done. Regulation 12 (2)(a)(b)
- The service must ensure the surgical admission policy in relation to body mass index (BMI) is always followed. Regulation 12 (2)(a)(b)
- The service must ensure that when changes are made in the order of the theatre list, it is updated and re-printed. Regulation 12 (2)(a)(b)
- The service must ensure NEWS scores are escalated in line with the provider's policy. Regulation 12 (2)(a)(b)

Action the service SHOULD take to improve:

Core service Medical Care

- The service should consider introducing a formalised standard operating procedure for oncology pharmacists to follow.

Core service Surgery

- The service should ensure all medicines are stored securely in theatres in line with the provider's policy.
- The service should ensure staff are aware of learning from incidents and how they would use this learning to prevent similar incidents reoccurring.
- The service should support pre-operative assessment multidisciplinary team working.
- The service should ensure patients are encouraged to drink fluids up to two hours before their operations in line with the providers fasting policy.
- The service should support theatre staff to participate in debriefing at the end of the theatre list to ensure there is discussion on teamwork, the theatre atmosphere, errors or near misses, and as an opportunity for learning and improvement.

Summary of this inspection

- The service should ensure there is a clear process for patients to receive enough information to understand the risks and benefits of anaesthesia.

Our findings

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Medical care (Including older people's care)	Requires Improvement	Good	Good	Good	Good	Good
Surgery	Requires Improvement	Good	Good	Good	Good	Good
Overall	Requires Improvement	Good	Good	Good	Good	Good

Good

Medical care (Including older people's care)

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

Are Medical care (Including older people's care) safe?

Requires Improvement

Our rating of safe improved. 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.

Staff received mandatory training face to face and via e-learning this covered topics such as; safety health and the environment, patient moving and handling, dementia awareness, infection prevention and control. Due to COVID-19 face to face training had been suspended and since it was reinstated clinical staff were prioritised for face to face training. Staff compliance was monitored through an electronic platform and staff told us they were sent a reminder when training was due for renewal. Staff told us they were supported by their managers to complete mandatory training and had time to do so.

Training data provided was for all staff employed and not broken down into different staff groups or areas. The training data showed that the majority of staff compliance rates were between 95% to 100% with a target rate of 90%. However, compliance with adult immediate life support including AED was 67.69% and below the providers target. Senior managers told us this figure included non-clinical staff and broken down by staff groups, clinical staff were 96.5% compliant.

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.

All staff received safeguarding training according to their role and training data showed a compliance rate of 97.15% for safeguarding training. Staff we spoke with demonstrated an awareness of safeguarding issues and knew how to report and escalate any concerns. Staff told us training included information on female genital mutilation (FGM).

The service had a criminal records policy (DBS) which included consultants with practising privileges. The service had a matrix which documented the DBS check and expiry date. Senior leaders were able to access this easily and take the necessary action.

Good

Medical care (Including older people's care)

Cleanliness, infection control and hygiene

The service controlled infection risk well. Staff used equipment and control measures to protect patients, themselves and others from infection. They kept equipment and the premises visibly clean.

The service took appropriate measures to reduce the risk of COVID-19 transmission and did not accept patients known to be COVID-19 positive into the service. Patients and visitors were screened at reception before entering clinical areas and patients were tested prior to admission for treatment. Patients receiving systemic anti-cancer therapy (SACT) were required to have a new PCR test before they started a new treatment course. During hand over staff discussed how it was necessary to remind visitors to comply with social distancing requirements and to wear a face covering at all times when visiting.

Staff received regular lateral flow tests for COVID-19 and the Testing of Patients and Staff for COVID-19 policy had been introduced. Meeting rooms had been changed to accommodate social distancing requirements and we saw signs on doors showing the maximum number of people allowed in a room.

The service carried out infection prevention and control (IPC) audits bi-monthly. Audits for April and June 2021 showed a compliance rate of 91%. We reviewed the IPC action plan for June 2021 which showed the planned actions and a target date for completion.

Ward areas were visibly clean and had suitable furnishings which were clean and well-maintained. Staff cleaned equipment and labelled equipment to show when it was last cleaned. We saw equipment with 'I am clean stickers' which were dated.

The service had a housekeeping policy which included a breakdown of areas from low risk to very high risk and the frequency of monitoring. We observed cleaners cleaning rooms and communal areas throughout our visit. The daily checklists for patient rooms and ward housekeeping which detailed the areas that needed to be cleaned. Cleaning records were up-to-date and demonstrated that all areas were cleaned regularly. The Pinner housekeeping audit showed that in six of the seven months the service was 100% compliant. In April 2021 the audit showed cleaning of medical equipment was not compliant. An action plan accompanied the audit which showed action had been taken and completed by the next monthly audit.

Staff followed infection control principles including the use of personal protective equipment (PPE). Staff we observed followed the Standard Infection Prevention and Control Precautions policy, they were bare below the elbow and always wore surgical masks during the inspection. Hand sanitiser was located on the walls outside patient rooms and we saw staff use it. We reviewed the hand hygiene audit, which included Pinner and Northwood ward. The data for the last three audits showed a compliance rate of over 90% and the last audit in June 2021 95%.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment kept people safe. Staff managed clinical waste well.

At our last inspection we found that some areas were not compliant with Health Building Note (HBN) 00-09 as some clinical areas were carpeted and did not have access to a handwashing sink. At this inspection we found that planned refurbishment works had been completed and all patient rooms on Pinner ward had laminate flooring and a sink in their room

Patients could reach call bells and we observed staff respond in a timely way. When a call bell was used it rang and a light flashed in the treatment room and could be heard from the nurse's station.

Staff carried out safety checks of specialist equipment. The monthly maintenance report detailed the equipment on Pinner ward and when maintenance checks were due. Staff told us equipment that had not been checked or was out of date was quarantined away from the ward until it had been serviced. At the time of the inspection the report showed there were two pieces of equipment in quarantine.

The service had suitable facilities to meet the needs of patients. The ward had 17 individual ensuite patient rooms.

Staff disposed of clinical waste safely. We saw different bins in use which were labelled to indicate where clinical waste should be disposed. The service had a waste management policy which included flow charts for the disposal of medicinal, infectious and chemical waste.

Assessing and responding to patient risk

Staff completed and updated risk assessments for each patient but did not always remove or minimise the risks. Staff did not always identify and quickly act upon patients at risk of deterioration

Staff used a nationally recognised tool to identify deteriorating patients, the national early warning score (NEWS). We reviewed seven patients records and found that all had a completed NEWS chart. However, two of the seven we reviewed the NEWS score had not been correctly calculated on all occasions. Where scores indicated escalation was required, there was not always evidence in the patient's notes escalation had occurred and in one case when there was evidence, escalation took place over an hour post the score being calculated. Therefore, deteriorating patients might not be assessed in a timely way and appropriate interventions provided. The service carried out an audit of NEWS scores every four months. The July 2021 audit showed the service was 97%. This audit result was hospital wide and not broken down for the medical ward.

The resident medical officer (RMO) could clearly describe the action they would take if a deteriorating patient was escalated to them. They were happy to contact consultants out of hours for support and described what action they would take if a patient needed to be transferred for higher level care.

Staff completed risk assessments for each patient on admission. We reviewed three sets of patients notes for patients attending on the day of our inspection. We found the adult risk assessment documentation had been completed for all three patients including falls and pressure ulcer risk assessments. The service carried out an audit of venous thromboembolism (VTE) assessments every four months, in May 2021 the audit reported 100% compliance.

The service collected data on incidents of; falls, pressure ulcers, urinary tract infections, VTE's and Healthcare associated infections (HCAI). Data for the last 12 months showed there were no HCAIs reported, nine falls and two pressure ulcers reported.

In the oncology notes we reviewed there was a periodic alert page reminding staff to consider sepsis and the signs of sepsis. One member of staff we spoke with told us sepsis was covered in the additional UK oncology nursing society (UKONS) training they received as part of their competency to deliver chemotherapy. They knew where to access the sepsis policy and could describe what they would do if they suspected sepsis.

Good

Medical care (Including older people's care)

The service had a service level agreement (SLA) with a local NHS trust to transfer deteriorating patients who required a higher-level of care. The care of the deteriorating patient policy had clear instructions for staff to follow should a patient deteriorate.

Shift changes and handovers included all necessary key information to keep patients safe. Staff discussed patient's specific needs and treatments. For example, staff were made aware there were two patients with the same name and additional identification checks should be made. The pharmacist updated staff on the expected ward medication deliveries for the day.

Staffing

The service had enough staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix, and gave bank, agency and locum staff a full induction.

To cover staff vacancies, which at the time of our inspection was 10.57%, and ensure there were enough nursing staff to keep patients safe, the service used agency or bank staff. Data provided by the service showed over the last 12 months 13% of hours were covered by bank staff and 11% agency staff. We were told two new members of staff had been recruited and were due to start after our inspection.

Managers accurately calculated and reviewed the number and grade of nurses, nursing assistants and healthcare assistants needed for each shift in accordance with national guidance. On the day of inspection, the number of nurses and healthcare assistants matched the planned numbers on Pinner ward which included bank and agency staff. Between April and June 2021, there were zero shifts left unfilled.

At the time of the inspection the pharmacy department was short staffed due to staff absence, which meant cover for the unit was limited. Staff told us they were concerned there would not be sufficient cover when annual leave was taken. Senior staff told us they could access regional support and cover should the oncology pharmacist be unavailable. Following the inspection, we reviewed the daily pharmacy staff rota which showed there were no gaps during August 2021. Senior staff told us the rota was reviewed daily and concerns were escalated regionally for support as required.

The clinical services manager adjusted staffing levels daily according to the needs of patients. The service knew in advance the number of patients attending for chemotherapy treatment and were able to arrange staffing levels accordingly. The service had a baseline number for the number of nurses and healthcare assistants required to care for inpatients on Pinner ward. Senior staff told us if the number of inpatients increased additional bank or agency staff would be booked.

Managers requested bank and agency staff who were familiar with the service and ensured they all had a full induction and understood the service. One agency staff member we spoke with confirmed they had received a full induction and worked frequently at the service. The bank member of staff we spoke with was a substantive member of staff who had moved to a bank contract and knew the ward and patients well.

Medical staffing

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

Good

Medical care (Including older people's care)

There was a resident medical officer (RMO) available on the ward 24 hours a day seven days a week and would contact patients' consultants out of hours if necessary. At the time of the inspection there were 23 consultants with different specialities who were able to provide care for the range of services the hospital provided.

The RMOs had a full induction to the service when they commenced in post. We spoke with an RMO on induction, who told us they had spent the week shadowing the RMO on shift and completing the provider's induction before they commenced work the following week.

The service granted consultants practising privileges that allowed them to treat and admit patients to the hospital. Consultants applications were reviewed at the medical advisory committee (MAC) prior to them being granted practising privileges to ensure they only provided care and treatment that they provided in their substantive NHS role.

Records

Staff did not always keep detailed records of patients' care and treatment. Records were not always clear and up-to-date. Records were stored securely and easily available to all staff providing care.

The service used paper notes which were available on the ward for each patient attending for chemotherapy and all inpatients. Most patient notes included a range of information and staff could access them easily. We reviewed seven sets of patient notes and found they had risk assessments completed, detailed treatment plans and reminders to consider sepsis and were mostly legible, dated and signed. However, the main health records included MDT records, these were difficult to follow in some cases. One set of notes we reviewed included a do not attempt cardiopulmonary resuscitation (DNACPR). The DNACPR was located at the front of the notes ensuring easy access to this information. However, there was no record of the discussions held with the patient, including who was present at the time of discussion or the ceiling of care to be provided. The details of the DNACPR were difficult to locate in the notes, meaning care may or may not be delivered in line with the patient's wishes. The notes did not include a body map of pressure areas or oral care plan.

The service carried out an audit of patients notes every four months, the results were location wide and not service specific. The last three audits showed compliance rates of 62% in November 2020, 89% in March 2021 and 88% in July 2021. The service provided the action plan which showed there were 15 actions to be taken and four were rated as high priority. The target dates for the actions were after the date of the inspection and it was too early to evidence improvements.

Records were stored securely; notes for patients who were in patients or day cases were kept in locked rooms on the ward only accessible to staff.

Medicines

The service used systems and processes to safely prescribe, administer, record and store medicines.

Staff followed systems and processes when safely prescribing, administering, recording and storing medicines. Medicines were stored in the treatment room accessible with a staff swipe card. In the treatment room-controlled drugs were stored in a locked cupboard and the nurse in charge held the key. Other medication, such as chemotherapy was stored in locked cupboards and keys were kept in a key safe accessible only to staff.

The service used an electronic prescribing system which had changed since our last inspection. Consultants could access the system remotely to amend prescriptions if required.

Good

Medical care (Including older people's care)

The service had a senior oncology pharmacist who was available Monday to Friday. The service had a small satellite pharmacy on the unit where medicines from the main pharmacy were brought. The oncology pharmacist reviewed the prescription against the blood test results escalating any discrepancies to consultants. However, this process was not formalised, and it was not clear if this process would be followed when another pharmacist covered the oncology pharmacist.

Oncology medication was ordered in advance through the compounding unit where medication could be customised. Medication was usually ordered three days in advance but could be ordered the day before if necessary. The oncology pharmacist told us some medication was delivered on the day of treatment and patient appointments were booked taking this into consideration.

The service carried out a medicine management audit every four months. We reviewed this audit which showed in July 2021 they were 100% compliant.

Staff did not always follow best practice when preparing medication requiring two signatures. We observed a staff member sign and label a bag of saline before the required medication had been added and without a second member of staff present. This presented a risk that the additional medication may not be added to the saline bag and was not in line with best practice.

Incidents

The service managed patient safety incidents well. Staff recognised and reported incidents and near misses. Managers investigated incidents and shared lessons learnt, however not all staff were aware of learning shared. When things went wrong, staff apologised and gave patients honest information and suitable support.

All staff knew what incidents to report and how to report them. Staff had access to the electronic incident reporting system. Staff we spoke with told us they were encouraged to report incidents and felt confident to do so. However, staff could not give an example of improvements made following an incident and were not aware of feedback from other wards or BMI hospital sites.

The service had zero never events over the last 12 months. There were 97 incidents in total all rated as low or no harm. The topic with the highest number of incidents was medication with 17 incidents recorded. Six of these were individual patient reaction to chemotherapy and six were due to incorrect prescribing. The service took action and discussed the incidents with each prescriber to make sure this was not repeated. However, there was no evidence this learning had been shared more widely.

Staff understood duty of candour. They were open and transparent and gave patients and families a full explanation if and when things went wrong. The provider had a Being Open and Duty of Candour policy which outlined the timeline to follow and staff responsibilities. Senior staff told us there had been no incidents meeting the regulatory statutory threshold to apply duty of candour, but the service followed being open and honest with patients when an incident occurred that did not meet the threshold to evoke duty of candour.

Managers debriefed and supported staff after any incident. Senior staff told us following the death of a patient a debrief was held immediately with a further debrief planned to take place once the investigation into the incident had been completed.

Safety Thermometer

Medical care (Including older people's care)

Good

The service used monitoring results well to improve safety.

The service used a safety performance dashboard to monitor and improve services. We reviewed the dashboard and found it measured metrics and showed performance across services in areas of safety, infection control and effectiveness. Data showed in the last 12 months there had been one hospital wide reportable infection, a E.coli Bacteraemia case, to Public Health England. However, data was not displayed for staff, patients and visitors to see.

Are Medical care (Including older people's care) effective?

Good

Our rating of effective improved. We rated it as good.

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence-based practice.

Staff followed up-to-date policies to plan and deliver high quality care according to best practice and national guidance. Policies were updated corporately, and weekly alerts were sent to locations when policies were updated with information to disseminate to staff.

The audit schedule was aligned to national guidance and standards such as National Institute for Health and Care Excellence (NICE).

Staff knew where to access policies and guidance on the intranet. Staff were knowledgeable about the policies quoting the national guidelines they included. All the policies we reviewed cited national guidance and legislation, for example the Neutropenic Sepsis policy cited NICE.

Nutrition and hydration

Staff gave patients enough food and drink to meet their needs and improve their health. They used special feeding and hydration techniques when necessary. The service made adjustments for patients' religious, cultural and other needs.

Staff made sure patients had enough to eat and drink, including those with specialist nutrition and hydration needs. We spoke with three patients who told us they were happy with the menu options and we observed staff asking patients on arrival if they wanted a drink.

Specialist support from a dietitian was available for patients who needed it. The service had a dietician who visited the ward when required. They developed meal plans for patients and provided nutritional advice. They liaised with the catering manager to provide bespoke meals for patients and supported the catering team to introduce nutritional smoothies.

Good

Medical care (Including older people's care)

Staff used a nationally recognised screening tool to monitor patients at risk of malnutrition. However, we saw a patient with a malnutrition universal screening tool (MUST) score of 2 that had not been escalated. Following the inspection senior staff told us staff had been re-educated on MUST screening, including the identification and escalation of risk.

Pain relief

Staff assessed and monitored patients regularly to see if they were in pain and gave pain relief in a timely way.

Staff assessed patients' pain using a recognised tool and gave pain relief in line with individual needs and best practice. BMI had a care pathway standard scoring tool which rated pain, potential symptoms and type of pain relief. In the patient notes we reviewed all included a pain score on admission. We observed staff asking patients whether they were in pain assessing the level using a numbered score. However, not all pain management plans were fully completed, for example, they lacked evidence that pain had been discussed with patients.

Patients received pain relief soon after requesting it and staff administered and recorded pain relief accurately. We observed a patient being provided with pain relief, two members of staff were present to administer and record the use of controlled drugs in line with best practice.

The service carried out a pain audit every six months. The audit included whether there was documented evidence patients had their pain score assessed and the use of a pain management care plan. In March 2021 the service was 98% compliant.

Patient outcomes

Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for patients.

The provider participated in relevant national clinical audits, but most were not applicable to this service. The service submitted data to the Breast & Cosmetic Implant Registry (BCIR), following recommendation 21 of the Keogh Review of the Regulation of Cosmetic Interventions.

Managers and staff carried out a programme of repeated audits. The audit schedule included a programme of monthly, bimonthly, quarterly, four monthly, bi-annual and annual audits and included IPC audits, administration of drugs and cancer services documentation.

Managers used information from the audits to improve care and treatment. We saw action plans were developed in response to audit results, these included areas for improvement and target dates for improvements to be made.

Competent staff

The service made sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and development.

Staff were experienced, qualified and had the right skills and knowledge to meet the needs of patients. The service had a central database of consultants with practising privileges and senior management could review the database to ensure individuals remained competent for the role they had been granted practising privileges to undertake.

The recently appointed clinical educator supported the learning and development needs of staff. They told us there were plans to review end of life care protocols and training would include bank staff.

Managers made sure staff attended team meetings. Staff told us meeting minutes were taken, shared and stored electronically. However not all staff knew how to find them and those that did could not find them easily.

Staff had the opportunity to discuss training needs with their line manager and were supported to develop their skills and knowledge. Managers also made sure staff received any specialist training for their role. Nursing staff looking after patients receiving chemotherapy treatment had completed training from UK oncology nursing society (UKONS). At the time of our inspection, six registered nurses were competent to administer chemotherapy.

The service used a dashboard to track appraisals and this included appraisals for bank staff. Data showed in the service 95% of staff had received an appraisal.

The clinical services manager was responsible for monitoring staff performance. Senior staff told us if poor performance was identified this would be managed by the line manager and escalated accordingly. At the time of the inspection there were no staff members under performance management.

Multidisciplinary working

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

The daily staff huddle had multidisciplinary (MDT) attendance, including the RMO, pharmacist, clinical nurse specialists and ward staff to discuss patients and improve their care.

Patients had their care pathway agreed by relevant consultants with input from a dietician. The RMO liaised with consultants to provide care when the consultant was not on site and nursing staff told us consultants were accessible and responded to calls when they were off site.

The service did not hold MDT consultant meetings, patients were mostly under the care of one consultant but staff told us consultants would discuss patients care and document it in the notes when a patient crossed services, for example if a patient had surgery before having systemic anti-cancer therapy (SACT).

Staff worked across health care disciplines and with other agencies when required. The palliative care clinical nurse specialist worked closely with other services including community services to provide an end of life care pathway for patients moving between services.

Seven-day services

Key services were available seven days a week to support timely patient care.

Staff could call for medical support from the on-site RMO 24 hours a day, seven days a week. Consultants visited their patients on admission and the clinical services manager told us consultants visited inpatients on the ward daily. The consultant was also available on-call and would provide advice to the RMO on the patient’s care or attend the hospital out of hours if necessary. The RMO we spoke with told us consultants had always responded to calls out of hours day or night.

Patients could contact the service at any time. Outside of working hours the RMO would speak with the patient if they had any concerns and would assess whether the patient needed to be admitted.

The pharmacy was open Monday to Friday in line with chemotherapy treatment times.. On Saturday the pharmacy was open for discharges only. Patients could access the service on Saturday for blood tests and swabs before treatment started.

Health promotion

Staff gave patients practical support and advice to lead healthier lives.

The service had relevant information promoting healthy lifestyles and support on the wards. The dietician worked with patients to support healthy eating according to their needs including diabetes management.

Staff assessed each patient's health when admitted. All seven patients' files we reviewed included a completed general health assessment, which included a CAGE assessment for nicotine and alcohol. CAGE is a psychological questionnaire staff can use to assess signs of possible dependency.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients' consent.

Staff gained consent from patients for their care and treatment in line with legislation and guidance and clearly recorded consent in the patients' records. All seven sets of patient notes reviewed had patient consent documented. The service also documented patient's consent to displaying their name on their room door. However, the consent audit showed that there was an 80% compliance rate across medical care and surgery.

Staff training in the Mental Capacity Act and Deprivation of Liberty Safeguards was included in safeguarding training and was not a separate course. The service had the Mental Capacity, Deprivation of Liberty and Restrictive Practice policy for staff to refer to and all staff we spoke with were aware of these policies and how to apply them.

Managers monitored the use of Deprivation of Liberty Safeguards. In the last 12 months the service had not needed to apply for a best interest decision to be made. Senior leaders told us it was rare for a patient in the service to be subject of a Deprivation of Liberty Safeguard.

Are Medical care (Including older people's care) caring?

Good

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

Compassionate care

Good

Medical care (Including older people's care)

Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.

Staff followed the service's privacy and dignity policy to keep patient care and treatment confidential. Staff were discreet and responsive when caring for patients. We observed staff knocking on doors before entering and all conversations with patients were held in the privacy of the patient's room. Staff took time to interact with patients and those close to them in a respectful and considerate way. All three patients we spoke with provided positive feedback and told us staff treated them well and with kindness.

Staff understood and respected the personal, cultural, social and religious needs of patients and how they may relate to care needs.

Emotional support

Staff provided emotional support to patients, families and carers to minimise their distress.

Staff gave patients and those close to them help, emotional support and advice when they needed it. At the time of the inspection the service generally did not allow visitors to accompany patients attending the hospital for day case treatment due to COVID-19. However, individual circumstances were reviewed, and staff provided an example of supporting a patient with anxiety by allowing their partner to attend.

The service could usually facilitate a relative or friend staying with the patient overnight, but COVID-19 had restricted this service. Staff told us if a patient requested a family member or friend to be allowed to stay overnight, this request would be reviewed and accommodated if possible. We spoke with one patient who told us this had been offered.

Staff understood the emotional and social impact that a person's care, treatment or condition had on their wellbeing and on those close to them. Staff we spoke with demonstrated an awareness of supporting patients emotionally throughout their stay. During hand over we observed discussions around patients and their relatives and how best to support them.

A multifaith chaplain visited the service weekly providing support for staff and patients. Patients were provided with information about local support groups such as the 'wonder women' group. However due to COVID-19 many of these groups had been unable to meet but this was under review and the groups would recommence when it was safe to do so.

Understanding and involvement of patients and those close to them

Staff supported patients, families and carers to understand their condition and make decisions about their care and treatment.

Staff made sure patients and those close to them understood their care and treatment. One patient we spoke with told us they felt included in conversations about their care and treatment and felt supported making decisions.

Staff spoke with patients, families and carers in a way they could understand. We observed a patient and family member talking with staff. Staff listened to the patient and helped address their query in a friendly supportive way.

Patients and their families could give feedback on the service and treatment, staff supported them to do this. Each patient room had a poster stand with details of how to provide feedback and touchscreen devices were available around the site for patients to use.

Medical care (Including older people's care)

Good

Staff supported patients to make advanced decisions about their care. The service employed a palliative care clinical nurse specialist to support patients make advanced decisions and supported them at end of life.

Are Medical care (Including older people's care) responsive?

Good

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

Service planning and delivery to meet the needs of the local people

The service planned and provided care in a way that met the needs of people. It also worked with others in the wider system and local organisations to plan care.

Managers planned and organised services to meet the needs of patients. Patients attending appointments for chemotherapy treatment were staggered throughout the day at one-hour intervals, so patients were not kept waiting for longer than necessary.

Facilities and premises were appropriate for the services being delivered. All patients had a private en-suite room and the ward was accessible by a lift. There were specific rooms designated for in-patient and day cases. We observed staff respond to patient needs. A patient having treatment on a day case bed was moved to an in-patient bed, so they were more comfortable.

Meeting people’s individual needs

The service was inclusive and took account of patients’ individual needs and preferences. Staff made reasonable adjustments to help patients access services. They coordinated care with other services and providers.

Managers made sure staff, patients and their family and carers had access to interpreters or signers when needed. Staff told us at the point of referral specific patient needs would be flagged and when the patient was booked for admission or an outpatient appointment an interpreter could be booked and provided either face to face or via telephone. The main reception used an assistive listening device. We spoke with one patient who used a hearing aid and told us they had been asked if they needed any additional support.

Patients were given a choice of food and drink to meet their cultural and religious preferences. The ward had a pantry that could accommodate patient requests and patients we spoke with told us they were happy with the food and drinks provided. The dietician told us they liaised closely with catering staff to ensure patients received food that met their needs.

The service considered patients clinical preferences based on cultural and religious beliefs. We reviewed a set of patient notes which were clearly marked on the front cover with the patient’s request not to receive blood products as part of their ongoing care. This information was also documented in the notes, clearly marked on the front page so the patient’s request was clear for all staff involved in their treatment.

Good

Medical care (Including older people's care)

Access and flow

People could access the service when they needed it and received the right care promptly. Waiting times from referral to treatment and arrangements to admit, treat and discharge patients were in line with national standards.

Patients could access services when needed and received treatment in a timely manner. The service saw private patients on referral and accepted patients within the capacity of the service. Patients were not placed on a waiting list and were booked once the referral had been triaged.

Managers and staff we spoke with told us they worked with healthcare insurers, to make sure patients were able to stay for the length of time they needed. Private healthcare insurers were consulted to agree time scales and we observed staff discussing a patient care plan taking into consideration different options whilst they waited on a decision from a private healthcare insurer.

The service did not move patients between wards and had not placed medical patients on non-medical wards in the last 12 months. Patients were transferred out of the hospital only when there was a clear medical reason to do so. The provider had a service level agreement in place to transfer deteriorating patients for higher level care should it be required. The service worked with community partners arranging care for patients at end of their life making sure patients achieved their preferred place of death.

Managers and staff worked to make sure patients were discharged before 8pm in line with the providers policy. Data showed between 01 February 2021 and 31 July 2021 only five of 670 oncology and medical admissions were discharged after 8pm.

Learning from complaints and concerns

It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff. The service included patients in the investigation of their complaint.

Patients knew how to complain or raise concerns. We spoke with three patients who told us they knew how to make a complaint and would feel comfortable to complain if they needed to.

The service clearly displayed information about how to raise a concern and patients were encouraged to provide feedback. The service monitored online reviews to ensure concerns that had not been raised formally were also reviewed.

Managers investigated complaints and identified themes. Data showed there were 47 complaints over the last 12 months across the hospital, this was not broken down by service or ward. Senior leaders told us themes for the medical care service were around waiting times once the patient had arrived for treatment. Staff stated they would discuss any delays to treatment with patients to keep them informed and minimise complaints.

Managers shared feedback from complaints but not all staff felt able to contribute to the complaints process. Staff told us learning from complaints was discussed at team meetings however, staff we spoke with could not give an example of a change in practice as a result of lessons learnt.

Good

Medical care (Including older people's care)

Are Medical care (Including older people's care) well-led?

Good

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

Leadership

Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff. They supported staff to develop their skills.

The service had a clear leadership structure with lines of reporting. The medical oncology service was overseen by the clinical services manager (CSM) who had been in post for five months and had an extensive background in oncology care. The CSM reported to the Director of Clinical Services.

Staff told us managers and senior leaders were visible and accessible and all staff we spoke with felt supported by their line managers. One member of staff commented there had been improvements since the CSM had joined the service.

Vision and Strategy

The hospital had a vision for what it wanted to achieve and a strategy to turn it into action.

The corporate provider had merged to become part of Circle Health Group and we were told work was underway with staff to embed the new vision and strategy. We saw posters in staff areas promoting the Circle Health Group philosophy which included the purpose, principle and values. Managers told us staff were encouraged to give feedback on the values and strategy.

The hospital had a vision and set of values that aimed to create a culture of 'ultimate care' but did not have a vision and strategy specifically for the medical care service. Following the inspection, senior staff told us work was underway to develop a Cancer strategy for the hospital which aligned with the recently launched Circle Health Group Philosophy.

Culture

Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service promoted equality and diversity in daily work and provided opportunities for career development. The service had an open culture where patients, their families and staff could raise concerns without fear

Staff we met were welcoming, friendly and helpful, they told us they worked well with colleagues and there was a positive culture.

Staff had access to a freedom to speak up guardian (FTSUG) to ensure staff could raise concerns in a safe supportive way. Managers told us the FTSUG sent regular emails and facilitated regular drop-in sessions in the canteen for staff to attend.

Good

Medical care (Including older people's care)

Senior leaders told us there was a focus on staff wellbeing. Staff had access to an employee assistance programme, locally teams nominated an employee of the week and there were long service awards.

The service won the Macmillan Quality Environment Mark award in October 2018 which is awarded to services that champion environments that go above and beyond to create a welcoming and friendly space. The service is due to be reassessed in October 2021.

Governance

Leaders operated effective governance processes, throughout the service. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.

The provider had a governance and assurance framework which detailed the local committee structure. The clinical governance committee met monthly and sub-committees reported into this group. The medical advisory committee (MAC) met monthly. The minutes from these meetings demonstrated there was representation from different departments. Consultants practising privileges were discussed at this meeting and there was evidence of consultants having practicing privileges withdrawn due to low or no activity and discussions of new applications.

The service held monthly staff meetings which had a set agenda and was minuted. Staff told us they attended these meetings and learning, and important updates were shared. The meeting minutes were stored electronically for staff to access. However, not all staff knew where to access them.

Management of risk, issues and performance

Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact.

The hospital had a risk register with 15 risks identified rated low and medium. There were three risks identified for Pinner ward, all had an assigned action owner and a review date in September 2021. Control measures were in place to mitigate the risk including continuing with local audits.

The hospital’s clinical governance committee met monthly. We reviewed the minutes for May and June 2021 and found there was good attendance from across the hospital. There were updates on actions, standing agenda items which included a review of the risk register and separate clinical governance agenda items.

The CSM attended the daily ‘comcel’ call where the clinical leads for each department presented and update for their department. They highlighted staffing levels, any gaps, activity and patients needing additional support.

Information management

The service managed and used information well, using secure electronic systems and paper records. Data or notifications were submitted to external organisations as required.

Good

Medical care (Including older people's care)

The service used an electronic prescribing system to prescribe chemotherapy which had improved since our last inspection. Prescriptions were clear and authorised correctly and consultants could now access the system remotely to amend prescriptions if required.

The hospital stored patients' medical records in the medical record room which was only accessible to authorised staff. Staff requested medical records which were delivered to the ward in a timely way.

The service submitted statutory notifications to the Care Quality Commission such as the death of a service user or injury caused and reportable infections to Public Health England. Between July 2020 and July 2021, the hospital reported one reportable infection.

Engagement

Leaders actively and openly engaged with patients and staff to plan and manage services. They collaborated with partner organisations to help improve services for patients.

The hospital carried out their annual staff survey in March 2021, there was a response rate of 68.63%. The results fed into the corporate action plan which had been developed with deliverable dates for actions, these were all due to be completed post this inspection. Actions were divided with headings such as develop, introduce, improve and create so it was clear how the action was to be delivered. In July 2021 a letter was sent to staff from the chief people officer to update staff on how they were responding to the staff survey feedback.

The hospital published the patient satisfaction survey in June 2021. There were 148 respondents over a 3-month period. This showed a patient satisfaction score for overall experience of the service of 97.8% which had increased by 6.2% from June 2020.

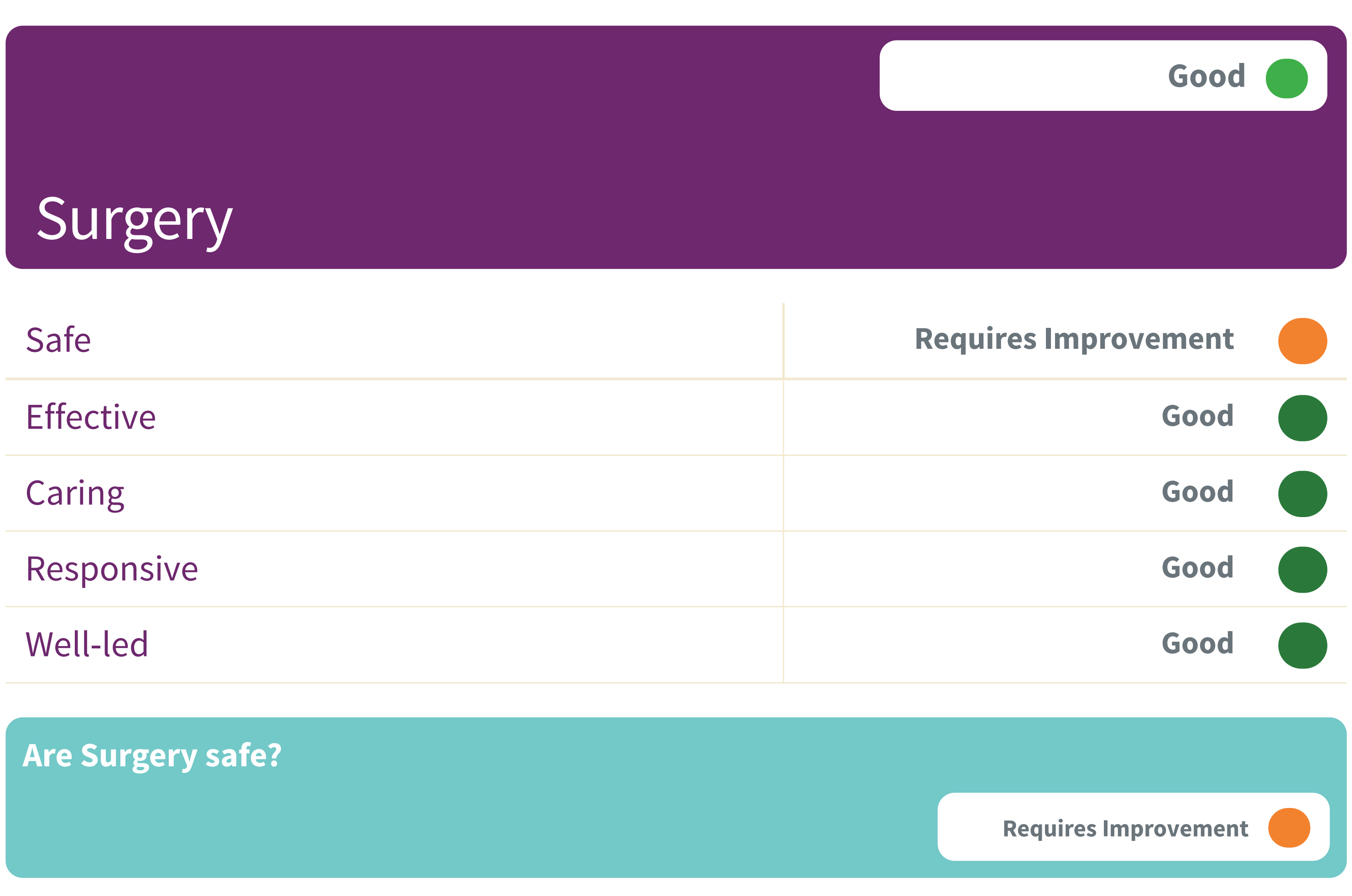
The service continued to support Macmillan coffee mornings to raise money for charity despite COVID-19 and corporately managers have been asked to identify local charities to support.

Patient user groups ceased during COVID-19 and have not recommenced. During this time the service used trends from complaints and patient satisfaction surveys to identify where improvements could be made.

Learning, continuous improvement and innovation

Systems and processes were implemented to facilitate continuous learning and improve services.

The hospital was in the process of embedding the Circle Operating System (COS). The COS aimed to recognise and resolve issues at the source, share learning and ensure improvement and innovation was continuous. COS included five tools to help staff achieve these aims.



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 supported staff to complete it.

Staff received and kept up to date with their mandatory training. Staff completed training through face-to-face and e-learning modules. The mandatory training met the needs of patients and staff and included fire safety, information governance, and basic life support amongst others.

Managers monitored mandatory training and alerted staff when they needed to update their training. Overall staff compliance with mandatory training was 93.7% which met the provider's compliance target of 90%. Staff told us they felt supported by their managers but that it could be difficult to find time to complete some training. There had been challenges where some face-to-face training was cancelled due to the Covid-19 pandemic and had to be rescheduled.

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 abuse and they knew how to apply it.

Staff received safeguarding training specific for their role on how to recognise and report abuse. The service provided safeguarding modules as part of staff's mandatory training, which included training on identifying and reporting female genital mutilation (FGM). All staff we spoke with knew how to identify those at risk of harm and who to inform if they had concerns. The director of clinical services was the nominated lead for safeguarding and had completed safeguarding vulnerable adults and children level four training.

Cleanliness, infection control and hygiene

Good

Surgery

The service controlled infection risk well. The service used systems to identify and prevent surgical site infections. Staff used equipment and control measures to protect patients, themselves and others from infection. They kept equipment and the premises visibly clean.

Ward areas were visibly clean and had suitable furnishings which were clean and well-maintained. The service performed well for cleanliness with overall positive feedback from patients of 97.5% satisfaction. Audits showed there was good cleanliness of the surgical ward.

The service had made significant environmental improvements from the last inspection on the ward and in theatres and was compliant with Health Building Note (HBN) 00-09. There were now handwashing basins in all patient rooms and in the sluice room in theatres. The service identified some areas in the hospital where flooring work was still needed, including the waiting area for walk-in patients for theatre. This risk was monitored through the hospital governance processes and was on the hospital risk register with an action plan in place.

Staff followed infection control principles including the use of personal protective equipment (PPE) and were observed to be bare below the elbow. Staff cleaned equipment after patient contact and labelled equipment to show when it was last cleaned. The service audited every other month for infection prevention and control and hand hygiene and performed well with compliance averaging 95% over the last three audits.

Staff worked effectively to prevent, identify and treat surgical site infections. As a result of the Covid-19 pandemic, the service ensured all patients were tested for Covid-19 prior to their admission. The service ensured patients for joint surgery had swabs for Methicillin-resistant Staphylococcus aureus (MRSA) and Methicillin-sensitive Staphylococcus aureus (MSSA). The service used an external contractor for decontamination of instruments off-site and for deep cleans of theatres. Audits showed deep cleans took place at regular intervals.

Environment and equipment

Staff were trained to use equipment, but some equipment was not checked as regularly as it should have been. The design and use of facilities and premises helped keep people safe. Staff managed clinical waste well.

The service had enough suitable equipment. However, we observed inconsistent documentation for checks of the anaesthetic machines and these checks were not conducted in line with the service's policy. The service's procedure was to complete the logbook prior to theatre activity for the day or if there was no activity, staff should record that the theatres were closed. However, there was no documentation in the logbook the day before or by the third case on the day of our inspection. Therefore, staff could not be assured their equipment was working properly and could put patients at risk. There were also regular gaps in the logbooks for the anaesthetic machine especially on days where the theatre and machine were not in use and for the weekend which was not in line with the service's policy. Following the inspection, senior staff told us an audit had been implemented to monitor the completion of the logbook.

The service had suitable facilities to meet the needs of patients such as two theatre suites, both with laminar flow to help reduce the incidence of surgical site infections. There was a surgical ward, all rooms were en suite, and a day case room for minor procedures. At the time of our inspection, the day case room was not in use for clinical services as it was being used for administrative purposes due to COVID-19 social distancing requirements.

The design of the environment now met national guidance following improvements made to address issues identified at the last inspection. Patients could reach call bells and staff responded quickly when called. There were emergency call pulls in each patient room and easily accessible resuscitation trolleys for staff to use in the case of an emergency. Staff checked the resuscitation trolley daily to ensure equipment there was sufficient equipment and that it was in good working order.

Staff disposed of clinical waste safely. The service had made improvements since our last inspection and was now compliant with HTM 07-01, safe management and disposal of healthcare waste. Hazardous waste was placed in the appropriate disposal bins and sharps bins were not overfull.

Assessing and responding to patient risk

The service was not doing all it could to remove or minimise risks to patients. Nationally recognised tools and guidance were not always being used in a way that minimised risk.

The service did not always share key information to keep patients safe when changes were made to the theatre staff and the theatre list order. On the day of our inspection, the order of the theatre list and the anaesthetist were changed but this information was not updated on the printed theatre list. Changes to the theatre list without reprinting the list meant that all staff may not have been aware or updated on changes which posed a risk to patient safety. In addition, as the service did not save all versions of the theatre list, it meant records did not reflect the actual theatre activity and it could not be used reliably for traceability when supporting incident investigations.

From observation in theatres, we found that although the service had processes in place to keep people safe, they did not always follow them consistently. Theatres used the World Health Organisation (WHO) safety checklist for surgery. We observed some good practice where the consultant led the 'time out' portion of the checklist. However, on one occasion staff had already completed the 'sign out' checklist before it had been done. This failure to follow the correct process placed patients at risk.

Not all staff clearly understood the services policy on admission criteria for accepting patients whose body mass index (BMI) was over 40. The hospital had an admission criteria policy which indicated the hospital would consider suitability of a patient with a BMI of more than 40 which would require an extended recovery unit which the service did not have. It also did not have access to bariatric equipment which placed this group of patients and staff at risk of injury or harm. The hospital policy states patients with BMI of 35 or greater must be discussed with the anaesthetist. However, staff told us anaesthetic input was not always available during the pre-operative assessment and that consultants sometimes agreed to take patients with a BMI 40 or greater with anaesthetic input or an anaesthetic assessment. Following the inspection, senior staff told us patients who require an anaesthetic review would have one after the pre-assessment appointment. Due to the operating model anaesthetists are not always available on the day of the pre-assessment appointment. At the time of our inspection, the service did not audit the anaesthetic review as part of pre-operative assessment. However, there was a review underway of the pre-operative assessment process and the service planned to include the anaesthetic review in the revised audit tool.

Staff used the national early warning system (NEWS) tool to identify deteriorating patients. Records we reviewed showed that NEWS scores were calculated correctly. However, when NEWS scores were high, they were not always escalated to the right healthcare clinician or in a timely manner. Following the inspection, the service provided a report summarising the

number of incidents involving patient deterioration for a seven-month period from March 2021.This showed on all occasion’s patients were assessed and had their care escalated in a timely manner. There was a service level agreement (SLA) with a local trust for the transfer of care of critically ill patients. However, most staff we spoke with were not aware of this agreement.

On the ward, shift changes and handovers included all necessary key information to keep patients safe. Staff grades of all levels knew their part to play identifying and responding to sepsis.

The patient’s health records included a surgical booklet with a range of risk assessments including falls, moving and handling, bed rail, pressure ulcer assessments. These were all completed, and any issues identified during these assessments had an action plan developed to mitigate the risk. The pre-admission checklists identified any communication needs such as requiring an interpreter to ensure individual patient needs were met.

Nurse staffing

The service’s nursing and support staff had the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. However, the service had several vacancies. Managers regularly reviewed and adjusted staffing levels and skill mix, and gave bank and agency staff a full induction.

The service had a 20% vacancy rate in theatres with some posts reportedly difficult to recruit to. To mitigate this risk, the service used one agency to provide staff, and if possible, these staff were employed on a line of shifts to reduce the number of agency staff used and improved continuity of care. In theatres, the service had been successful in recruiting several new nurses but at the time of inspection they had not commenced in post. There were no vacancies on the surgical ward.

Managers accurately calculated and reviewed the number and grade of nurses, nursing assistants and healthcare assistants needed for each shift. The ward manager could adjust staffing levels daily according to the needs of patients. The service staffed the ward and theatres appropriately to ensure the right staff were on site to provide appropriate care and treatment.

Managers made sure bank and agency staff had a full induction. However, in theatres, bank and agency staff did not always follow the local policies, for example entering checks in the anaesthetic logbook. The service was looking at ways to improve communication with bank and agency staff and reinforce policies and procedures.

Medical staffing

The service had enough medical staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix and gave locum staff a full induction.

The service had enough medical staff to keep patients safe. There was a resident medical officer (RMO), with the relevant experience on site 24 hours, seven days a week with on-call access to patients’ consultants during evening and weekends. Managers made sure locums had a full induction to the service before they started work.

Good

Surgery

The service had processes in place for consultants applying for practicing privileges at the hospital. The service had a medical advisory committee (MAC) for governance of doctors working in the service to ensure they continued to meet the standards to practice at the hospital.

Records

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

When patients transferred to a new team, staff could easily access their records. Staff requested records from medical records which were supplied to them in a timely way. Records were stored securely in a locked room only accessible to authorised staff.

Patient records were comprehensive. All records we reviewed were legible with evidence of completed risk assessments. All surgical patient records we saw had a fully completed WHO check list, a discharge checklist and evidence a post-operative call 48 hours post the procedure had been made. The discharge letter was sent to the patient and GP and included post-operative instructions.

Medicines

The service used systems and processes to safely prescribe, administer and record medicines. However, medicines were not always stored in line with the service's policy.

Staff followed systems and processes when safely prescribing, administering and recording medicines. On the ward, all medicines we checked were within date and stored appropriately. However, in theatres we saw that medicines drawn up for anaesthetics were not always stored in line with the service's policy. Following our inspection, the managers told us they were reminding staff of the importance of securely storing medicines between patient procedures.

The service had an onsite pharmacy with availability Monday to Saturday and processes in place to access the pharmacy out of hours. Records reviewed showed allergies were documented, prescriptions were signed for in line with the medication's management policy and antibiotics were prescribed as per guidelines and reviewed appropriately. The service had systems to ensure staff knew about medicine safety alerts and incidents, so patients received their medicines safely. A range of medicine audits were undertaken to ensure compliance with local and national guidance, with results discussed at the medicine management committee. Minutes from this committee indicated appropriate actions were taken where any issues were identified.

Incidents

Staff recognised and reported incidents. Managers investigated incidents and shared lessons learnt with the team. However, not all staff were aware of incidents and learning across the service. When things went wrong, staff apologised and gave patients honest information and suitable support. Managers ensured that actions from patient safety alerts were implemented and monitored.

Staff knew what incidents to report and how to report them using an electronic incident reporting system. They raised concerns and reported incidents and near misses in line with the provider's policy. The service had two hospital acquired surgical site infections and one never event in theatres between August 2020 and July 2021. Staff received feedback from investigations of incidents that had occurred both internally and other BMI hospitals. However, there was variable

understanding and learning from never events and incidents that had occurred within the service and in other organisations. Not all staff were able to articulate what had been learnt from incidents they described or how processes had changed to prevent incidents from happening again. Staff understood their duty in being open and honest when things went wrong and apologising.

Safety thermometer

The service used monitoring results well to improve safety.

The service continually monitored safety performance. The hospital had a system to monitor pressure ulcers, falls, venous thromboembolism (VTE) and infection rates. Staff used the data to further improve services.

Are Surgery 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-based practice. Staff protected the rights of patients in their care

Staff followed up-to-date policies to plan and deliver high quality care according to best practice and national guidance. Managers followed an audit programme linked to best practice standards and guidance, such as National Institute for Health and Care Excellence (NICE) guidance, General Medical Council (GMC) good medical practice, and the Nursing and Midwifery Council (NMC) professional standards of practice. All policies we sampled were regularly reviewed and included appropriate references to relevant national guidance.

Nutrition and hydration

Staff gave patients enough food and drink to meet their needs and improve their health. The service planned for patients' religious, cultural and other needs. Staff did not always follow national guidelines to make sure patients fasting before surgery were not without food for long periods.

Staff fully and accurately completed patients' fluid and nutrition charts where needed. Staff used a nationally recognised screening tool to monitor patients at risk of malnutrition. Specialist support from staff such as dietitians was available for patients who needed it. On the wards and in recovery, staff made sure patients had enough to eat and drink. Patients were offered a meal and beverages of their choice that met their individual needs.

We saw that staff did not always follow best practice or the service's policy on making sure patients did not fast too long before surgery. We observed a patient who had been without fluids for five hours before their operation due to the order of the theatre list being changed. The service conducted quarterly audits for fasting times. An audit from October 2020 to

December 2020 showed 70% compliance and we saw evidence the service put an action plan in place to improve compliance. The two audits following showed improvement with 100% compliance with the service's policy on fasting times. Following the inspection senior staff told us they have implemented a daily review of case complexity of all theatre lists to ensure patient order is reviewed as mitigation so patients should not be without fluids longer than necessary.

Pain relief

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

Staff assessed patients' pain and gave pain relief in line with individual needs and best practice. Patients we spoke with said their pain was well-controlled and they received pain relief soon after requesting it. Staff prescribed, administered and recorded pain relief accurately. The service monitored pain relief through regular audits which showed 99% compliance with the service's goals to safely prescribe and manage pain.

Patient outcomes

Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for patients. The service had been accredited under the Association for Perioperative Practice (AfPP).

The hospital submitted data to national audit programmes such as the national joint registry (NJR) to help improve patient safety. The service collected information on patient reported outcome measures (PROMs) for hip and knee replacements. PROMs use patient questionnaires to assess the quality of care and outcome measures following surgery. The service submitted outcome data to the Private Healthcare Information Network (PHIN) and outcomes for patients were overall positive and met national standards. The service had an established and clear pathway for patients undergoing joint replacement to support their outcomes after surgery.

Managers and staff participated in the service's audit programme which demonstrated compliance and identified areas for improvements to improve patient care. treatment and outcomes. Managers shared and made sure staff understood information from the audits.

The service was accredited by the Association for Perioperative Practice (AfPP) in April 2021, demonstrating it met national standards and recommendations for safe perioperative practice.

Competent staff

The service made sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and development.

Staff were qualified and had the right skills and knowledge to meet the needs of patients. Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge, specialist training for their role.

Good

Surgery

All new staff participated in an induction tailored to their role before they started work and were supported to develop through yearly appraisals of their work. Staff stated they were able to access training courses to support their professional development. The service had recently recruited a clinical educator to support the learning and development needs of staff. Managers identified poor staff performance promptly and supported staff to improve.

Managers ensured staff attended team meetings or had access to full notes when they could not attend.

Multidisciplinary working

In wards and theatres, doctors, nurses and other healthcare professionals worked together as a team to benefit patients. They supported each other to provide good care. However, there was room for improvement in multidisciplinary working in pre-operative assessment.

Multidisciplinary team (MDT) work was recorded in patient notes. However, we observed staff did not complete a debrief in theatres following procedures. This meant the service missed an opportunity to discuss team performance in a constructive, supportive environment to improve patient safety.

In pre-operative assessment there was not a consistent approach to multidisciplinary team working. Staff told us consultants and nursing staff did not always agree on the admission criteria and there was not consistent anaesthetic input when accepting patients with higher risk. They also said they did not always feel supported by consultants and managers to follow the service's policy for admission criteria. This meant that sometimes consultants would accept a patient for a procedure but when they arrived at the hospital they might be cancelled if they were too high risk for theatres. Staff told us there was room for improvement in learning from patient cancellations but there was no MDT meeting for this to happen. Following the inspection senior staff told us patient cancellations were discussed at the monthly clinical governance meeting. We reviewed the minutes for May 2021, June 2021 and August 2021 and found patient cancellations were not discussed. Senior staff told us a weekly patient admission meeting was held and was now MDT. The meetings were not minuted but the provider sent the attendance list which showed representation from all services, however consultants did not attend.

Seven-day services

Key services were available seven days a week to support timely patient care.

Consultants were available either during the daily ward rounds, including weekends or on call 24 hours a day. Staff could call for support from doctors 24 hours a day, seven days a week.

The service could access physiotherapy seven days a week and occupational therapy was available according to patient need. There was an out-of-hours on-call rota for diagnostic imaging. However, for emergent out-of-hours imaging needs, staff would call an ambulance.

Health promotion

Staff gave patients practical support and advice to lead healthier lives.

Staff assessed each patient's health on admission and provided support for any individual needs to live a healthier lifestyle. The service supported patients to be as fit as possible for surgery. Patients having joint surgery, such as for hip or knee replacement, would see a physiotherapist on a one to one basis with tailored information specific for the patient. Patients were given pre-operative and post-operative exercises and assessed for need of occupational therapy or support from social services.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients' consent. However, there was no clear process to ensure patients were given enough information to understand the risks related to anaesthetics.

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. Staff gained consent from patients for their care and treatment in line with legislation and guidance. Records reviewed showed staff clearly recorded consent in the patients' records. However, there was no clear process to ensure patients were given enough information to understand the risks relating to anaesthetics. Most staff we spoke with could not confirm if patients were given information leaflets before their procedure to ensure they provided informed consent.

Staff received and kept up to date with training in the Mental Capacity Act and Deprivation of Liberty Safeguards. Staff could describe and knew how to access policies and get accurate advice on Mental Capacity Act and Deprivation of Liberty Safeguards.

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

Compassionate care

Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.

Staff were discreet and compassionate when caring for patients. Staff took time to interact with patients and those close to them in a respectful and considerate way. Patients said staff treated them well and with kindness and anticipated their needs. Staff told us communication was a key factor in making sure patients felt cared for in a compassionate way.

Staff followed the service's privacy and dignity policy to keep patient care and treatment confidential. On inspection, we observed all care and treatment of patients was undertaken in a way to maintain the patient's dignity. Staff understood and respected the personal, cultural, social and religious needs of patients and how they may relate to care needs.

Emotional support

Staff provided emotional support to patients, families and carers to minimise their distress. They understood patients' personal, cultural and religious needs.

Staff gave patients and those close to them help, emotional support and advice when they needed it, for example supporting patients who experienced anxiety with surgical procedures. The service offered treatment plans in line with the patients' wishes. We saw evidence in patient records where staff supported a patient with anxiety and developed a treatment plan tailored to their needs.

Staff understood the emotional and social impact that a person's care, treatment or condition had on their wellbeing and on those close to them. Staff told us they were mindful of their non-verbal communication with patients and how they could help patients feel more at ease through their interactions.

Understanding and involvement of patients and those close to them

Staff supported and involved patients, families and carers to understand their condition and make decisions about their care and treatment.

Patients and their families could give feedback on the service and their treatment and staff supported them to do this. Patients could provide feedback in the hospital or at home; they gave positive feedback about the service overall. The service had received several thank you cards, and some were displayed on the ward. Patients we spoke with were very positive about the staff, food, and outcomes of their care.

Staff communicated with patients about their care and treatment in a way they could understand. Patients told us staff were thorough when explaining what would happen and they had enough time to ask questions. Patient records showed discussions had taken place about the potential risk and complications of surgery, as well as the benefits and alternative treatment available. Staff supported patients to make informed decisions about their care.

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 care in a way that met the needs of the people it served. It also worked with others in the wider system and local organisations to plan care.

Managers planned and organised services to meet the needs of those who chose to use the service. Admissions to the surgical ward were all elective and planned in advance. In response to the Covid-19 pandemic, the service had taken on some NHS work to support elective surgical services at a nearby local NHS trust. There was also a service level agreement (SLA) with another local NHS trust to provide a cancer surgery service.

Meeting people's individual needs

The service was inclusive and took account of patients' individual needs and preferences. Staff made reasonable adjustments to help patients access services. They coordinated care with other services and providers.

Good

Surgery

Managers made sure staff, and patients, families, and carers could get help from interpreters or signers when needed. At the time of booking, staff flagged if the patient required an interpreter. This meant interpreters support was planned for each part of the patient journey. Patients with hearing or sight impairments were flagged during pre-operative assessment, which meant staff could ensure patients could access information according to their needs. Staff could provide leaflets in 'larger print'. An assistive listening device was available at reception to support patients with hearing impairment.

Access and flow

People could access the service when they needed it and received the right care promptly. The service did not always meet referral to treatment targets in line with national standards.

The service offered treatment for NHS patients but did not always meet the national 18-week referral to treatment target. Managers had a system to monitor where they would not meet the targets and made plans for patients to receive care as soon as possible. Staff supported patients when they were referred or transferred between services. Managers worked to minimise the number of surgical patients on non-surgical wards. When patients had their operations cancelled at the last minute, managers made sure they were re-arranged as soon as possible.

Managers and staff started discharge planning as early as possible, ensuring patients did not stay longer than they needed to. Managers monitored the number of delayed discharges and took action to prevent them.

Learning from complaints and concerns

It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learnt with all staff. The service included patients in the investigation of their complaint.

Patients, relatives and carers knew how to complain or raise concerns. The service clearly displayed information about how to raise a concern and for patients on how to provide feedback to the service. Staff understood the service's complaints policy and knew how to effectively manage these including reporting complaints through the electronic reporting system, acknowledging a complaint and how to escalate if necessary.

The service treated concerns and complaints seriously, investigated them and learnt lessons from the results. Managers aimed to resolve patient complaints at the point of care to improve the patient's experience. Patients and staff received feedback from managers once the complaint investigation had been concluded and the learning was used to improve the service. For example, the service identified a trend of complaints around delayed discharge, the root cause was identified as delays in the dispensing of to-take-away (TTA) medications. Changes were made to address and improve processes with TTAs.

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

Leadership

Good

Surgery

Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff. They supported staff to develop their skills and take on more senior roles.

The hospital was led by a senior management team consisting of an executive director (ED), director of clinical services and an operations manager. Surgical services had a theatre manager and a ward manager. The service also had a lead infection prevention and control (IPC) nurse and a clinical educator. Although there was no quality and risk manager in post at the time of our inspection, it did not impact negatively on risk management as this was overseen by the director of clinical services.

Staff told us their managers were very supportive and encouraged their career progression. All levels of staff told us the executives were visible, accessible and supportive. Leaders worked together to support and improve patient safety and patient experience.

Vision and Strategy

The hospital had a vision for what it wanted to achieve and a strategy to turn it into action.

There was no specific vision and strategy for surgical services, however the hospital had identified values and a vision. The vision and values were still in the process of being embedded but staff were aware of them. Staff told us to exemplify the values they put the patient first, were striving for excellence and were putting measures in place to get it right. There was also a focus on good communication and promoting an environment that supports reporting and learning from incidents.

Culture

Staff were focused on the needs of patients receiving care. The service had an open culture where patients and staff could raise concerns without fear.

Staff we met were welcoming, helpful and friendly. Staff told us they worked in a supportive environment and they were able to speak up about concerns and were supported by managers to do this. The hospital had a freedom to speak up guardian to ensure staff could raise concerns in a safe and supportive way. Staff understood duty of candour and the need to be open and transparent and give patients and families a full explanation when things went wrong.

Governance

Leaders operated effective governance processes, throughout the service and with partner organisations. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.

The service's hospital governance and clinical governance committee met monthly. The three sets of committee meeting minutes reviewed all included evidence of audit feedback, incidents and complaints, information security, policies, the risk register and business continuity being regularly discussed. Subcommittee reports, such as those from safeguarding, medicines management, and infection prevention and control (IPC) fed into the hospital governance meetings. Theatres was noted to have effective risk management strategies and a commitment to patient safety.

Good

Surgery

There were regular, monthly, staff meetings for theatre and ward staff. Staff meetings were recorded and regularly discussed key topics, such as safeguarding, staffing, quality and risk, IPC, and learning from incidents.

The medical advisory committee (MAC) had good representation of different specialities and met regularly. The MAC provided effective oversight of doctors with and those applying for practicing privileges at the hospital.

Management of risk, issues and performance

Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events.

The service maintained a risk register, that documented the type of risk, location, risk rating, owner, review date, description and controls in place. The hospital governance and clinical governance committee met monthly to discuss the risk register and update the action plan. At the time of our inspection, the director of clinical services was responsible for the risk register as there was a vacancy for the role of quality and risk manager.

Staff we spoke with were able to identify risks in the service and what actions were being taken to minimise the risk. The service had plans to cope with unexpected events, including adverse reactions during procedures. The service collected performance data through patient reported outcome measures (PROMs).

The provider had a system for managing critical safety alerts. They acted upon safety alerts and reviewed the practice in line with recommendations to ensure alerts' recommendations were complied with and risks were minimised.

Information Management

The service managed and used information well, using secure electronic systems and paper records.

Patient information and records were stored securely in all areas we visited. Staff received information governance awareness training and followed a policy to keep patient information safe and secure. However, staff told us they found the paper record system to be cumbersome and repetitive, meaning they spent a lot of time completing documentation.

Staff could find the data they needed. In theatres, staff felt there could be better use of the anaesthetic machine to print data in real time to support their practice.

Data or notifications were consistently submitted to external organisations as required.

Engagement

Leaders engaged with patients and staff to plan and manage services. They collaborated with partner organisations to help improve services for patients.

The service worked with local NHS trusts to meet the needs of the local population. The service asked all patients to complete a provider feedback questionnaire about their experience. They were also encouraged to complete reviews on search engine websites. The service reviewed and monitored patient satisfaction through their quality improvement committee and created an action plan to address trends from feedback.

Good

Surgery

Staff were able to give feedback through an annual staff survey. The survey from March 2021 had a good participation rate of 68%. There was evidence of an action plan directly derived from the results of the staff survey, actions included expanding the benefits package, improving the offering of wellbeing services and introducing a recognition programme. Staff were aware of the actions taken in response to their feedback and were optimistic about improvements being made. However, as deadlines for the action plan were in the future, we could not assess how successful staff found its delivery.

Learning, continuous improvement and innovation

Staff were committed to continually learning and improving services.

Managers were responsive to feedback from patients and staff and worked to improve services. In theatres, staff made safety improvements based on recommendations to achieve Association for Perioperative Practice (AfPP) accreditation. The service aimed to recognise and resolve issues at the source, share and act upon areas for improvement, and continuously innovate and adapt. The service empowered staff to feel like they could make a difference and that their contributions were valued.

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
Surgical procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment • The national early warning score (NEWS) was not always calculated accurately. • NEWS scores were not always escalated in line with the provider's policy and clearly documented in patient's notes. • The anaesthetic machine was not always checked in line with the provider's policy and there was not always evidence recorded in the logbook of these checks. • The surgical safety checklist (WHO) was not always correctly documented as each stage was completed and there was evidence it had been completed before steps had been carried out. • The surgical admission policy in relation to body mass index (BMI) was not always followed. • There was evidence that changes made to the order of the theatre list was not updated and re-printed.