BMI The Chiltern Hospital

Quality Report

London Road, Great Missenden, Buckinghamshire.
HP16 0EN
Tel:01494 890890
Website: www.bmihealthcare.co.uk/hospitals/bmi-the-chiltern-hospital

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

Ratings

Overall rating for this location

Requires improvement 

Summary of findings

Letter from the Chief Inspector of Hospitals

BMI The Chiltern Hospital opened in March 1982 and is part of BMI Healthcare. The Chiltern Hospital is part of the BMI South Buckinghamshire Hospitals group. The senior management is shared between this hospital and two other services. We inspected one of these services, The Shelburne Hospital at the same time as The Chiltern Hospital.

The Chiltern Hospital has 66 inpatient beds with 55 in use, which are divided between three wards. These are Misbourne Ward, the oncology and endoscopy unit; Chalfont Ward for in-patients and for day cases and short-stay Shardeloes Ward.

The operating department consist of three theatres. In out patients there are 11 consulting rooms with the additional supporting services of audiology, a minor operations room, colposcopy and treatment rooms. The hospital also provides pathology service, has a radiology department providing x-rays, ultrasound scans, Computerised Tomography (CT), Magnetic Resonance Imaging (MRI), bone density scanning, and mammography, a physiotherapy department with a hydrotherapy pool, and pharmacy.

The hospital provides a range of services to patients who are self-funded or use private medical insurance. Some treatment was available for NHS funded patients through the NHS e-Referral Service. Services include general surgery, orthopaedics, cosmetic surgery, ophthalmology, ENT, gynaecology and urology, oncology, physiotherapy and diagnostic imaging. The hospital was not providing services for children and young people.

The executive director, had recently moved from another hospital within the group, was applying to become the registered manager. They were supported by a director of clinical services, a director of operations and a team of heads of departments.

We inspected the hospital as part of our planned inspection programme. This was a comprehensive inspection and we looked at the three core services provided by the hospital: medicine, surgery, outpatients and diagnostic imaging.

The announced inspection took place on 26 and 27 July and an unannounced visit on 1 August 2016.

The hospital was rated good for caring and responsive and requires improvement for safe, effective and well-led services.

Our key findings were as follows:

Are services safe at this hospital?

By safe, we mean people are protected from abuse and avoidable harm.

- Staff were clear about their responsibilities to report incidents, however the process for the management of reported incidents was not robust and investigations and the sharing of learning did not always take way in a timely way.
- Processes to protect people from harm, such as infection control, the safe handling of medicines and equipment safety checks were being followed. However staff in theatres did not always follow systems and processes to keep patients safe.
- Patients were assessed and action was taken in response to risk. This included the assessment of patients to ensure only patients who the hospital could safely support received treatment.
- Patient records were stored securely. However, medical staff did not always achieve the required minimum standard of documentation in patient records.

Summary of findings

- Staff were aware of safeguarding and were clear about their responsibilities to safeguard people at risk. However training to safeguard children was not currently being provided to the level described in the hospitals policy or safeguarding children and young people: roles and competencies for health care staff Intercollegiate document : March 2014.
- In general staffing levels and skill mix were planned, implemented and reviewed to keep people safe at all times. This was not the case for the operating departmentwhere staffing levels were not always in line with national guidance. Staff in the operating department were also undertaking dual roles without the support of a local hospital policy or risk assessments.
- The hospital compliance target for mandatory training was 85%. As of April 2016, compliance with mandatory training for staff working at the hospital was less than 50% compliant.
- There was a good understanding of the principles of the duty of candour, and the need to be open and honest.

Are services effective at this hospital?

By effective, we mean that people's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence.

- Patients' care and treatment was planned and delivered using evidence based guidance.
- Most staff were qualified and had the skills needed to carry out their roles effectively. Some theatre staff were undertaking the role of surgical first assistant without fully completing a recognised competency based course. There was no assurance that staff were competent to undertake the role.
- There was good multidisciplinary working across all teams in the hospital so patients received co-ordinated care and treatment.
- The hospital provided care to inpatients seven days a week, with access to diagnostic imaging and theatres via an on-call system.
- Staff had access to the information needed to assess, plan and deliver care to people in a timely way.
- Consent to care and treatment was obtained in line with legislation and guidance, and staff had an understanding of the principles of the mental capacity act.
- The hospital had systems in place for granting practicing privileges to consultants and when necessary suspended or removed these. However, the process for the biennial reviews was not being effectively managed.
- The hospital routinely collected and submitted data on patient outcomes. Although senior staff discussed this information at regional level, there was no evidence of how the hospital shared and used the information locally to improve outcomes for patients.

Are services caring at this hospital?

By caring, we mean that staff involve and treat people with compassion, kindness, dignity and respect.

- Nursing, theatre and medical staff were caring, kind and treated patients with dignity and respect.
- Patients felt they received sufficient information about their planned treatment and were involved in decisions about their care.
- Patients consistently told us they would recommend the service to friends and family.

Are services responsive at this hospital?

Summary of findings

By responsive, we mean that services are organised so they meet people's needs.

- The hospital planned and delivered services in a way that met the needs of the local population. The importance of flexibility and choice was reflected in the service.
- Patients had timely access to initial assessment, diagnosis and urgent treatment at a time to suit them.
- The needs of different people were generally taken into account when planning and delivering services including cultural, language, mental or physical needs. The service had strict selection criteria to ensure only patients whom the hospital had the facilities to care for were referred
- Discharge arrangements were planned but flexible, and care was provided until patients could be discharged safely.
- The hospital dealt with the majority of complaints promptly, and there was evidence that the complaints were discussed amongst staff. Complaints were used to improve the quality of care.

Are services well-led at this hospital?

By well-led, we mean that the leadership, management and governance of the organisation assures the delivery of high-quality person-centred care, supports learning and innovations and promotes an open and fair culture.

- There was a corporate vision in place, supported by a hospital business plan. Senior managers were aware of the key risks that may affect them achieving the vision.
- Governance processes were not always effective in monitoring the quality and safety of the service at a local level. Practices were taking place in the operating department that were not reflective of corporate polices or current national guidance.
- Managers and staff did not use the hospital risk register effectively to identify and manage risks within the service and there were no risk register at department level.
- The lack of a consistent and experienced theatre manager to lead and manage the operating department had resulted in no-one taking clear accountability and responsibility for the quality and development of the service. Local leadership was being developed with some department managers being new to the organisation.
- Heads of department found the daily senior team meeting an effective way to share key information with them.
- Staff felt they supported each other well in their teams and this had helped during a number of senior staffing changes at the hospital.
- They valued the changes the new executive director had made, particularly improving the appearance of the hospital and listening to their concerns.

After the inspection the provider was issued with a requirement notice letter, as we had identified potential failings to comply with two regulations relating to good governance and staffing; the detail of which is contained within the report and listed in the must actions at the end of the report. We asked the provider to submit an action plan to show how they would address these concerns and demonstrate how they would reduce the associated risks to patients and staff. The provider submitted a detailed action plan within the agreed timeframe which we felt was sufficient to comply with the requirement notice. A responsible person was allocated to each action, with a date for completion. Compliance with the action plan will be monitored through regular engagement meetings with the provider.

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

Importantly, the provider must:

Summary of findings

- The provider must ensure that all staff acting as a surgical first assistant have been assessed as competent for the role. In addition, the evidence of completed competencies and log of cases should be available in accordance with the BMI Healthcare Surgical First Assistance policy.
- The provider must ensure it completes regular reviews of compliance with BMI Healthcare policies, with action taken for areas of non-compliance, including the renewal of practising privileges.
- The provider must ensure that staffing levels in theatres are in line with current national guidance and the BMI Healthcare policy.
- The provider must ensure when staff are undertaking a dual role this is supported by a local policy and risk assessment.
- The provider must ensure staff in the operating theatre fully comply with the Five Steps to Safer Surgery at all times.
- The provider must ensure there is robust monitoring of the safety and quality of the surgery service at a local level, with risks identified and timely action taken to manage the risks.
- The provider must ensure the hospital risk register reflects the current risks faced by the hospital and in sufficient detail to show how they are monitoring the risks.
- The provider must ensure there is robust monitoring of the safety and quality of the outpatients and diagnostic imaging service at a local level, with risks identified and timely action taken to manage risks.
- The provider must ensure that all incidents are monitored at each hospital and individual clinical location to be able to identify trends.

In addition the provider should:

- The provider should ensure a trend analysis of all incident reports is completed, with action plans devised as a result.
- The provider should ensure all patient chairs have a wipeable surface to ensure they can be appropriately cleaned.
- The provider should ensure all floors in the operating department are kept clear so they can be cleaned and there are no trip hazards to staff.
- The provider should ensure all areas in the operating department meet fire safety regulations.
- The provider should ensure all patient care records are completed in full, by the multidisciplinary staff providing care and treatment
- The provider should ensure all staff are up-to-date with all of their mandatory training.
- The provider should ensure all staff complete safeguarding children training appropriate to their role.
- The provider should ensure all the key recommendations of the Perioperative Care Collaborative Statement on Surgical First Assistants have been considered, with action taken as indicated.
- The provider should ensure patient surgical outcome data is shared and discussed at relevant departmental meetings so changes can be made to practice where necessary.
- The provider should ensure for all audits there is a clear action plan, with accountability for completion of any actions, by an agreed date.
- The provider should ensure all theatre staff receive an annual appraisal.
- The provider should ensure formal written on-call arrangements are in place for all relevant teams.

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- The provider should ensure the gastroenterologists explain to patients the need for possible transfer to the NHS hospital should complications from the procedure occur.
- The provider should consider arranging an external review of its theatre service to seek an independent review of the standards of the service.
- The provider should consider reviewing the layout of the changing rooms in diagnostic imaging to ensure it meets the needs of all patients.
- The provider should consider displaying safety thermometer information in all clinical areas as considered best practice.
- The provider should train staff in line with the BMI Safeguarding Children policy. All staff who have some degree of contact with children should complete a minimum of level 2 safeguarding training.

The provider should consider formalising arrangements for diabetic specialist nurses from the NHS to assess and treat patients at both the Chiltern and Shelburne hospitals

Professor Sir Mike Richards Chief Inspector of Hospitals

Professor Sir Mike Richards
Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Medical care	Good 	We found evidence that medical services were 'good' for safe, and 'good' for effective, caring, responsive and well led. All areas of the service we visited were visibly clean, systems were in place to ensure nurses, medical, and domestic staff adhered to infection control policies and procedures. In clinical areas, we observed all staff were bare below the elbows. Care and treatment took account of current legislation and nationally recognised evidence-based guidance. Policies and guidelines were developed organisationally and locally to reflect national guidance. Feedback from patients about their care and treatment was consistently positive. We observed staff treat patients courteously and respectfully with kindness, compassion and dignity throughout our visit. Staff respected patients' privacy and confidentiality at all times. Patients told us they felt informed about their treatment and were included in decisions about their care. Staff told us anxious patients or patients with a learning difficulty given the opportunity to visit the treatment area before their treatment and care commenced. Patients had a comprehensive assessment of their needs. The clinical staff monitored patients' pain levels regularly and responded appropriately with a variety of methods for pain relief. Patients told us they had adequate and timely pain and sickness relief. Staff were aware of the values of the organisation and were passionate about good patient care. Staff were actively engaged so that their views were reflected in the planning and delivery of services and in shaping the culture
Surgery	Requires improvement 	We rated this service as requires improvement because:

Summary of findings

Staff in theatres were not always adhering to systems and processes designed to keep patients safe and to ensure staff were working in accordance with corporate policies and relevant national guidance.
Staff acting as a surgical first assistant had not been competency assessed and this additional role was not included in their job description. They were not rostered to complete this role as an additional member of the theatre team. Therefore, theatre staffing was not always in line with national guidance and staff were acting in a dual role without a local policy or risk assessments to support them.
We observed staff not always completing the Five Steps to Safer Surgery in full and the outcomes from hospital observational audits in theatres had not been shared with staff to encourage learning and changes to practice.
There was insufficient monitoring of the quality and risks of the service at a local level. There had been a change of theatre manager twice in the last year and at the time of the inspection, there was no theatre manager in place. Concerns identified by senior staff tended to be shared at regional level but this information was not always cascaded back to frontline staff to enable them to develop and improve their service. The hospital wide risk register was not in sufficient detail to provide assurance on how risks were monitored and by whom. Although audits were completed there were no detailed action plans, showing who was responsible for monitoring areas of non-compliance.
Across the hospital, there were delays in managers investigating incidents and the hospital was significantly behind on some of its biennial clinical reviews for consultants practising privileges.
Across the service there was limited monitoring of compliance with hospital policies.
The hospital was not compliant with its mandatory training target of 85% for around 65% of the training courses staff needed to complete. Staff found there were sometime delays accessing

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practical based courses There was a high use of agency staff, across the service, to ensure safe staffing levels due to difficulties with recruitment and retention of staff.
The hospital collected patient outcome data and submitted this to a number of national databases but the hospital did not use this data locally to keep staff informed about how effective care and treatment had been. Staff involved in the surgery service did not meet as a whole team to discuss outcome data, although the hospital had just introduced a theatre user group who would consider the quality of the service.
However: We saw staff providing compassionate care and treatment to patients. Nursing, theatre and medical staff were caring, kind and treated patients with dignity and respect. Patients felt they received sufficient information about their planned treatment and were involved in decisions about their care. Patients consistently told us they would recommend the service to friends and family.
Areas we visited were visibly clean and tidy and we saw staff following good infection prevention and control practices.
Patients told us the booking, admission and discharge process had all been prompt and efficient, they felt fully informed at each step in the process. Although, waiting times for surgery for NHS patients did not always achieve the 18-week referral to treatment time indicator.
There was good multidisciplinary working across all teams in the hospital so patients received co-ordinated care and treatment. Patients' care and treatment was planned and delivered using evidence based guidance. Nursing staff completed risk assessments for patients. In the event that a patient became unwell, there were systems in place for staff to escalate these concerns and refer the patient to another hospital if necessary. The hospital provided care to inpatients seven days a week, with access to diagnostic imaging and theatres via an on-call system.
Staff felt they supported each other well in their teams and this had helped during a number of

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senior staffing changes at the hospital. They valued the changes the new executive director had made, particularly improving the appearance of the hospital and listening to their concerns.

Outpatients and diagnostic imaging

Requires improvement 

We rated this service as requires improvement because:
The incident reporting system used by the hospital at the time of the inspection was not robust. There was a delay in the investigation and closure of incidents. Although the hospital addressed the delay after the inspection. There was a lack of assurance who had oversight for timely investigations and that the hospital had implemented any learning quick enough to ensure patient safety. Managers and staff could not accurately describe the trends of incidents or learning in their department and staff did not always receive feedback on incident reports.
The diagnostic imaging department could not provide assurance staff always practised within Ionising Radiation (Medical Exposure) Regulations (IRMER). In the diagnostic imaging department, staff did not always perform patient safety and identification checks prior to carrying out a radiation scan. A consultant did not document dosage levels when using the image intensifier in theatre although the hospital had written to the consultant three times there was no evidence of improvement.
There was new management across departments who were still familiarising themselves with the service, departments and hospital. The outpatients department had recently appointed a new manager who had not yet commenced in post and the outpatient manager was acting up as manager in an interim role. At the time of our inspection, managers did not demonstrate an understanding of the risks or clear oversight of the governance processes to monitor the quality standards of the service.
There was no departmental risk register and therefore the hospital could not provide assurance that departments managed key concerns in a

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timely way. The hospital risk register did not reflect the risks at a department level and was not in sufficient detail to outline how risks were monitored and by whom.
Not all staff completed mandatory training appropriate to their role. Not all staff knew how to recognise a child or adult at risk of abuse. The hospital had not provided safeguarding children training level two to some members of staff as required by their own corporate policy.
However:
Staff treated patients with dignity and respect and provided emotional support throughout their treatment. Staff helped patients to understand their condition or treatment by giving written information after their treatment and allowing time to ask questions. Patients could request to have a chaperone present during their examination or consultation if needed.

Summary of findings

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Services we looked at
Medical care; Surgery; Outpatients and diagnostic imaging;

Summary of this inspection

Background to BMI The Chiltern Hospital

BMI The Chiltern Hospital opened in March 1982 and is part of BMI Healthcare. The hospital has 66 inpatient beds with 55 in use, which are divided between three wards. These are Misbourne Ward the oncology and endoscopy unit; Chalfont Ward for in-patients and for day cases and the short-stay ward Shardeloes Ward.

The operating department consist of three theatres. In out patients there are 11 consulting rooms with the additional supporting services of audiology, a minor operations room, colposcopy and treatment rooms. The hospital also provides pathology service, has a radiology department providing x-rays, ultrasound scans, Computerised Tomography (CT), Magnetic Resonance Imaging (MRI), bone density scanning, and mammography, a physiotherapy department with a hydrotherapy pool, and pharmacy.

The hospital provides a range of services to patients who are self-funded or use private medical insurance. Some treatment was available for NHS funded patients through the NHS e-Referral Service. Services include general surgery, orthopaedics, cosmetic surgery, ophthalmology, oncology, ENT, gynaecology and urology, physiotherapy and diagnostic imaging. The hospital was not providing services for children and young people.

The executive director, had recently moved from another hospital within the group, was applying to become the registered manager. They were supported by a director of clinical services, a director of operations and a team of heads of departments. There are similarities in our findings and the content of both reports due to this and the overall management of the hospitals being the same.

We inspected the hospital as part of our planned inspection programme. This was a comprehensive inspection and we looked at the three core services provided by the hospital: medicine, surgery, outpatient and diagnostic imaging and services for children and young people.

Our inspection team

Our inspection team was led by:

Inspection Manager: Lisa Cook, Care Quality Commission (CQC)

The inspection team of 12 included an inspection manager, five CQC inspectors, an assistant inspector and four specialist advisers, a theatre nurse, outpatients nurse manager, governance lead, radiographer and a specialist doctor in gastroenterology. .

How we carried out this inspection

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

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

Before visiting, we reviewed a range of information we held about the hospital. We carried out an announced inspection visit on 26 and 27 July and an unannounced visit on 1 August.

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

Summary of this inspection

We would like to thank all staff for sharing their views and experiences of the quality of care and treatment at The Chiltern Hospital.

Detailed findings from this inspection

Good

Medical care

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

Information about the service

The Chiltern Hospital is part of the BMI South Buckinghamshire private Hospitals healthcare group. The senior management is shared between this hospital and two other services. We inspected one of these services, The Shelburne Hospital at the same time as The Chiltern Hospital. The hospital is registered for sixty-six inpatient beds

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

The BMI Chiltern Hospital policy was not to admit patients with primary respiratory or cardiac complaints. The ward occasionally admitted medical patients for blood transfusions or intravenous antibiotics for skin infections.

The hospital was working through the Joint Advisory Group (JAG) accreditation in the endoscopy unit.

There were 966 endoscopy procedures carried out during April 2015 to March 2016. The endoscopy unit consisted of a treatment room, a scope washer room, drying room and a segregated recovery area for three patients. Following the endoscopy procedure, all patients returned to the ward.

The oncology day-case unit was open Monday to Thursday 8am to 4pm and Friday 8am to 12pm. An on-call service runs 24 hours a day seven days a week for patients. On average 20 patients are treated per week with breast, colo-rectal, haematology and bladder cancers. The hospital has recently introduced an electronic prescribing of chemotherapy regimens. The hospital has a oncology lead nursing sister who is a dedicated breast care nurse along with a team of chemotherapy-trained nurses.

The oncology day unit had four en-suite rooms and a bay with "pods" with comfortable reclining chairs for four patients. The chemotherapy provided was intravenous or administered directly into the bladder via a catheter. The hospital did not treat NHS oncology patients. The vast majority of oncology patients funded through insurance. The minority were self-paying. Patients who were not eligible for treatment on the NHS or patients that chose to pay for drugs not available on the NHS self-funded their treatment.

During our inspection, we visited the wards, endoscopy, and oncology suite. We spoke with seven patients and two family members. We spoke with 19 members of staff including, consultants, nurses, endoscopy staff, senior engineer, ward administrators, the cleaning manager and team, physiotherapists, occupational therapists, and senior managers.

Throughout our inspection, we reviewed hospital policies and procedures, staff training records, audits and performance data. We looked at the environment and the equipment in use. We reviewed six sets of patient records and we observed interactions between staff and 11 patients.

Good

Medical care

Summary of findings

We found evidence that medical services were 'good' for safe, and 'good' for effective, caring, responsive and well led.

- All areas of the service we visited were visibly clean, systems were in place to ensure nurses, medical, and domestic staff adhered to infection control policies and procedures. In clinical areas, we observed all staff were bare below the elbows.
- Care and treatment took account of current legislation and nationally recognised evidence-based guidance. Policies and guidelines were developed organisationally and locally to reflect national guidance.
- Feedback from patients about their care and treatment was consistently positive. We observed staff treat patients courteously and respectfully with kindness, compassion and dignity throughout our visit. Staff respected patients' privacy and confidentiality at all times.
- Patients told us they felt informed about their treatment and were included in decisions about their care. Staff told us anxious patients or patients with a learning difficulty given the opportunity to visit the treatment area before their treatment and care commenced. Patients had a comprehensive assessment of their needs. The clinical staff monitored patients' pain levels regularly and responded appropriately with a variety of methods for pain relief. Patients told us they had adequate and timely pain and sickness relief.
- Staff were aware of the values of the organisation and were passionate about good patient care. Staff were actively engaged so that their views were reflected in the planning and delivery of services and in shaping the culture.

Are medical care services safe?

Good

By safe we mean that people are protected from abuse and avoidable harm

We rated safe as 'good' because:

- Staff assessed, managed and monitored risks to patients daily. Nurses used the national early warning score to identify patients whose condition might deteriorate and there were appropriate transfer arrangements of patients to a local NHS hospital if required.Staff were aware of the hospital's safeguarding process and were clear about their responsibilities to safeguard people at risk.
- Staffing levels and skill mix were planned, implemented and reviewed to keep people safe at all times. Any staff shortages were responded to quickly and adequately. There were effective handovers and shift changes, to ensure staff managed risks to people who used services.
- All clinical areas were equipped to provide safe care and were visibly clean. Regular infection control audits were completed in the endoscopy and oncology department and monitored by the infection control nurse.

However

- The incident reporting system used by the hospital at the time of the inspection was not robust. There was a delay in the investigation and closure of incidents staff had reported, although the hospital addressed the delay after the inspection. There was a lack of assurance who had oversight for timely investigations and that the hospital had implemented any learning quick enough to ensure patient safety.

Incidents

- Oncology and endoscopy staff was aware of how to report incidents and followed the hospitals adverse event /near miss reporting policy 2015. Hospital staff received training in completing the paper incident form. The sister or head of department reviewed the form and signed it off before sending to the quality and risk

manager to enter the details of the incident report onto the electronic system. The clinical manager role was to decide if the incident needs investigating and to sign off the incident once complete.

- At the time of our inspection, there was a delay in closing a total of 105 incidents across this hospital and a second hospital managed by the same team. The quality and risk team had to chase managersto complete investigations so they could record the outcome and close the incident. The senior management told us they had closed 100 of these incidents by 8 August 2016. The remaining five were within the 20-day timescale for the relevant department to investigate and report on the learning and outcomes. We had concerns the backlog had delayed the hospital applying learning and action, with a potential impact on safe care and treatment for patients.
- From March 2015 to April 2016 there has been no never events relating to medicines. Never events are a type of serious incident that are wholly preventable, where guidance or safety recommendations that provide strong systemic protective barriers are available at a national level,be implemented by all healthcare providers. However, there had been a never event in another part of the hospital. Staff told us lessons learnt discussed at ward meetings and included improving documentation. Minutes of clinical governance, ward meetings and medical advisory meetings confirmed this had occurred.
- From March 2015 to April 2016, there have been clinical incidents across both hospital sites. The quality of the content of incident reporting was satisfactory. However, the newly appointed executive director for both the Chiltern and Sherburne hospitals was open and honest and informed us of a priority action plan whichincluded ensuring each hospital and clinical locality had their own audit data to investigate trends and analysis. Of the incidents were categorised as no harm, 120 were categorised as low harm, were categorised as moderate harm, was categorised as severe and none were categorised as inpatient death.
- From March 2015 to April 2016, there were non-clinical incidents within other services and clinical incidents throughout the hospital. Staff told us one of the lessons learnt from a clinical incident in endoscopy was ensuring patients with a history of diabetes moved to the top of the list so they do not have to wait too long before receiving drinks and food.
- A staff nurse and a health care assistant discussed an example of shared learning, and confirmed by the clinical manager, which had improved; clinical practice following a recent medical equipment patient falls incident. Staff hot washed raised toilet seats in-between patients in the bedpan washer. Following the hot wash the rubber seals dislodged and when the patient used the equipment, they slipped and fell. The patient came to no harm. The clinical team discussed the incident with the infection control nurse and therapy team. The decision was that as patients have their own individual room to use single use toilet seats for each patient . The patient could take the seat home following discharge from the hospital and save further home assessments by the occupational therapy teamto fit a raised toilet seat. This meant no further hot washing was required and no further falls incidents have occurred. Staff were aware of this incident at the daily communication team meeting, monthly ward meeting, the medical advisory and the clinical governance committee.
- The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of 'certain notifiable safety incidents' and provide reasonable support to that person. All clinical staff we spoke with understands the duty of candour requirements for a written apology. All clinical staff told us they worked with the principles of the duty in mind, being open, offering verbal apologies and documenting errors in patient notes. An example of this was poor communication by a member of staff. This was dealt with immediately, and the patient informed directly they awoke from anaesthetic and a written apology sent by the senior consultant. Staff were aware of this incident at the monthly ward meeting, clinical governance meetings and at the medical advisory meeting.

Safety thermometer or equivalent (how does the service monitor safety and use results)

- The NHS Safety Thermometer is a local improvement tool for measuring, monitoring and analysing patient 'harm or harm free' care. The hospital collects data for

all patients and is only required to submit data for the NHS patients, which the hospital are caring for on the day of the data input. The submission included data on patient falls, pressure ulcers, catheter and urinary tract infections and these showed 100% harm free care for the past year (March 2015 to March 2016) totalling 27 NHS patients. The wards did not display the audit results as considered best practice. However, we saw minutes from clinical governance meetings to demonstrate clinical staff were aware of the audit findings.

- Staff routinely assessed patients for venous thromboembolism (VTE). The VTE screening rate was 100% from April 2016 to March 2016. There had been no incidents of hospital acquired VTE or pulmonary embolism over the same period.

Cleanliness, infection control and hygiene

- The infection control lead's hours had been increased to full time working across both the Chiltern and Shelburne Hospital sites.
- Named infection control link nurses carried out compliance audits and attended infection control meetings in the endoscopy and oncology clinical departments.
- Microbiologist support was available through agreement with a local NHS Trust. The microbiologist would offer advice and could identify infection control risks within the environment
- Nursing staff told us they would contact the National BMI infection control lead if any patient contracted hospital acquired (E-Coli, Clostridium difficile (C-diff), MRSA) or methicillin-sensitive staphylococcus aureus (MSSA) to ensure all clinical procedural steps were correct.
- From March 2015 to April 2016 the infection control nurse reported, that the hospital had no incidences of hospital acquired MRSA or MSSA or C-diff and one incident of hospital acquired E-Coli. The clinical team implemented the corporate BMI infection control policy 2015
- The hospital employed a team of five cleaning staff including a manager and a deputy. All areas visited were visibly clean. Staff were clear who was responsible for cleaning equipment and areas. 'I am clean' stickers attached to equipment so that staff knew they were ready for use. The cleaning manager had a daily schedule to ensure all areas were cleaned on an on-going basis.
- In clinical areas, we observed all staff adhered to the bare below the elbows policy to enable proper hand washing and reduce the possibility of cross infection. There was a monthly hand washing audit. The July 2016 hand hygiene audit showed 100% compliance for staff in the endoscopy and oncology department.
- Personal protective equipment such as disposable aprons and gloves were readily available. We observed staff washed their hands properly and wore gloves and aprons to administer chemotherapy. Staff wore long gloves and eye shields for endoscopy procedures to prevent the spread of infection.
- Results from the most recent hand hygiene audit in July 2016 Learning and actions were shared with staff at the daily 'huddle' and through the Infection Prevention Control (IPC) local lead. 'The huddle' is a brief meeting of hospital staff to improve communication, cooperative problem solving and focus priorities of the day. All staff could also access the minutes from the IPC meetings.
- Two members of staff in the endoscopy suite took the lead for decontamination of clinical equipment. Both members of staff had undertaken a training and competency assessment programme to City and Guilds level in decontamination. These two staff members documented daily cleaning and sterility checks of endoscopy equipment. Two other staff members completed this task at all other times, having received in-house training and competency checks.
- Monthly endoscopy audits were conducted to ensure cleaning of equipment was in line with national guidance. For example, the endoscopy decontamination facilities audit institute of healthcare engineering and estate management. (IHEEM). The endoscopy manager audited the system in May 2016, which showed there was 100% cleaning compliance. The results of the audit showed the hospital complied with guidelines.
- The endoscopy sterilisation machines were tested every morning, to ensure they reached the correct

temperature for the required amount of time to sterilise the used scopes. The hospital had a service level agreement with an outside contractor to service the endoscopy sterilising machines twice yearly.

- The infection control lead identified and added to the hospital risk register that carpet in clinical areas is an infection control risk, as carpets cannot be properly cleaned. There were plans in place to the removal of carpets and replace them with easy to clean linoleum.

Environment and equipment

- We saw that clinical equipment such as the endoscopy sterilisation machines and endoscope-drying cupboard was serviced according to manufacturers' instructions. The minutes of the clinical governance meeting (March 2016) included a service level review of equipment.
- There was oxygen, suction and a bag and mask by each endoscopy patient's bed, ensuring the necessary equipment was available in case of an emergency. A defibrillator was available in case of a cardiac arrest. Staff documented daily checks for emergency equipment on the oncology, wards and endoscopy unit.
- The endoscopy manager risk assessed their clinical equipment, had closed down one washer, as it was not fit for purpose. Plans for a new machine were waiting for approval.

Medicines

- All chemotherapy was prescribed through an electronic prescribing system, using local cancer network protocols. Oncology nurses used the electronic prescribing system to perform checks and record administration.
- Chemotherapy was supplied pre-prepared to the hospital, and staff reported a timely service. The hospital pharmacists verified prescriptions and checked blood results before releasing any chemotherapy for administration. The oncology pharmacists at the hospital had completed specialist oncology training.
- Oncology staff did not administer chemotherapy out of hours and if clinical staff wanted medicine advice the RMO was on site and accessible. Nurses worked within the hospital chemotherapy policy and did not administer chemotherapy to patients unless blood test results from within the previous 48 hours showed it was safe to do so.
- Oncology nurses told us they had received training and competencies regarding medicine management and adhered to the hospitals policy. A registered nurse always held the medicine keys. We saw two nurses correctly check chemotherapy drugs administered to the patient. The nurse checked the patient's details to be sure the right dose given to the right person, at the right time and by the right route.
- If oncology nurses saw a new drug prescribed, they accessed an official website and read the 'summary of product characteristics' (SPC) so that they knew all the necessary information before administering it or asked the in-house pharmacist to give advice. The oncology nursing staff arranged for drug representatives to visit to explain the risks and side effects at least twice a year at nurses meetings.
- The pharmacy team completed regular audits including missed dose, controlled drugs and medicines reconciliation. The results for the most recent reconciliation audit found staff had not achieved all the standards so a re-audit planned at the end of September 2016. The team shared audit results at the medicines management meetings held every two months, with managers cascading the information at team meetings, confirmed in the minutes we reviewed.
- There was a pharmacist on call service or in an emergency the resident medical officer and senior ward nurse could together access the pharmacy out of hours to obtain the required medication
- Nurses followed the medicine policy and discussed medicines with patients before discharge from the hospital; the pharmacist was involved if the medicine considered high risk.
- The clinical staff locked and secured the medicine trolley within the locked treatment room when not in use.
- We found oncology medicine fridges locked and clean with suitable minimal stock. Maximum and minimum temperatures were recorded daily and when checked

were within safe parameters. There was evidence of pharmacy auditing fridge temperatures monthly to ensure that the fridge was at the correct temperature for medication storage.

- The designated staff nurse in each clinical setting completed medication stock checks. The hospital pharmacist checked the stock lists on a weekly basis.
- Controlled drugs (CDs) were stored in appropriate cupboards as dictated by the Home Office 2016 drug licensing and compliant unit. The oncology unit nurse completed a daily stock check and documented this in the CD record book. We saw administration, stock checks and receipts of stock signed and countersigned in the CD record books including patients own CDs. Pharmacy staff completed a quarterly CD audit and any deficiencies identified had action plans.
- Anaphylaxis kits were in all clinical departments. The pharmacist team sealed kits securely with tags and the kits were readily available if needed.
- Clinical staff told us that they did not use patient group directives, as the resident medical officer was always available. Patient group directives are written instructions for the administration of medicines to a group of patients not individually identified before presentation for treatment.
- The hospital clinical manager was the named controlled drugs accountable officer for the hospital, attends the controlled drug local intelligence network meetings (CDLIN), and submits CDLIN reports prepared by the pharmacy team. There was evidence of completion of quarterly audits.

Records

- Patient records private or NHS were in paper format and these were stored securely on the wards in a lockable trolley We reviewed six sets of patient records. The care records contained patient assessments, observations, medical and nursing notes plus on-going risk assessments and discharge planning documents. We saw that all relevant timely assessments were completed entries were signed, dated and legible.
- Medical records were stored off site in a secure locality. Notes were transported between sites daily by a designated driver, in bags clearly labelled for the site and department. Notes for an individual or department and not a clinic or patient admission were logged on a tracker until returned to medical records or recalled for a forthcoming appointment.
- To prevent unauthorised access to patient information, patient records were stored in locked cupboards/ trolleys with a tracker to locate and record if removed.

Safeguarding

- The director of clinical services was the safeguarding lead and had received level 3 adult and children safeguarding training. The registered medical officers at the hospital had received level 3 adult and children safeguarding training.
- The safeguarding lead demonstrated a clear understanding of their responsibilities concerning both adult and children safeguarding concerns.
- Staff knew who the safeguarding lead was and told us they would contact a member of the on call senior management team if the lead were not available.
- Staff told us they completed safeguarding children and vulnerable adults modules in their mandatory training. Hospital records showed 92% of staff had completed level one safeguarding children training and 91% of staff had completed level one safeguarding vulnerable adults training. This met the hospital target of 85%.
- We were told by senior staffing April 2016 BMI introduced training package on their e-learning system, which introduced the different levels of training to bring this in line with the intercollegiate document with the four different levels of training being provided. We were told prior to April 2016 all staff at the hospital were trained using one training module that would have covered the aspects required for level one and level two safeguarding children training.
- Information provided by the hospital indicated that only staff in a management or supervisory role were required to undertake level two safeguarding children and adults training and 96% of staff in this group had completed training. However, the BMI Safeguarding Children policy states that all staff who have some degree of contact with children, young people and/or parent or carers should complete a minimum of level 2 safeguarding training. The policy takes this requirement from the intercollegiate document Safeguarding children and

young people: roles and competencies for health care staff (2014). This meant all staff caring for adult patients who have children required level 2 safeguarding children training. The service therefore did not provide its staff with safeguarding training that met the requirements of its own corporate policy.

- Frontline staff could describe the signs of abuse and knew the policy and process to follow if they needed to raise a safeguarding concern. The policy included what action staff should take if they had concerns a patient had undergone female genital mutilation (FGM). We saw contact telephone numbers for the local council safeguarding team displayed in the oncology, ward area and endoscopy unit for staff to find quickly.
- There were no reported safeguarding alerts in 2015.
- Ninety one per cent of staff had completed Protecting people at risk of radicalisation (PREVENT) training. The PREVENT strategy requires healthcare organisations to work with partner organisations to contribute to the prevention of terrorism by safeguarding and protecting vulnerable individuals who are at greater risk of radicalisation.

Mandatory training

- Staff were expected to attended yearly mandatory training based on their job profile to ensure they trained to care for the patients safely.
- Clinical staff were given protected time to complete mandatory training. Bank staff were required to complete the training to agreed timelines and the ward sister said bank staff must be up to date with training requirements to continue working at the hospital.
- The training modules were a mix of e-learning and practical sessions. The e-learning training included, for example, information governance, incident reporting and fire safety. Practical training sessions included blood transfusion competencies and resuscitation.
- The hospital compliance target for mandatory training was 85%. As of April 2016, compliance with mandatory training for staff working at the hospital was poor. The compliance target was achieved for 16 of the 50 courses. Courses, which were less than 50% compliant, included patient moving and handling (47%).An action plan to improve included advising staff to complete training within 28 days, as the outcome would be linked to individual pay bonuses. At the time of inspection oncology and endoscopy staff demonstrated 100% compliance with their mandatory training.

Assessing and responding to patient risk

- Staff were aware of and worked within the hospital risk policy and process guide updated February 2016.
- Staff stored risk assessments in the main patient record to ensure colleagues accessing the clinical notes understood risks. Staff gave patients a paper copy of their summary record on discharge from the hospital.
- We saw efficient medical patient care handovers between clinical staff. For example, staff on the wards introduced the next nursing staff shift to the patients to familiarise both the patient and staff to each other and highlight any patient allergies or anxieties such as needle phobia's.
- Staff on the oncology unit only treated 'level one' lower risk haematology patients, any patient who might require high dependency care was not accepted for treatment at the hospital.
- Patients requiring chemotherapy had a wallet-sized medical alert card to carry which advised them about the risks of developing an infection and told them what symptoms to act on and the hospital's contact numbers.
- Nurses followed the hospital policies and told us that if a chemotherapy patient's symptoms were cause for concern they would not risk the patient developing a blood infection. Nurses would recommend the patient attended for a blood test. If they felt the patient had an infection, they would start them on intravenous antibiotics immediately (before the blood test results were ready) as directed in the hospital policy and call the resident medical officer to assess the patient with the transfer to an acute NHS hospital if the hospital could not meet their clinical needs.
- Staff scheduled complex chemotherapy regimens so that patient treatment times did not overlap, enabling staff to spend the required time responding to increased risks if presented.
- Staff in the endoscopy and oncology unit told us that there was a service level agreement for patient transfers for the local NHS trust to accept patient who require

acute treatment and care. In-between March 2015 and April 2016, the hospital had five unplanned transfers of inpatients to other hospitals giving a rate of 0.07 per 100 patients, which was better than other hospitals in the BMI group.

- Patients booked for endoscopy procedures completed a medical questionnaire, reviewed by nurses on arrival at the hospital to identify risks such as allergies prior to the procedure.
- We saw clinical staff in the endoscopy theatre consistently following the World Health Organisation (WHO) safety checklist 'Five Steps to Safer Surgery', to reduce harm by consistent use of best practice, which included team brief, sign in, time out, sign out.
- Qualified nurses accompanied patients who had undergone an endoscopy back to the ward for further assessment and supervision. If a patient became unwell, staff would return the patient to the endoscopy recovery area until their condition was stabilised.
- Patients received out of hour's telephone numbers on discharge from the hospital, in case they became unwell after their endoscopy, or chemotherapy treatment. Oncologists provided an on call service for patients who felt unwell and needed to contact the hospital out of hours and the resident medical officer (RMO) supported this process.
- In the case of patient's condition worsening, the RMO would review and liaise with the consultant for advice about managing increased risks and consider transfer to an acute NHS hospital if needed.
- Patients assessed as high risk of falls or allergy had a red wrist label to alert this known risk to all staff members.
- Staff demonstrated confidence and competence during discussions to request urgent medical assistance if a patient showed signs of deterioration using the National Early Warning Scores (NEWS) for adults. There was adequate medical cover and specialist availability for on going treatment and care.
- The oncology staff said that they would call a diabetic specialist nurse from the local NHS if a patient condition required assessment, treatment, and the resident medical officer discussed that the diabetic specialist nurse had visited promptly following a request to visit and assess in person.

Nursing staffing

- Nurse staffing was one of the highest risks identified on the hospital risk register. The Chiltern hospital had 100 hours per week of nurse staffing to fill. The hospital was located in an isolated area, with poor transport links. Staff told us that they used a team of regular bank nurses and one selected agencies to cover nursing vacancy hours.
- The endoscopy unit employed seven registered nurses and two healthcare assistants. A months staffing rota highlighted safe staff levels. They rarely used agency staff and managed staff shortages by working additional hours.
- The oncology unit employed four registered nurses, a month staffing rota highlighted safe staff levels with two registered nurses on every shift. Staff told us they had never used agency staff as they covered additional hours.
- Endoscopy and chemotherapy nursing staff told us they worked flexibly to meet any extra demands of the service. If the permanent staff were unable to cover any extra work, bank staff filled the shift.

Medical staffing

- The hospital had two Resident Medical Officers from an agency to ensure medical cover was on site twenty-four hours a day seven days a week. They reviewed patients' daily, prescribed additional medication and liaised with the consultants responsible for individual patients care. The consultant was required to be available to attend the hospital in person within 30minutes of an urgent clinical request.
- The RMOs had appropriate advanced life support training and skills. The RMOs reported that the on-call consultant covering their own patients was available at any time of the day or night and responded quickly to any clinical concerns in the hospital.
- The employment compliance co-ordinator had a system had a system for checking medical staff were current with practicing privileges.
- The hospital had 194 doctors and dentists employed or practicing under rules and privileges for the provider of which all, had their registration validated in the last 12 months.

Good

Medical care

- We observed patient handovers between the RMOs, there was detailed and respectful discussion about the patients within the hospital, with appropriate signposting to patients requiring clinical reviews.

Major incident awareness and training

- Training in major incident awareness was available to all new staff during their induction and refreshed annually.
- Hospital business continuity plans were in place and the hospital clinical manager discussed major incident plan details which managers would refer to if a major incident declared. Arrangements included a back- up generator in case of power failure. The senior engineer told us they had a service level agreement with a contractor to grit the car park to allow staff and visitors safe access to the hospital. The senior engineer said he lived close to the hospital and would walk in to ensure the hospital systems were safe for staff and patients.

Are medical care services effective?

Good

By effective, we mean that people's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence.

We rated effective as good because :

- Care and treatment followed current legislation, nationally recognised evidence-based guidance and best practice.
- The unplanned readmission rate for 2015 per 100 discharges within the BMI healthcare group was positive in that it showed that readmission rates were 6% lower for the Chiltern hospital compared to other hospitals within BMI healthcare hospitals group
- The resident medical officer provided medical cover for the site 24 hours a day, seven days a week.
- Most of the consultants working at the BMI Chiltern hospital also worked in the local NHS hospital. There was a clear process for transferring un-well patients to the local NHS hospital.
- The hospital followed National Institute of Clinical Guidelines (NICE) guidance on the management of neutropenic sepsis and achieved 95% compliance in December 2015.

Evidence-based care and treatment

- The endoscopy sister was part of the British society of gastroenterology group. The endoscopy manager ensured that endoscopy staff worked in line with British Society of Gastroenterology (BSG) guidance, which highlights staff allowing sufficient time for procedures to prevent endoscopy staff failing to detect abnormalities.
- The endoscopy service was working towards Joint Advisory Group (JAG) accreditation. This is formal recognition that an endoscopy service demonstrates it has the competence to deliver against the measures in the global rating scale standards. The service had benchmarked its services against the JAG standards. We saw a detailed action plan with timelines and named leads for completion.
- The hospital used the National cancer intelligence network chemotherapy protocols, based on National Institute of Clinical Guidelines (NICE) 2014
- The hospital followed National Institute of Clinical Guidelines (NICE) guidance on the management of neutropenic sepsis. The guidance recommends patients assessed within 15 minutes of arrival and all tests completed within 60 minutes. The hospital achieved 95% compliance in December 2015
- Oncology staff attended appropriate quarterly local cancer multidisciplinary team meetings and discussed patient care with other BMI Hospitals and two local NHS chemotherapy units.
- The oncology team discussed strong links either with local palliative care services delivered at home or at one of the local hospices.

Pain relief

- Patients reported nursing staff acted promptly and appropriately if they complained of pain Patients told us that staff assessed and scored their pain between zero and four; and clinical staff gave the patient prompt patient pain relief.

- Oncology nurses could refer patients to the NHS palliative care team for pain management advice if necessary.

Patient outcomes

- The unplanned readmission rate for 2015 per 100 discharges within the BMI healthcare hospitals group showed that readmission rates were 6% lower for the Chiltern hospital compared to other hospitals within the BMI healthcare hospitals group..
- BMI healthcare hospitals group produced an audit tool to measure compliance with the policy for prevention and management of hospital acquired venous thromboembolism (VTE). We saw evidence of compliance with this annual audit. Clinical staff achieved the 100% target for venous thromboembolism screening rate in the reporting period April 2015 to March 2016 and pulmonary embolism was zero.
- Both clinical and non - clinical staff used the National 6 C's which are a set of values that underpin compassion in practice, a vision and strategy for all health and care staff on a daily basis. The '6Cs' help staff to focus on six key areas; care, compassion, competence, communication, courage and commitment the new hospital executive director, who had been in post for three weeks, had introduced the '6Cs' as a way of supporting staff to achieve the corporate vision. Staff were beginning to adopt this new approach and the cleaning team were checking daily that they were using this new approach.
- The endoscopy Sister collected performance data and we were told this information was submitted to the Endoscopy Global Rating Scale. We did not see any evidence of how the hospital used this information.

Nutrition and hydration

- Staff offered patients a wide range of food and drinks to meet their nutritional and hydration needs there was always a choice of good quality food.
- Patients told us the food is tasty and presented well and that staff assists by getting positioning tables within easy reach to help manage eating.
- Staff offered oncology patients a range of alternative food choices if the menu choices did not appeal to them due to side effects of chemotherapy.
- Staff said they had recently attended a course, which reminded them not to wear heavy perfume as this could make the patients receiving chemotherapy nauseous especially around mealtimes.
- Patients in the oncology unit could access fresh water, fresh juice and hot drinks. Patients in the endoscopy suite were offered fresh water and food when safe to do so after treatment,
- The catering team told us that they took pride in presenting quality meals for patient, staff and visitors to the hospital.
- Clinical staff used the five step national malnutrition universal screening tool (MUST) to identify adults who are malnourished and follow guidelines to improve food intake

Competent staff

- Nursing, therapists and health care assistants were competent and safe to practice their roles after completing the organisational competency framework.
- All staff successfully completed competency checks, even if they were experienced in a skill when they joined the hospital, prior to undertaking specific procedures. Assessment included a wide variety of skills, such as cannulation and use of the hospital's medical devices.
- A dedicated breast care nurse was the lead sister for the oncology unit and had completed a degree in cancer care. The team consisted of four chemotherapy-trained nurses. These staff members attended chemotherapy course updates every two years.
- The endoscopy nurse manager had developed a paper-based system to check all the staff members' competencies and training records were up to date and easily accessible.
- Nursing staff told us they had received 'spill kit training' and competencies to safely deal with a chemotherapy spillage, which included the necessary personal protective equipment, safe handling and disposal to ensure patients and staff not exposed to unsafe levels. Cleaning staff confirmed they had received training and competency checks in the 2015 BMI spillages cleaning policy.

- Oncology staff had received one-to-one training in assessing patients using the United Kingdom Oncology Nursing Society's (UKONS) 'Oncology/Haematology 24 Hour Triage Rapid Assessment and Access Tool Kit'.
- During quiet periods, nurse's accessed online training to increase their clinical knowledge such as management of chemotherapy induced nausea and vomiting and medical emergencies.
- Nurses working in the endoscopy and oncology service receive an appraisal at the beginning of year, mid-year and end of year. If there was a serious incident the clinical lead would carry out additional appraisal and plan objectives and progression to improve
- Staff told us the appraisal system was worthwhile and engaged them in improving themselves and the service to patients. The appraisal highlighted to manager and staff opportunities for further training and development. Staff told us that there was funding available for further training and managers supported staff to access further training and development.
- Consultants worked under a practising privileges arrangement. The granting of practising privileges is an established process whereby a medical practitioner granted permission to work within the independent sector. The Chiltern hospital followed processes to ensure all medical staff who worked at the centre had the appropriate skills and competencies that included regular supervision and appraisals. The oncology nurse lead told us they had clinical supervision with the NHS palliative care consultant four times per year.
- Oncology nursing staff told us they had received limited training in end of life care, however, discussed having strong links and training with the local hospice teams. Training included managing communication to bereaved family, and difficult organ donation conversations.
- The ward sister was pleased to discuss that the one day per week business case for a practice development nurse to assist with training and developing staff was recently been approved.

Multidisciplinary working (in relation to this core service)

- There was strong multidisciplinary team working with a daily ward round attended by medical, nursing, and pharmacist and therapy staff.
- Patients were discussed and treatment protocols agreed by the cancer multidisciplinary team (MDT), as part of BMI healthcare hospitals group cancer standards, to ensure that a team of experts came to a decision in line with national guidance about what was the best treatment for a patient, rather than one doctor making a decision alone; these matched Government standards.
- Oncology and endoscopy nurses had good working relationships with the resident medical officer and colleagues in pharmacy and x-ray. They told us they felt oncology and endoscopy consultants trusted them and listened to their opinion.
- Staff in the oncology unit had good working relationships with their peers in other local trusts for example; they administered the chemotherapy and prepared patients for stem cell transplant elsewhere.
- Oncology nurses felt able to challenge medical staff if, for example, they noticed a drug protocol was not what they expected.

Seven-day services

- During working hours, all clinical staff including consultants concerned about patient care would call the clinical manager or resident medical officer for support. All clinical heads of service rotated on a weekly basis to cover clinical care issues out of hours. These staff members would attend in person if there were a clinical risk / concern to deal with.
- There was a laboratory to process blood tests on site between 8.30am to 4.30pm Monday to Friday. However if an oncology patient was unwell outside of those hours, they could attend the hospital for their blood test, and their blood sample would be couriered to the local NHS hospital for processing. The resident medical officer would not delay giving the patient antibiotics as per hospital policy if these were required or refer the patient to the local NHS hospital if this was required.
- Appointments for medical treatments of cancer could only be accessed Monday to Friday, However to accommodate people working office hours, appointments for clinical assessments were available between 5pm and 8.00pm.

Good

Medical care

- As per NICE guidelines, myeloma: diagnosis and management guidelines 2016, chemotherapy treatment was not administered out of hours
- If a patient admitted for symptom control, oncology consultants were on call to carry out weekend ward rounds. The resident medical officer said that the consultant always visited the patient if this was required.
- Chemotherapy patients could access advice from the oncology unit between 8am to 5pm Monday to Friday. Out of hours there was a system in place for calls to be diverted to the RMO
- Other support services were available as standard at the weekend, such as physiotherapy.
- The endoscopy service was available Monday to Friday.

Access to information

- The nurses and patients we spoke with agreed consultant notes were always present for the appointment time.
- The hospital used a BMI corporate patient pathway document. This document enabled different clinical team's access to key information about the patient. Clinical notes were hand written and were accessible to all staff, including agency staff. All the relevant information for each patient such as outpatient clinic letters, surgery records and observational charts were all stored in one file for ease of access.
- Nurses had access to the local NHS hospital's pathology results so they could check the results of any chemotherapy patients' blood tests out of hours.
- Staff had access to the intranet, and folders with policies and procedures were in all clinical areas. Notice boards reminding staff clinical information were in accessible areas such as the medication room.
- Patients and general practitioners received same day discharge information, which included medication use, possible side effects and what to do in event of a problem.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- We observed an endoscopy procedure from admission to discharge and saw written and verbal consent obtained from the Consultant.
- The consultant gastroenterologist said he did not generally inform patients the need for possible transfer to a NHS hospital if complications arise from the procedure.
- The oncology sister audited chemotherapy consent forms and found 96% fully completed between January and March 2016.
- Staff completed the BMI corporate adults at risk training every two years, which included Mental Capacity Act 2005 and Deprivation of Liberty Safeguards awareness training. Staff we spoke with had an understanding of how this applied to patient consent but told us they implement the training infrequently as the majority of patients had capacity. As of March 2106, 91% of hospital staff had completed this training.

Are medical care services caring?

Good

By caring, we mean that staff involve and treat people with compassion, kindness, dignity and respect.

We rated caring as good because:

- We saw patients treated with dignity, respect and kindness Between March 2015 and April 2016, the scores for the Friends and Family Test (FFT) were above 99.7%.
- Staff took time to involve patients in their care. Patients told us staff involved hem in all decisions about their care.
- Flexible visiting hours allowed patients to maintain supportive relationships with those close to them. Staff supported patients to keep their independence and connections with family and friends.

Compassionate care

- Between March 2015 and April 2016, the scores for the Friends and Family Test (FFT) were above 99.7%.Patient satisfaction results showed that 92% were satisfied with

the overall care they received, 81.8% rated their experience at the hospital as excellent and 10.9% rated their experience as good. Patients said they would recommend the hospital to their family and friends

- Endoscopy staff told us they were proud of the results of their patient satisfaction surveys. One patient commented, "I am very particular, I was very pleased to see the high standards of care from all the staff, the receptionist, nurses and consultants. I could not fault my care!"
- Patients we spoke with said they found the care to be compassionate and understanding. One patient who had attended the oncology unit many times described staff as "they treat me like an old friend and they tell me as they go along what they are doing" another patient said " I cannot speak to friends about my diarrhoea, I know I can just call up the nurse in the night, to talk about these subjects, they are so helpful and stop the loneliness of being on your own at night"
- We saw 34 letters and cards thanking the consultant and nurses for their care in the oncology unit

Understanding and involvement of patients and those close to them

- Patients we spoke to in the chemotherapy and endoscopy wards discussed being involved in their care. Patients' relatives discussed and appreciated that they could stay as long as they liked.
- Patients told us that they received "constant reassurance" from the staff.'The staff make sure you understand information and the consultant draws diagrams to help understand procedures" Another patient and his son told us " the news it was cancer was terrifying, but staff have been there for us at every step, everyone, the cleaner, nurses and consultants have been just great, you could not ask for a nicer bunch of people"
- Family members were always involved where possible in discussions about care and treatment. Staff acknowledged chemotherapy affected all family members and included relatives in care planning. Staff considered the needs of the patients loved ones when planning cancer treatment.
- Patients told us about the positives and negatives of wearing a scalp-cooling hat during chemotherapy, as nurses understood it could be painful in certain circumstances. This meant patients understood what treatment involved and enabled patients to make informed choices about their care.
- The oncology nurse lead ensured oncology specific patient satisfaction questionnaire sent to all patients treated in the previous quarter. We saw the results from 2015's survey showed high levels of patient satisfaction. The oncology nurse lead showed us action plans that they had written to address any concerns patients raised. All actions completed to date by the lead oncology nurse and the team.
- One patient said the nursing staff explained the best way to take pain relief so they could manage to get to the toilet without asking for help. The patient said this was especially important to ensure he did not disturb his wife at night when discharged home.

Emotional support

- All patients were given a BMI healthcare hospitals group "going home" information leaflet. We saw leaflets individually tailored to suit the patient and family needs, such as managing wounds, mobility, and pain relief and whom to contact if concerned. Patients said this information was useful so they knew what to expect and did not become unduly anxious on discharge from the hospital.
- After endoscopy, we saw that if a diagnosis of cancer suspected, nurses took the patient to a private room to discuss the findings, and then called the oncology clinical nurse specialist to speak with them and work as a team to assist the patient during this difficult time.
- Patients told us that the oncology nurses always rang them the next day to ask how they were after their treatments.
- Patients could access a clinical psychologist assigned from the NHS Trust if clinical staff assessed this was required. One patient in the oncology department discussed excellent care from the hospitals stoma nurse who took time to discuss the effects of having a stoma bag and the impact this would have on his life and family. This patient said "this nurse really understood me and helped me cope with this life changing operation"

Good

Medical care

- Staff told us that they could request on their behalf for a chaplain to visit from the neighbouring NHS Trust.
- Counselling services were available upon request from the NHS Trust via the oncology service. One patient in the oncology unit confirmed a referral and receiving an appointment for family therapy treatment in a local NHS Trust.
- Staff responded to call bells promptly and treated patients with dignity and respect when providing care, keeping bedroom doors closed to maintain confidentiality
- The oncology lead nurse had initiated the first steps towards the award of the Macmillan Quality Environment Mark (MQEM), a detailed quality framework used for assessing whether cancer care environments meet the standards required by people living with cancer. The oncology staff recognised this award would demonstrate that the unit was a place respectful of peoples' privacy and dignity, supportive to users' comfort and well-being, giving choice and control to people using the service. Listening to patients and achieving this award was a high priority for the hospital.
- Two patients commented on their satisfaction with the standard of the cleaning at the hospital. One patient said "the cleaning staff are so friendly, they always knock and ask if they can clean my room" another patient said " You cannot fault the cleaning here"

Are medical care services responsive?

Good

By responsive, we mean that services are organised so that they meet people's needs.

We rated responsive as good because:

- The hospital planned and delivered services in a way that met the needs of the local population. The importance of flexibility and choice reflected in the service. The people who use the service have timely access to initial assessment, diagnosis and urgent treatment at a time to suit them
- The service met national waiting times for patients to wait no longer than 18 weeks for treatment after referral. The hospital only cancelled care and treatment when necessary. The reason for the cancellation fully explained in person. Access to further appointments for care and treatment promptly arranged.
- There were good examples where staff adapted procedures and worked flexibly to meet individual requirements, such as working with patients to allow them to continue working whilst receiving chemotherapy treatment. The hospital engaged and planned services with people who are in a vulnerable circumstance such as chemotherapy treatment.
- Staff responded to complaints and concerns in a timely way. Learning from complaints distributed in mandatory training sessions and used to improve the quality of care.
- Staff were very responsive to dealing with small complaints before they became formalised.

Service planning and delivery to meet the needs of local people

- Staff delivered oncology services to meet the needs of patients. One member of staff told us, "our team try to fit around the patient's needs the best we can"
- To enable relatives of patients receiving chemotherapy to stay together during treatment, staff nursed patients in a single room not to disturb other patients receiving treatment.
- The hospital had service level agreements with the local NHS trust for acutely ill patients requiring intensive care treatment.
- The endoscopy lead nurse told us that they had taken proposals regarding their service to clinical governance meetings. The proposal was to change the layout of the endoscopy cleaning room to meet the compliance requirements of Joint Advisory Group (JAG) accreditation. Endoscopy staff told us that the non-compliance was documented in the risk register as a potential financial risk to the hospital if consultants chose to take business to other facilities.
- The BMI Chiltern Hospital policy was not to admit medical patients with primary respiratory or cardiac complaints. The ward occasionally admitted medical

patients always under the care of the consultant for example multiple blood transfusions or intravenous antibiotics for skin infections such as cellulitis under the care of the dermatology consultant.

Access and flow

- The Hospital did not have any waiting lists for endoscopy or chemotherapy treatments.
- Patients were offered treatment according to their availability, taking into account the need for a 'cooling off' period following consultation and the clinical need/ urgency for the treatment.
- All of the patients we spoke with told us they had short waits for their treatment in both the oncology and endoscopy units. One patient told us, "On the first consultation my consultant said he was away on leave for two weeks, but I am pleased to say that the consultant went out of his way to refer to another Consultant, so I could start the treatment regime with no delay"
- Patients suspected of having cancer, could access needle biopsies and mammograms on the same day as their initial consultant appointment.
- Staff gave chemotherapy patients a choice of appointment times, whilst at the same time patients were scheduled to ensure there was flow through the unit, taking into account patients' varying treatment times.

Meeting people's individual needs

- There was not a dementia lead role for the hospital, however 89% of staff had completed mandatory dementia training (as of March 2016). The ward sister had received in-depth dementia training awareness and stated clinical staff would come to her if they had concerns about a patient.
- Staff treated patients as individuals. Endoscopy staff gave an example of how they made reasonable adjustments for a patient living with dementia, by allowing their relative into the preparation area and allowing them to sit with the patient on the ward following the procedure to help ease anxiety for the patient.
- The hospital had a standard operating procedure for chaperoning as part of the 'Privacy and Dignity' policy (2015), outlining arrangements for adults. We saw chaperone notices displayed around the hospital.
- Staff worked hard to ensure individual needs met. One patient said the staff always allowed them first treatment of the day so that they could continue to go to work and not be so tired.
- Staff told us that occasionally patients receiving chemotherapy stayed overnight in the hospital if they were frail or nauseous and had no support at home.
- Staff did not receive any specific training about caring for individuals with learning disabilities, but recalled learning from their safeguarding adults training and told us that one patient with learning difficulties requiring an endoscopy was shown the theatre and layout the day before the procedure to reduce concerns. Patients with individual specific needs were able to visit the clinical environment prior to any treatment interventions to see the clinical area, meet staff and reduce fears.
- Endoscopy staff told us they drew the curtains around patients waiting for and recovering from endoscopy. There were three segregated bays and staff told us that they had a male and female morning or afternoon list for endoscopy procedures.
- We saw staff acting on the hospitals 2015 privacy and dignity policy. We saw rooms available so that bad news delivered to patients and families in private.
- Easy read books were readily available for patients with a learning disability diagnosed with cancer. Booklets produced by the National cancer care centre covered all aspects of tests and treatment care.
- Patients and families received an information leaflet explaining different endoscopy and chemotherapy procedures. Clinical staff reported that the National cancer care centre produced leaflets in whatever language is required for the patient. Leaflets were only available in English at the time of inspection.
- Staff we spoke with said they could access translation services for patients whose first language was not English. This meant that these patients were able to hold detailed discussions about their care and treatment.
- A private large garden and lake within the hospital grounds provided a tranquil place so that patients and relatives had space to think, away from the ward environment.

- All rooms in the oncology unit had televisions and free Wi-Fi was available.

Learning from complaints and concerns

- Patients and relatives had various ways of raising concerns. These included completing satisfaction survey questionnaire, hospital website/enquiry forms, written complaints or verbal complaints. Complaint forms were available in various locations around the hospital.
- The hospital had an up to date complaints policy with a clear process to investigate, report and learn from a complaint.
- From April 2015 to March 2016, the hospital received 57 complaints; one complaint referred to the Ombudsman for an independent review. The Executive Director had overall responsibility for all complaints. The Quality and Risk Manager tracked complaints and assigned each complaint to the relevant head of department for investigation.
- From April 2015 to March 2016, the oncology unit staff told us that they had received one complaint regarding a slight delay in blood results. Endoscopy theatre suite for the same period discussed three complaints regarding short delay in procedure time Staff told us learning from complaints involved staff being clearer in verbal expectations for patient treatment and care. All of these complaints were resolved locally. The clinical manager and the executive director phoned one patient to invite them to discuss the concern directly and successfully resolved the patients concern.
- We saw that staff responded to 90% of complaints within the hospital policy of 20 working days. There was sometimes a delay waiting for a response from the Consultant.
- We saw that staff trained in the use of the complaints policy could give examples of listening to concerns and acting to improve as soon as the concern identified. There were procedures for sharing and learning from complaints across the hospital. Complaints were discussed bi- monthly at senior level, the MAC meeting and Clinical Governance meeting, monthly at the Heads of Department meeting, weekly at the Executive Team meeting and at the daily communication meeting
- We saw that both the 2015 annual clinical governance report and at the December 2015 MAC meeting discussed the complaints from 2015; learning identified two examples of patient's not being clear regarding treatment payment charges. Learning from complaints included staff amending information leaflets to give clear information regarding treatment costs for patients and families to view and ensuring posters were clearly visible in treatment room and waiting areas of the hospital.

Are medical care services well-led?

Good

By well-led, we mean that the leadership, management and governance of the organisation assures the delivery of high-quality person-centred care, supports learning and innovation, and promotes an open and fair culture.

We rated well-led as good because:

- Staff were aware of the values of the organisation and were passionate about good patient care. Staff were actively engaged so that their views were reflected in the planning and delivery of services and in shaping the culture
- Staff had strategy 'built into' their appraisal process. Staff spoke positively about the 'no blame' culture of the team and of the visibility and support of managers. Senior clinical leaders and staff strive for continuous learning, improvement and innovation in the delivery of clinical care. There was a governance structure, which oversaw quality, audit and risk.
- People who use the service and those close to them were engaged and involved in the decision making of the service.

However,

- There was no risk register completed at departmental level.
- The provider 85% compliance target for mandatory training was not met.
- The provider were behind on the administrative checks for 135 consultant practising privilege reviews.

Good

Medical care

Vision and strategy for this this core service

- The oncology strategy included providing a high level of service and updating GP clinics on the services provided in order to be the market lead. For 2016, the unit was working towards accreditation of the Macmillan Quality Environmental Mark (MQEM).
- The endoscopy manager had developed a clear strategy for the service at this hospital.The strategy linked to the hospital's overall strategy and staff given objectives to help the service meet its aims and the staff could discuss the plans to obtain Joint Advisory Group (JAG) accreditation.
- The lead nurse in oncology and the lead nurse in endoscopy clearly described the vision in the units, to give patients the best experience at a difficult time, be the market leader and offer the best clinical care in the area. The oncology team discussed that they felt very well supported by the new executive director regarding future service development.
- Endoscopy and oncology staff we spoke to were aware of their individualised unit vision and hospital strategy and could therefore demonstrate their role to improve patient's services for the future.

Governance, risk management and quality measurement for this core service

- The hospital worked within the BMI hospital committee terms of reference. This structure allowed for an appropriate cascade of information from the Hospital management team meetings via the Management team meeting (Heads of Department) and subsequently to individual departments.
- Each clinical department lead reported to the senior team through the bi-monthly leadership and governance meetings. The senior team provided monthly reports from their hospital clinical governance and medical advisory committees to the regional team who then fed up to the corporate clinical governance committee.
- Agendas and minutes for meetings followed a standardised format, with actions listed, who was accountable for the action and by when. We saw from minutes of the clinical governance meetings that staff discussed complaints and incidents, including any learning and trends related to these events. They also discussed audits, policy reviews, updates from clinical committees and any external guidance or new legislation.
- The Medical Advisory Committee (MAC) met bi-monthly and reviewed clinical quality governance matters. Minutes and actions from these meetings, such as health and safety and infection control reported to the MAC, and to the management team through the team service leads meetings.
- Although the hospital were up-to-date with the administrative checks for consultant practising privileges, they were behind on the biennial review of clinical work for 135 consultants. This did not follow BMI Healthcare 'Practising privileges policy' (2015) and raised concerns about monitoring compliance with policies. We reviewed the minutes for the last three meetings and these did not contain discussions for medical staff due a biennial review. We discussed this with the executive director who was accelerating the reviews, with the aim of being up-to-date by the end of October 2016.
- Staff told us they found the daily 15-20 minute 'huddle' a useful way of communicating information quickly across the hospital. Senior staff and heads of department discussed daily activity, incidents and complaints at these meetings.
- Senior managers had not given sufficient priority to the investigation and closure of incidents. There were 105 outstanding at the time of our inspection (across the two locations managed by the one team), although the management had since addressed this. Systems and processes to keep patients safe were not being adhered to and prompt action taken to address any risks.
- There were no departmental risk registers for the endoscopy operating department. There was a hospital wide risk register; this listed the top concerns and risks.
- Oncology and endoscopy staff attended monthly team meetings where action plans and timelines for completion and learning from incidents and complaints discussed.
- There was a rolling programme of audits. Action plans and re-audits showed improvements in the services. For example, the clinical manager had audited 20 sets of

clinical care notes and found that the doctor had not documented each time he called to the ward to treat a patient or give advice to clinical staff overseeing a patient's care. Actions included highlighting to nurses at the nurses meetings to remind doctors to document every time they review a patient in the patient's notes. The audit results regarding poor documentation were discussed at clinical governance and medical advisory meetings. A date for re-audit was set for the following quarter to check if improvements occurred.

- We saw that minutes of the monthly management strategy meetings well attended by staff with named leads and key action points monitored.
- Senior clinical staff maintained quality measurement and performance dashboards for each service. They discussed outcomes at the clinical governance meetings and made comparisons with other BMI healthcare hospitals group. Clinical staff had access to these performance dashboards.
- The hospital monitored patient safety via the electronic reporting system. Staff reported the information gathered through this system in the clinical governance meeting, and they monitored it via the organisation's quality dashboard.

Leadership and culture of service

- We observed a positive staff culture across the hospital. The oncology lead nurse told us they worked positively encouraging "open and frank dialogue" with all the staff in their team. They described a "no blame culture". Nurses and administrative staff confirmed there was a supportive, nurturing culture within the hospital.
- The clinical staff said they "really loved working at the hospital, it's like one big family, everyone knows each other" and that they felt valued and respected and listen to.
- Oncology and endoscopy staff were encouraged and supported to develop and potential was recognised.
- Oncology and endoscopy staff told us the senior managers kept them informed about what was happening in the hospital.
- The endoscopy manager told us a discussion to ensure there would be sufficient trained staff in place within the unit to manage retirements of staff members had taken place with senior management and a plan of action was developing.
- The culture of the endoscopy and oncology team was nurturing and professionally supportive of each other.
- Oncology and endoscopy staff told us senior staff were approachable and visible and had an "open door" to discuss concerns.

Public and staff engagement

- Staff asked all patients to complete a patient survey questionnaire. The clinical manager sent copies of any patient satisfaction surveys to staff specifically mentioned by patients or families.
- Staff received both electronic and paper hospital newsletters highlighting good practice, new ideas and praised staff. Staff told us that there was an "open door" approach of senior managers to discuss ideas or concerns and staff said they' felt valued and respected'
- To celebrate staff that had gone the "extra mile' we saw that the BMI hospital employee recognition scheme was introduced in February 2016 rewarding staff with shopping vouchers or an additional day off working. Most staff told us that this was a good idea.
- The hospital also held a monthly customer experience meeting. There were no patients as members of the group to seek their views and take action in response to suggestions made, even though the group identified one of its purposes was to 'understand situations from the customer's perspective'. Service improvement had occurred as a result of learning from verbal comments and the hospital now had a rolling programme in place for modernisation of patient rooms, which included replacement of beds and mattresses.

Innovation, improvement and sustainability

- Management discussed plans to invest in the endoscopy service as they recognised they were not compliant to enable the service to become Joint Advisory Group (JAG) accredited. The improvement plan had been drafted, discussed at clinical governance meetings and was awaiting financial approval.

Good

Medical care

- Staff told us they found the daily 15-20 minute 'huddle' a useful way of communicating information quickly across the hospital. Senior staff and heads of department discussed daily activity, incidents and complaints at these meetings
- The hospital had set up a customer experience group January 2016. Service improvement occurred because of learning from verbal comments and the hospital now has a rolling programme in place for modernisation of patient rooms, which has included replacement of beds and mattresses.

Requires improvement

Surgery

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

Information about the service

The Chiltern Hospital provides elective surgical care to patients aged 18 and over, both NHS and other funded (self-pay or through private medical insurance), as inpatients and day cases. The specialities providing surgery included orthopaedics, plastic surgery, ophthalmology and gynaecology. From April 2015 to March 2016 there were 6,999 admissions for surgery, of which 1,350 where inpatients and 5,648 day cases. The majority of admitted patients (84%) were other funded. The three most commonly performed procedures were image guided injection (579), cataract surgery (565) and total hip replacement (240).

From April 2015 to March 2016, 132 of the 6,999 admissions were for children and young people aged three to 17 years. After a review of patient safety and service compliance, the provider decided to suspend surgery for this age group and at the time of our inspection, only adults were admitted for surgery.

The hospital has three operating theatres, two with laminar airflow ventilation systems (a system of circulating filtered air to reduce the risk of airborne contamination). There is a dedicated recovery area. There are 46 patient rooms, spread over two wards, all are single rooms with en-suite. One ward in used predominantly for inpatients, the other for day cases and short stay patients,. There are no critical care facilities. In an emergency, the hospital transfers patients to the local NHS Hospital.

The Chiltern Hospital is part of the BMI South Buckinghamshire Hospitals group. The senior management is shared between this hospital and two other services. We inspected one of these services, The Shelburne Hospital at the same time as The Chiltern Hospital. There are similarities in our findings and the content of both reports due to this and the overall management of the hospitals being the same.

During our inspection, we inspected the operating department and the wards. We spoke with nine patients and 13 members of staff, including theatre and nursing staff, medical staff, allied health professionals and administrative staff. We also reviewed eights patient records and four personnel files and observed care on the ward, in the operating theatres and in the recovery area. We analysed data provided by the hospital before, during and after the inspection.

Requires improvement

Surgery

Summary of findings

We rated this service as requires improvement because:

- Staff in theatres were not always adhering to systems and processes designed to keep patients safe and to ensure staff were working in accordance with corporate policies and relevant national guidance.
- Staff acting as a surgical first assistant had not been competency assessed and this additional role was not included in their job description. They were not rostered to complete this role as an additional member of the theatre team. Therefore, theatre staffing was not always in line with national guidance and staff were acting in a dual role without a local policy or risk assessments to support them.
- We observed staff not always completing the Five Steps to Safer Surgery in full and the outcomes from hospital observational audits in theatres had not been shared with staff to encourage learning and changes to practice.
- There was insufficient monitoring of the quality and risks of the service at a local level. There had been a change of theatre manager twice in the last year and at the time of the inspection, there was no theatre manager in place. Concerns identified by senior staff tended to be shared at regional level but this information was not always cascaded back to frontline staff to enable them to develop and improve their service. The hospital wide risk register was not in sufficient detail to provide assurance on how risks were monitored and by whom. Although audits were completed there were no detailed action plans, showing who was responsible for monitoring areas of non-compliance.
- Across the hospital, there were delays in managers investigating incidents and the hospital was significantly behind on some of its biennial clinical reviews for consultants practising privileges. Across the service there was limited monitoring of compliance with hospital policies.
- The hospital was not compliant with its mandatory training target of 85% for around 65% of the training courses staff needed to complete. Staff found there were sometime delays accessing practical based courses There was a high use of agency staff, across the service, to ensure safe staffing levels due to difficulties with recruitment and retention of staff.
- The hospital collected patient outcome data and submitted this to a number of national databases but the hospital did not use this data locally to keep staff informed about how effective care and treatment had been. Staff involved in the surgery service did not meet as a whole team to discuss outcome data, although the hospital had just introduced a theatre user group who would consider the quality of the service.
- After the inspection the provider was issued with a requirement notice letter, as we had identified potential failings to comply with two regulations relating to good governance and staffing; the detail of which is contained within the report and listed in the must actions at the end of the report. We asked the provider to submit an action plan to show how they would address these concerns and demonstrate how they would reduce the associated risks to patients and staff. The provider submitted a detailed action plan within the agreed timeframe which we felt was sufficient to comply with the requirement notice. A responsible person was allocated to each action, with a date for completion. Compliance with the action plan will be monitored through regular engagement meetings with the provider.

However:

- We saw staff providing compassionate care and treatment to patients. Nursing, theatre and medical staff were caring, kind and treated patients with dignity and respect. Patients felt they received sufficient information about their planned treatment and were involved in decisions about their care. Patients consistently told us they would recommend the service to friends and family.
- Areas we visited were visibly clean and tidy and we saw staff following good infection prevention and control practices.
- Patients told us the booking, admission and discharge process had all been prompt and efficient,

they felt fully informed at each step in the process. Although, waiting times for surgery for NHS patients did not always achieve the 18-week referral to treatment time indicator.

- There was good multidisciplinary working across all teams in the hospital so patients received co-ordinated care and treatment. Patients' care and treatment was planned and delivered using evidence based guidance. Nursing staff completed risk assessments for patients. In the event that a patient became unwell, there were systems in place for staff to escalate these concerns and refer the patient to another hospital if necessary. The hospital provided care to inpatients seven days a week, with access to diagnostic imaging and theatres via an on-call system.
- Staff felt they supported each other well in their teams and this had helped during a number of senior staffing changes at the hospital. They valued the changes the new executive director had made, particularly improving the appearance of the hospital and listening to their concerns.

Are surgery services safe?

Requires improvement

By safe, we mean people are protected from abuse and avoidable harm.

We rated this service as requires improvement for safe because:

- Staff in theatres did not always follow systems and processes to keep patients safe. We observed on two occasions staff not following best practise when completing the World Health Organisation (WHO) surgical safety checklist. There had also been a never event, associated with staff not following all of the Five Steps to Safer Surgery. Although the hospital completed observational audits of compliance with the WHO, there was no evidence of how they shared the results with frontline staff to enable them to make changes to practice.
- Staffing levels in the operating department were not consistently in line with national guidance, when theatre staff were acting as a surgical first assistant. Staff in the operating department were also undertaking dual roles without the support of a local hospital policy or risk assessments. The roles which staff were undertaking for a session were not included on the rota. However, staffing levels on the ward were maintained at a safe level, although there was a high use of agency staff due to difficulties with recruitment and retention.
- The incident reporting system used by the hospital at the time of the inspection was not robust. There was a delay in the investigation and closure of incidents staff had reported, although the hospital addressed the delay after the inspection. There was a lack of assurance who had oversight for timely investigations and that the hospital had implemented any learning quick enough to ensure patient safety. Learning from local incidents was shared with frontline staff but there was no evidence that learning from incidents in other BMI hospitals was shared, although this information was discussed at senior team meetings.
- The access to the operating department was not secure, as there was no swipe card or key pad entry required. This was a security risk due to access to medical

equipment and confidential information. There were concerns identified about fire safety in an emergency and also the safe storage of equipment, such as sterile instrument packs. Staff were concerned the airflow system in one of the three theatres was noisy and meant they could not always hear each other when doing safety checks.

- Staff could not follow good infection control practices as patient chairs in the pre-assessment unit were not wipe able and an electrical cable was taped to the floor between two rooms in the operating department, preventing staff from cleaning the floors properly.
- Not all staff were up-to-date with the mandatory training and there were delays in accessing practical based courses. Although staff received adult safeguarding training, staff had not receive safeguarding children training appropriate to their role.
- Medical staff did not always achieve the required minimum standard of documentation in patient records. They did not always sign to confirm the WHO surgical safety check list had been completed by theatre staff or complete the signature sheet to show they had been involved with caring for the patient. The hospital patient record audits also identified additional concerns relating to completion of patient records by consultants.

However

- Staff demonstrated a good understanding of duty of candour and gave examples where they had used this to support patients.
- All clinical areas were visibly clean and staff had access to sufficient equipment to provide safe care and treatment. Staff adhered to infection prevention and control practice on the wards and in the operating department.
- Staff were knowledgeable about the hospital's safeguarding policy and clear about their responsibilities to report concerns. Staff routinely assessed and monitored risks to patients. They used the national early warning score to identify patients whose condition might deteriorate. There were appropriate arrangements in place to transfer patients to a local NHS hospital if required.

Incidents

- Staff knew how to and felt confident to report any incidents which occurred. They currently used a paper based reporting system, with incidents uploaded to a central database, by a member of the quality and risk team. The hospital planned to introduce electronic reporting of incidents in October, with training for staff starting in August. There was a current risk of the quality and risk team not uploading information correctly due to being unable to read the hand written forms and they did not actually witness the incident.
- At the time of our inspection, there was a delay in closing a total of 105 incidents across this hospital and a second hospital managed by the same team. The quality and risk team had to chase managers to complete investigations so they could record the outcome and close the incident. The senior management told us they had closed 100 of these incidents by 8 August 2016. The remaining five were within the 20-day timescale for the relevant department to investigate and report on the learning and outcomes. We had concerns the backlog had delayed the hospital applying learning and action, with a potential impact on safe care and treatment for patients.
- Staff told us their manager made them aware of any incidents at their daily team 'huddle' or through the daily information sheet printed and shared with staff after the senior team 'huddle'. Team leaders would discuss any immediate actions at the 'huddle' or share at routine team meetings. 'The huddle' is a brief meeting of hospital staff to improve communication, cooperative problem solving and focus priorities of the day. Minutes from the medical advisory committee (MAC) meetings showed the hospital presented a summary of the most recent incidents but this did not include the actions taken, to show how the hospital had shared learning with medical staff.
- We did not see any evidence of sharing of learning from incidents at other BMI hospitals at departmental level, although senior staff discussed these at their meetings, such as the clinical governance group. However, we were told by the senior staff there was a corporate clinical bulletin distributed to all clinical departments on a monthly basis for all staff to read. The bulletin was

reported to contain lessons learned from incidents across the company, a summary of alerts received during the month and synopsis from serious incidents, lessons learned from regulatory inspections.

- From April 2015 to March 2016, staff had reported 375 clinical incidents, the majority (94%)were graded as no or low harm with one incident graded as severe. One hundred and fifty two incidents occurred in surgery and inpatients.
- There had been one never event during the same period. A never event is a serious incident which is wholly preventable, where guidance or safety recommendations that provide strong systemic protective barriers are available at a national level, and should have been implemented by all healthcare providers. A root cause analysis had been completed, debrief held with staff and learning shared locally and regionally, with an agreed action plan. The root causes were staff not completing the Five Steps to Safer Surgery checklist and team communication. Human factors training had not been considered as an action point.
- There were no regular mortality and morbidity meetings to discuss unexpected deaths or adverse incidents affecting patients. The hospital told us such cases would be included in the clinical governance and medical advisory meetings as required.
- The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain notifiable safety incidents' and provide reasonable support to that person. Staff we spoke with understood their responsibility to be open and honest with the family when something had gone wrong. Senior staff were aware of their role to investigate a notifiable safety incident, keep the family informed and offer support. Staff gave examples of when they had applied duty of candour and learning because of an incident.

Safety thermometer or equivalent

- The hospital submitted safety thermometer data for NHS patients having surgery at the hospital. The NHS safety thermometer is a monthly snapshot audit of the prevalence of avoidable harm that includes new pressure ulcers, catheter-related urinary tract infections, venous thromboembolism and falls. Results for February 2016 to July 2106 showed all patients had received harm free care.

  Although, the wards did display the audit results this was not in an obvious position for visitors to see. It is considered best practice to display the results of the safety thermometer audits as this allows staff, patients and their relatives to see how the wards have performed.
- Staff routinely assessed patients for venous thromboembolism (VTE). The VTE screening rate was 100% from April 2016 to March 2016. There had been no incidents of hospital acquired VTE or pulmonary embolism over the same period.

Cleanliness, infection control and hygiene

- All clinical areas we visited in theatres and on the ward were clean and tidy. We observed staff following good infection control practices, such as cleaning their hands before and after patient contact and ensuring they were 'bare below the elbow', to minimise the risk and spread of infection to patients. Staff also had access to personal protective equipment such as gloves and aprons, which we observed them using appropriately. There were hand sanitiser points around the hospital for visitors to use, to reduce the spread of infection to patients.
- There was an infection prevention and control (IPC) lead for the hospital and an IPC link for each department. Quarterly IPC meetings took place, with performance in IPC audits such as hand hygiene discussed at these meetings and other areas of concern found at the hospital. This included the lack of a separate hand-washing sink on Chalfont ward. Senior staff were aware of this, with agreed long-term plans to remodel the layout of the room and with staff using hand gel as an additional step at the current time.
- Results from the most recent hand hygiene audit in July 2016 showed 100% compliance for staff on the ward and in theatres. Learning and actions were shared with staff at the daily 'huddle' and through the IPC local lead. All staff could also access the minutes from the IPC meetings. Staff completed annual IPC mandatory training, the time of the inspection compliance was 75% against the hospital target of 85%.

Requires improvement

Surgery

- From April 2015 to March 2016, there had been no cases of Methicillin Resistant Staphylococcus Aureus (MRSA) or Methicillin-sensitive Staphylococcus Aureus(MSSA) across the hospital. There had been no incidents of Clostridium difficile and one incident of Escherichia coli (E-Coli). The hospital followed the corporate BMI Healthcare policy 'Methicillin resistant staphylococcus aureus screening and management' (2015), which did not require hospitals to screen all admitted patients for MRSA. Instead, patients were screened depending on their answers to set questions about previous infection with MRSA, previous admittance to hospital and all NHS patients were screened as part of the contract agreement with clinical commission group. Patients with a positive result received treatment prior to the hospital admitting them for surgery.
- There had been six surgical site infections from April 2015 to March 2016. A root cause analysis had been completed for each infection, with the outcomes discussed at the IPC meeting. There had not been any reoccurring themes between the causes of the infections.
- The hospital had a contract in place for decontamination and sterilisation of surgical instruments, which took place off-site.
- There were carpets in some of the inpatient rooms, ward areas and the pre-assessment area. The hospital recognised this was an infection control risk and there was a rolling programme for removal of carpets, although there was no deadline for when the hospital would achieve this. We observed the carpets were clean and staff signed and dated to show carpet cleaning schedules were complete, including when a deep clean was completed. There was a policy for management of spillages on carpets, with a steam clean taking place. As the pre-assessment rooms were carpeted, nursing staff did not take blood in the department, instead patients attended the pathology department.
- In the operating department, there was a long electrical cable taped to the floor, between two rooms. This was an IPC risk as domestic staff could not clean the floor properly and a trip hazard to staff. Also, in pre-assessment, patient chairs were fabric covered and therefore could not effectively be cleaned, which was a cleanliness and hygiene risk.
- The infection control lead conducted an annual mattress audit which identified new mattresses were required. As a result ten new mattresses were due to be delivered in August 2016.

Environment and equipment

- Staff told us there was sufficient equipment for them to care for patients and we saw staff maintained stock levels well for both reusable and single use items. Equipment in general was stored appropriately, with clear labelling in storage rooms.
- We observed some specific concerns about the environment in the operating department. The access to the operating department was not secure, such as via a swipe card. No staff challenged us when we initially entered the department. There was a potential security risk both in terms of access to confidential patient information and equipment. The door to the prosthetics room was propped open, enabling access to expensive implants. In addition, this was a fire door and should have been kept closed.
- In theatre two, there was a thin gap between and below the fire doors of the anaesthetic room, there was a potential risk in the event of a fire.
- Theatre staff raised two concerns about equipment, in theatre one the laminar airflow system was noisy and made it hard for staff to hear each other, such was when doing swab and instrument counts before and after an operation. There was no local risk register for the operating department and this was not on the hospital one. Also, the capnography monitors (used to monitor a patient's blood gas levels) in the recovery area where not compatible with the ones in the operating theatre. This meant staff had to change the blood pressure cuff to enable observations to continue. The hospital had plans to replace these by December 2016.
- We saw sterile instrument packs stored above shoulder height, the weight of the pack was only on the top of the pack, not on the side. This was a moving and handling risk to staff as they could not see the weight until they had lifted the pack down. Staff did not monitor the temperature in the storage room to ensure instruments were stored between 18-21 degrees, in line with recommendations from the Association for Perioperative Practice (AfPP).

- Staff understood their responsibility to ensure they segregated and disposed of clinical waste appropriately. Clinical waste bins were clearly labelled and we observed staff kept the rooms used to store clinical waste clean and tidy to minimise infection risk.
- Staff had access to the use of a hoist for transferring patients. The hospital provided disposable slings for individual patient use. Staff received training on the use of equipment as part of the contract held with the supplier. The hospital serviced and tested clinical equipment according to manufacturer's guidance; there were a number of service level agreements in place for servicing of equipment.
- We reviewed the records for daily and weekly checks of the resuscitation trolleys in the operating department and on the ward for the last month and these were complete. There was a list with each trolley to show when items were due to expire, to ensure items were kept in date and ready to use in an emergency. Trolleys had a security tag on them, so it was immediately evident if they had been accessed and the contents potentially tampered with.
- We requested health and safety risk assessments for the wards and operating department. There were comprehensive records for theatres, such as for patient transfer and handling of sharps, all records were in date for review. For the wards, an occupational risk assessment had been completed in June 2016, with actions identified to reduce the level of risk to staff.

Medicines

- Overall, medicines management systems in place in the operating department and on the ward kept people safe.
- The pharmacy team completed regular audits including missed dose, controlled drugs and medicines reconciliation. The results for the most recent reconciliation audit found staff had not achieved all the standards so a re-audit was planned. The team shared audit results at the medicines management meetings held every two months, with managers cascading the information at team meetings, confirmed in the minutes we looked at.
- On Shardeloes ward, medicines were stored in a locked cabinet, behind the nurses station. Staff monitored the temperature in this area and records confirmed they had done this for July on the days when the ward was open. The hospital had obtained quotes to relocate the clean utility room and for medicines to be stored there.
- Pharmacy and nursing staff monitored and managed stock levels of medicines and controlled drugs appropriately. Staff completed the controlled drugs registers in line with current national guidance and the hospital policy. We checked 10 medicines and found all were in date.
- Staff on the wards told us they had good access to the pharmacist for advice and support. The pharmacists spent the majority of their time on the ward checking prescriptions. They informed staff of any medicine safety alerts at the daily 'huddle'.
- Pre-assessment nursing staff supplied one medication to patients under a patient group direction (PGD). A PGD provides a legal framework that allows some registered health professionals to supply and/ or administer a specified medicine(s) to a pre-defined group of patients, without them having to see a doctor. A PGD is used in situations that offer an advantage to patient care, without compromising patient safety. The PGD was reviewed and found to be authorised and in date for use.
- Patients told us nursing and medical staff had given clear instructions and advice about any medications they needed to use at home, prior to discharge from the ward. Patients made staff aware of any allergies at their pre-assessment. They recorded this information on the front page of the care pathway so the information was immediately visible to reduce the risk of harm to patients and patients wore a red wristband to make staff aware they had an allergy.

Records

- Patient records were in paper format and these were stored securely on the wards in a lockable trolley. Staff did not raise any concerns about lack of availability of patient records.
- Staff used specific paperwork for each patient which ensured they kept records appropriate to the care

pathway being followed. For example, patients admitted for hip surgery had their clinical entries recorded in the 'Primary hip replacement care pathway' documentation.

- The care records contained pre-operative assessments, records from the surgical procedure and anaesthetic, recovery observations, nursing and medical staff notes and discharge checklists and assessments. The records also included multidisciplinary clinical notes, including those from physiotherapists.
- We reviewed eight patient records and found non-medical staff had completed the required information and patient details on every page, although, we could not read the staff designation on the signature sheet for three sets of records. For five sets of records, the consultant had not signed to confirm staff in theatre had completed the WHO surgical safety checklist and in three records, no medical staff had signed the signature page to enable easy identification of who had provided care to the patient. All clinicians looking after the patient had to sign this sheet. The hospital patient records audit from July 2016, found concerns with consultants not completing daily progress notes, signing and dating entries and completing discharge summaries. The standard of record keeping we saw was not in keeping with best practice and systems designed to keep patients safe.
- The hospital completed patient record audits every month. A senior member of staff reviewed ten sets of records and recorded compliance with 40 set questions. The audit had only been completed in full for May to July 2016. For January to April 2016, staff had either not looked at enough records or not answered all the questions. There was no reason given for this. Compliance for May to July, improved from 82% to 87%. The hospital did not give a compliance target. Actions from the most recent audit included reminding staff to call patients two days post-surgery and ensure they documented this in the care pathway. The audit did not state how this information would be shared and by whom, to provide accountability. However, we did see in the minutes from Shardeloes ward team meeting in May 2106, that the team discussed the most recent notes audit.
- Theatre staff maintained a comprehensive log of implants on their prosthetics register to enable traceability if an incident occurred. Theatre personnel retained a sticker from each implant in the register as well as in the patient notes.

Safeguarding

- Safeguarding was part of mandatory training for all staff, the level of training required determined by their clinical role. Staff knew what the term safeguarding meant and how to recognise signs of abuse. They could explain the reporting process and how to seek support if they needed to. Flowcharts of the safeguarding process were on display in the ward office and in theatres, including all the relevant local telephone numbers. Staff could access the BMI safeguarding policy on the intranet for reference.
- The policy included what action staff should take if they had concerns a patient had undergone female genital mutilation (FGM).
- Staff told us they completed safeguarding children and vulnerable adults modules in their mandatory training. Hospital records showed 92% of staff had completed level one safeguarding children training and 91% of staff had completed level one safeguarding vulnerable adults training. This met the hospital target of 85%.
- We were told by senior staffing April 2016 BMI introduced training package on their e-learning system, which introduced the different levels of training to bring this in line with the intercollegiate document with the four different levels of training being provided. We were told prior to April 2016 all staff at the hospital were trained using one training module that would have covered the aspects required for level one and level two safeguarding children training.
- Information provided by the hospital indicated that only staff in a management or supervisory role were required to undertake level two safeguarding children and adults training and 96% of staff in this group had completed training. However, the BMI Safeguarding Children policy states that all staff who have some degree of contact with children, young people and/or parent or carers should complete a minimum of level 2 safeguarding training. The policy takes this requirement from the intercollegiate document Safeguarding children and young people: roles and competencies for health care

staff (2014). This meant all staff caring for adult patients who have children required level 2 safeguarding children training. The service therefore did not provide its staff with safeguarding training that met the requirements of its own corporate policy.

- Ninety one per cent of staff had completed Protecting people at risk of radicalisation (PREVENT) training. At the time of our inspection 91% had completed this training against a target of 85%. PREVENT strategy requires healthcare organisations to work with partner organisations to contribute to the prevention of terrorism by safeguarding and protecting vulnerable individuals who are at greater risk of radicalisation.

Mandatory training

- Staff we spoke with told us they were up-to-date with most of the statutory and mandatory training. They sometime had difficulties accessing the practical training courses as they were not all held locally. Staff would value the hospital arranging more local courses.
- Each member of staff was assigned a role-specific mandatory training plan via the online e-learning system used by BMI. This sent reminder emails to staff and their manager when they needed to renew a training module. Staff completed most training electronically but the provider included practical training where appropriate, such as for manual handling and infection prevention and control. Managers gave staff time at work to complete their training or they paid staff to complete online training at home to improve compliance and ensure patient safety.
- As of April 2016, compliance with mandatory training for staff working across the whole hospital was inconsistent. The hospital target was 85% compliance, this had been achieved for 16 of the 50 courses. Courses which were less than 50% compliant included patient moving and handling (47%).

Assessing and responding to patient risk

- Staff assessed patients for key risks at their pre-assessment and continued to monitor these before and after their surgery. These included risks about mobility, medical history, skin damage and VTE. Patients had to meet certain criteria before they hospital would accept them for surgery, these minimised the risk of harm to the patient due to lack of appropriate facilities.
- Patients were required to complete a comprehensive preadmission questionnaire to assess if there were any health risks that may compromise their treatment. Nurse discussed the health questionnaires with patients in the pre-admission clinics. If staff identified a patient as being at risk, they discussed these concerns with the patient's consultant, the resident medical officer (RMO) or anaesthetist as appropriate. If a patient appeared to have an abnormal ECG result, the RMO reviewed the results and they arranged a referral to a cardiologist.
- Staff used the National Early Warning System (NEWS) to monitor patients and identify deterioration in their health. This is a series of observations that produce an overall score. An increase in the score would show a deterioration in a patient's condition. A plan was available in each patient's records for staff to follow if the score did increase.
- Nursing staff on the ward had to complete acute illness management training, every three years as part of their mandatory training. As of April 2016, 73% of nurses and 70% of HCAs had completed this training against a target of 85%.
- If a patient's condition deteriorated, service level agreements were in place for transfer of the patient to the local NHS trust by ambulance. There were strict guidelines for staff to follow which described processes for stabilising a critically ill patient prior to transfer to another hospital. Nursing staff and the RMO were aware of the correct process to follow to ensure prompt and timely intervention for a patient who required additional medical treatment.
- All staff completed adult basic life support, immediate or advanced life support training depending on their role. As of April 2016, 80% of clinical staff had completed adult basic life support training, against 64% of non-clinical staff. Seventy one per cent of staff had completed immediate life support and 50% (1 out of 2) staff had completed advanced life support.
- In theatre, staff followed the "Five Steps to Safer Surgery" checklist. This is a nationally recognised system of checks designed to prevent avoidable harm and mistakes during surgical procedures. These checks included a team brief at the beginning and end of each theatre list and the World Health Organisation (WHO) surgical safety checklist, which included sign in, time

out and sign out. We observed two operations and for both staff said shall we 'do the WHO', rather than defining which stage they were at. We did not have confidence that staff were fully engaged with the process and recognised the importance of its completion for ensuring patient safety. For one operation, the sign out was ticked as completed in the patient record but the questions were not read out aloud. For the other, the surgeon unnecessarily interrupted the time out, there should be full engagement from all members of the theatre team for each stage. This is a requirement of the BMI Healthcare 'Safer Surgery Policy' (2016). However, a record of the team brief was kept in theatres, in accordance with best practice.

- The hospital told us they completed monthly observational audits of completion of the WHO surgical safety checklist for 10 patients; this did not include whether the brief and debrief had taken place. The results for January to July 2106, showed 100% compliance for three months. For the remaining months compliance ranged from 82% to 99%. There was no evidence of any actions from the audits were 100% was not achieved and the theatre staff we asked about the audit were not aware it was completed or could remember the results being discussed with them. Minutes from theatre meetings did not include discussion of the WHO audit results. We raised this with senior staff who acknowledged the information was cascaded up but not back to frontline staff. There was no assurance how the hospital were supporting staff to improve the quality of the service and ensure patient safety.
- The hospital arranged simulated cardiac arrest scenarios to assess how staff would respond should a real life cardiac arrest occur. Feedback was given to individuals on their performance and further unannounced scenario sessions planned by management.
- A resident medical officer (RMO) was on site at all times. The RMO was the doctor responsible for the care of the patients in the absence of the consultant. The RMO was trained in advanced life support and held a bleep for immediate response, for example, in the case of cardiac arrest.

Nursing staffing

- We had concerns the staffing levels in theatres did not always meet the Association for Perioperative Practice (AfPP) recommended minimum and therefore the staffing level in theatres was not always safe.
- The AfPP is a national group supporting staff working in the perioperative setting. The guidance from AfPP on 'Staffing for patients in the perioperative setting' (2014) recommends a minimum of one anaesthetic practitioner, two scrub practitioners, one circulating practitioner and one recovery practitioner. The minimum staffing in theatres being five, unless there is only one case, when only one scrub practitioner is needed.
- We reviewed the theatre off duty, allocation rota and operating lists for the week of the announced inspection. The allocation rota was written in pencil in a diary and was not clear to read. The rota did not state which theatre staff were working in (although it did state which consultant) or the role they would be undertaking for that session. It was not clear if staffing was sufficient in theatres and which theatre staff needed to set-up for the planned session.
- We had additional concerns that the corporate BMI Healthcare 'Policy for management of operating sessions for elective scheduled surgery' (2016) referenced the AfPP guidance but their staffing model was not in line with this guidance. The BMI Healthcare staffing model was based on the grade of surgery being performed, using a scale of one to four. This indicated the maximum staffing for that theatre session, although due to overlap the staffing for a grade two to four level operation were the same. The BMI maximum staffing only met the minimum AfPP guidance for grade three/four operations when specific risk assessments had been undertaken to show five staff were needed. The normal staffing for grade two to four operations was three staff; one anaesthetic practitioner, one scrub practitioner and one circulating practitioner. The provider considered recovery practitioner staffing separate to this policy but review of the allocation rotas showed this was planned for appropriately, giving a total of four staff in theatres. There were therefore occasions when staffing in theatres met the BMI policy but not the AfPP recommended minimum.

- For the 30 planned operating sessions during the week of the inspection, staffing met the corporate policy but not the AfPP guidance for 10 sessions, however, it did meet the AfPP guidance for the remaining 20 sessions.
- There was a second concern around staffing due to staff acting as a surgical first assistant, which affected the total number of staff in theatres. The Perioperative Care Collaborative Position Statement 'Surgical First Assistant' (2012) states that a practitioner undertaking the role of the SFA must be an additional member of the team. The BMI Healthcare 'Policy for the provision of surgical first assistants' (2013) also supported this. No staff were listed on the allocation rota as acting as SFA, although staff told us they undertook this role and we observed this during our session in the operating theatre on 26 July 2016. Also, data submitted by the hospital after the inspection looking at daily key performance indicators showed for August 2016, they had allocated 22.9 hours to theatre staff acting as a surgical first assistant.
- A further review of the allocation rotas and surgical lists when considered against sessions where staff told us someone would act as a SFA, did not meet the AfPP recommendations for an additional eight sessions as there was not sufficient scrub practitioners. There were though four occasions when there were enough staff in theatres to meet the AfPP minimum and include someone to act as SFA. It was not possible to confirm if staff acted as a SFA as this was not listed on the rota and review of six sets of records, showed staff had recorded this in only one set of patient records.
- This reduction in staffing meant the scrub practitioner was sometimes also acting as a SFA, meaning they were undertaking two roles at the same time, referred to as dual rolling. We observed this during our session on 26 July. The staffing in theatres for this session was initially as AfPP guidance but one member of staff assisted the surgeon, resulting in them dual rolling. This should be supported by a local policy and risk assessment for each situation where staff can dual role to ensure patient safety as recommended in the Perioperative Care Collaborative Position Statement 'Surgical First Assistant' (2012). The corporate 'Policy for management of operating sessions for elective scheduled surgery' (2016) supported this position statement. We discussed our concerns with the director of clinical services who told us theatre staff did not routinely dual role but if they did there should be local policies and risk assessments in place. We looked for these documents on site with staff and requested them after the inspection. The hospital did not provide any policies or risk assessment to support those staff undertaking a dual role. These situations together represented a significant risk to patient safety.
- On the wards, senior staff used a patient acuity and dependency tool to plan the required level of nurse staffing. This showed the required nursing hours, any unallocated hours were filled using bank or agency staff. The rota was finalised one week in advance, with daily review due to changes in operating lists or patient need. There was a high use of agency staff due to difficulties with recruitment and retention of nursing staff. There was a minimum of two trained nurses on each shift, with a four week rolling off duty.
- From April to June 2016, 35% of planned staffing hours were covered by agency staff and 19% by bank staff. Contract agency staff were used to ensure consistency. For theatres, 23% of planned staffing hours were covered by bank staff and 16% by agency staff. As of June 2106, there were seven vacant posts across both wards and three in theatres.
- Nursing staff on Chalfont ward raised concerns it was difficult to monitor the work completed by health care assistants, due to the staffing shortages, although they still had to countersign in the patient's record. They did not feel comfortable doing this. Also, when the day case ward was closed, they said it was difficult to manage the differing needs of patients on Chalfont ward, due to the mix of day case, short stay and inpatients. Evening day case patients sometimes returned late from theatre, after 9pm and some then needed to stay overnight. This created additional pressure for the night staff. During our inspection, both nursing staff and the Director of Clinical Services raised concerns about the night staff skill mix on the wards, when nursing unplanned inpatients. Management were aware of this issue and said they had been encouraging day staff to also work night shifts, in an attempt to increase the skill mix.

Surgical staffing

Requires improvement

Surgery

- Consultants led and delivered the surgical service at the hospital. Surgeons and anaesthetists were required to be able to attend within 30 minutes drive of the hospital, in case they needed to urgently visit a patient.
- Nursing and theatre staff told us they could contact any consultant, out of hours or when not on-site, if they needed advice about the best care and treatment for a patient. They told us they had a good working relationship with the medical staff, who normally attended the hospital promptly when called in.
- Each consultant was responsible for arranging a colleague who would be on call for any of their patients staying overnight, if the consultant was not available to be contacted by staff.
- There was a resident medical officer (RMO) on-site 24 hours a day. If the RMO had any concerns, they would speak with the consultant responsible for the patient. The RMO also responded to emergency calls and was advanced life support trained. The RMO we spoke with confirmed they were up-to-date with their training.
- Patients told us the consultant and anaesthetist had seen them prior to surgery.

Major incident awareness and training

- The hospital had local and corporate business continuity plans for use in events such as a power failure or adverse weather conditions.
- There was a corporate 'Major Incident' policy for staff to follow should a significant event occur at the hospital or in the local area.
- All staff completed annual fire safety training as part of their mandatory training.

Are surgery services effective?

Requires improvement

By effective, we mean that people's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence.

We rated this service as requires improvement for effective because:

- Some theatre staff were undertaking the role of surgical first assistant without fully completing a recognised competency based course. Assessments of competencies had not taken place and the required evidence for the role was not kept in the operating department in keeping with the corporate surgical first assist policy. There was no register on-site of staff who could perform the surgical first assist role and the role was not listed in their job description. There was no assurance that staff were competent to complete the role and that the department had considered and was adhering to corporate policy and relevant national guidance.
- The hospital had a policy and system in place for granting of practising privileges for medical staff wishing to work at the hospital. There was a backlog in completion of the required biennial clinical reviews for 135 medical staff for assurance on local clinical performance.
- The hospital routinely collected and submitted data on patient outcomes. Although senior staff discussed this information at regional level, there was no evidence of how the hospital shared and used the information locally to improve outcomes for patients.
- There were no documented formal on-call arrangements for the radiologists to ensure a member of the team could always be contacted out-of-hours.

However:

- Staff worked effectively within their team and with other teams to provide co-ordinated care to patients, which focused on their needs. Staff could access all the information they needed to provide care for patients. Discharge planning started during the pre-assessment process to ensure the hospital discharged patients with all the support they needed and at the right time.
- Patients told us they had made an informed decision to give consent for surgery. They could access pain-relieving medication as needed post-surgery.
- The hospital had systems in place to ensure they provide care for inpatients seven days a week, including access to on-call theatre and medical staff in an emergency. Planned operations were performed mainly during the week.

- Staff provided care and treatment to patients that took account of nationally recognised evidence based guidance and standards, although reviews of this information did not take place at departmental level.

Evidence-based care and treatment

- Some staff described how they provided care and treatment to patients based on relevant national guidance and standards, such as the National Institute for Health and Care Excellence (NICE). However, although updates to national guidance were an agenda item at clinical governance meetings, there was no evidence of discussions at departmental meetings. There was therefore no assurance that care and treatment was in keeping with the most current recommendations.
- The corporate provider policy on 'Provision of Surgical First Assistants' (2013) referenced Association for Perioperative Practice (AfPP) staffing guidance from 2007, although updated guidance had been issued in 2012 and 2014. The central policy team had not reviewed this policy in view of this more recent guidance and there was a potential risk that services were not following current recommendations.
- Staff running the pre-operative assessment clinic followed the National Institute for Health and Care Excellence (NICE) guidance CG3 'Preoperative tests for elective surgery', to ensure patients had relevant tests performed prior to surgery, to minimise the risk of complications or harm. Theatre staff followed NICE guidance (QS49) 'Surgical site infection'. This included steps to follow to minimise the risk of infection during surgery. Staff recorded completion of these steps in the patient pathway document.
- Patients received a risk assessment for venous thromboembolism (VTE) prior to surgery in line with NICE (Quality standard 3) 'Venous thromboembolism in adults: reducing the risk in hospitals' with appropriate prophylaxis given to reduce the risk of VTE. The hospital audited compliance with this and the results shared with heads of department.
- The hospital submitted data to Public Health England Surgical Site Infection (SSI) surveillance audit programme, to contribute to national information recorded on SSI following hip replacement but also to enable them to compare nationally their rates of SSI. For the most recent audit period (October-December 2015), the hospital had not reported any surgical site infections following hip replacement surgery.
- The hospital used a number of different care pathways depending on the type of surgery a patient was having, to ensure staff followed a set care pathway that met the needs of each patient.
- Staff in theatres and on the wards told us there had been less time recently to complete audits due to staffing shortages and needing to ensure they met the needs of patients. The hospital planned to train more health care assistants to be able to complete audits. We did though see evidence in minutes from departmental and clinical governance meetings that audit results were discussed.

Pain relief

- Five patients specifically commented on the prompt response and action taken by nursing staff when they were experiencing pain. Nursing staff answered call bells quickly and provided medication to help reduce the level of pain. One patient told us how supportive the nurse had been during the night when they were in a lot of pain.
- Staff asked patients to score their pain using a scale of zero to three. They then documented the result in the patients' care pathway, as part of the National Early Warning System (NEWS) chart along with any action taken to manage the patients' pain. For patients with persistent pain, a patient controlled anaesthesia pump was considered, there was a separate risk booklet for staff to complete to ensure all associated risks were monitored.
- Nursing staff discussed post-operative pain relief with patients as part of their pre-assessment and gave them written information as well to support these discussions.
- The resident medical officer (RMO) could prescribe additional pain relieving medication or if there were significant concerns nursing staff would speak with the patient's consultant.

Nutrition and hydration

- Nursing staff advised patients about fasting times prior to surgery at pre-assessment. They also completed the malnutrition universal screening tool (MUST) as part of the patient's risk assessments during their pre-assessment. This is used to identify patients at risk of malnutrition. Staff could contact a dietician, from the local NHS trust for additional advice if needed.
- Specific dietary needs were also recoded at pre-assessment, so the catering team could be informed and provide suitable food for the patient during their stay. A patient told us staff had them supported to make healthy meal choices.
- Staff monitored patients were for post-operative nausea and vomiting. Staff gave anti-sickness medication to patients as needed, which the consultant had prescribed prior to surgery.

Patient outcomes

- The hospital submitted patient outcome data to a number of national audits, including the National Joint Registry, to enable it to monitor its performance and clinical outcomes against other services. The hospital also audited readmission rates and reported on this data as part of the quality account.
- Patient reported outcome measures (PROMs) were recorded for NHS funded patients having primary knee or hip replacement and hernia repair. Data for April 2014 to March 2015, showed for hip and knee surgery that the adjusted average health gain was within the England average; for hernia the adjusted average health gain was significantly better than the England average.
- Monthly PROMs data was also reported on in the quality account, these enabled patient outcomes at the Chiltern Hospital to be compared to the BMI healthcare average and national average.
- At a corporate level the provider was working with the Private Health Information Network (PHIN). PHIN planned to provide information for the public from April 2017 on 11 key performance measures, so a patient could make an informed choice where to have their care and treatment for providers offering privately funded healthcare.
- From April 2015 to March 2016, there were five unplanned transfers to another hospital, six unplanned readmission within 28 days of surgery and five unplanned returns to theatre. Theatre staff were asked what learning had taken place after these events, they could not describe any learning and seemed surprised this should be considered. Information from the hospital showed all staff had taken appropriate action at the time of the incident. Escalation procedures had been effective in managing the risks to patients. There was though no detailed discussion of these cases at the MAC, clinical governance or departmental meetings.

Competent staff

- We had concerns that staff acting as a surgical first assistant (SFA) were not able to demonstrate competency assessments for this role and some staff had only partially completed the required qualification for the role. This did not meet national guidance or corporate policy. There was no assurance that staff were competent to undertake the role or the hospital was following corporate policy and national guidance to keep staff and patients safe.
- The Perioperative Care Collaborative (PCC) position statement on 'Surgical first assistant' (2012) recommends 'the role of the SFA must be undertaken by someone who has successfully achieved a programme of study that has been benchmarked against nationally recognised competencies underpinning the knowledge and skills required for the role'. In addition, the role of the SFA should be included in the person's job description.
- The BMI 'Policy for the provision of surgical first assistants' (2013) required a register of staff designated to perform the SFA role to be held in the operating department, along with evidence of skills and knowledge assessment. Staff had to complete a recognised training programme, which could be the BMI SFA training course or an externally recognised course. Staff could act in the role of SFA after completing day one of the four day BMI course. Also, staff were required to keep a log of procedures undertaken to demonstrate ongoing competency. Finally, an assessment of competence should take place for staff acting as a SFA.
- The acting theatre manager told us five staff acted as a SFA during surgery. We reviewed the personnel files for these staff and none of them had this role listed in their job description. One member of staff had completed an external course, the remainder had completed day one

of the BMI SFA course but had been unable to complete the remaining three days as they trainer had left. These staff members told us BMI had not run any further courses. Senior managers told us there were no national plans in place for the trainer to be replaced to enable staff to complete their training.

- There was no register in the operating department of staff who acted in the SFA role and staff were unable to produce evidence of completed competency assessments. Staff told us they had a folder to record their competencies but none were available during the announced or unannounced inspection. No staff had a log of procedures where they acted as SFA and they did not seem aware they needed to complete this in-line with the policy.
- We did see evidence of completed competencies for health care assistants (HCAs) working in pre-assessment. Also, across the hospital some HCAs had completed the 'Care certificate'. This is a set of standards that social care and health workers stick to in their daily working life. On the ward to HCA were being supported to undertake a level four foundation course.
- The need to develop the nursing staff skill set to care for the changing needs of the patients group, particular when day case patients and long stay patients weremixed on the ward had been recognised.Seven and a half hours of time had been allocated for a practise development nurse to be based on the wards.
- Senior management completed a number of checks prior to granting consultants practising privileges at the hospital. The term 'practising privileges' refers to medical practitioners being granted the right to practice in a hospital. In order to maintain their practising privileges consultant medical staff were required to supply copies of current insurance, a disclosure and barring scheme check, their registration, last appraisal for their main place of work and evidence of completion of the required mandatory training. The hospital were up-to-date with these annual checks but they were behind for the review of clinical performance that took place biennially with the MAC, in keeping with the BMI Healthcare 'Practising privileges policy' (2015). The policy contained a standard agenda that the MAC should adopt which included biennial review of practising privileges. We reviewed the minutes for the last three meetings and these did not contain discussions for medical staff due a biennial review.
- There were a total of 135 medical staff who were due a biennial review, seven reviews were significantly out of date 1 from 2007, three from 2009, one from 2010 and two from 2011. Six of the seven medical staff were undertaking clinical work at the hospital. There was no assurance that the hospital were actively monitoring the local clinical performance of staff who held practising privileges for the hospital. We discussed this with the executive director who was accelerating the reviews, with the aim of being up-to-date by the end of October 2016.
- However, we did see in the minutes from the MAC meetings that the group had reached decisions to grant or stop practicing privileges and appropriate action taken, where the MAC had identified concerns about performance or conduct.
- Staff told us they had received an appraisal within the last year and the hospital supported them financially and gave them the time to complete relevant additional training for their role. This included supporting students to complete their training. There were mentors on-site to support students and a member of staff told us they completed a refresher course every year for this role. However, staff working on the wards sometimes found it difficult to support and observe students if they were short staffed.
- As of July 2016, 60% of theatre staff, 75% of ward staff and 100% of pre-assessment staff had received an appraisal. The appraisal year ran from October to September. Changes in the theatre manager resulted in only 2% of theatre staff receiving an appraisal last year.

Multidisciplinary working

- Throughout the inspection, our observations of practice, review of records and discussions with staff confirmed good multidisciplinary working between the different teams involved in a patient's care and treatment.

Requires improvement

Surgery

- There was clear communication between staff from different teams, such as theatre staff to ward staff and between the ward staff and physiotherapists. We observed safe and effective handovers of care, between the ward, theatre and recovery staff.
- Nursing, theatre staff and the RMO told us it was easy to contact a consultant if they needed advice. The consultant had overall responsibility for a patient's care.
- The hospital had a service level agreement for pathology services, hospital staff did not raise any concerns about contacting or using this service.
- If a patient needed to be transferred to another hospital, the consultant was responsible for liaising with the hospital and arranging for the transfer.
- Pre-assessment staff told us the liaised with a patient's GP if there were any concerns about tests results or the needed confirmation of any medications the patient was taking. When the hospital discharged a patient, they sent a letter to the patient's GP.
- Physiotherapy staff recorded if they made a referral to social services or other community services as part of the pre-admission discharge planning process.

Seven-day services

- Planned operations took place Monday to Friday, during the day and early evening. There was occasional operating sessions on a Saturday. Theatre staff were on-call should there be any unplanned returns to theatre. Nursing cover was available on the wards, all day, every day, when the hospital was open.
- The RMO was on-call at all times and was based at the hospital, should staff need to escalate concerns about a patient. The RMO told us they were woken at night infrequently and therefore were normally able to rest between midnight and 7am.
- Consultants were required as part of the BMI practising privileges agreement to be contactable by phone and able to attend the hospital within 30 minutes, if they had admitted patients at the hospital. It was their responsibility to arrange appropriate cover if they could not be available and to arrange an anaesthetist if their patient was readmitted to theatre.
- The radiology department provided an on-call service outside of normal working hours and at weekends. Staff could contact the radiologists out of hours to authorise requests and review results but there was no documented on-call arrangements.
- Physiotherapy staff supported effective recovery and rehabilitation by providing sessions to inpatients daily, including at weekends.
- The pharmacy service had recently extended its opening hours to 8am to 6pm, to provide additional support to the wards. Outside of these hours the RMO and nursing staff dispensed medications which had already been prescribed, with access to an on-call pharmacist as needed.

Access to information

- Nursing, theatre and medical staff did not raise any concerns around access to patient records, they told us these were available when they admitted a patient for surgery.
- The pre-assessment team checked for test results for their patients each morning. They printed out any results and filed them in the patients' record. They told us they could access the electronic results system and the company providing the service normally kept to the agreed turnaround times for return of results. However, in the MAC minutes for May 2016, a consultant raised concerns around the time for the service to return microbiology results.
- The use of the patient pathway document enabled different teams to access key information about the patient. Notes were hand written and were accessible to all staff, including agency staff. All the relevant information for each patient such as outpatient clinic letters, surgery records and observational charts were all stored in one file for ease of access.
- A discharge letter was sent to the patients' GP, staff recorded this had been completed in the patient pathway document.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- All patients told us they had been able to make an informed decision about surgery, before signing the

consent form. The consultant discussed the risks and benefits of surgery with them and these were included on the consent form. The four consent forms we checked confirmed this.

- Relevant staff groups completed consent training as part of their mandatory training. As of March 2016, 93% of required staff had completed this training.
- The results from the last quarterly consent audit, for June 2016, showed 89% compliance. Areas of poor compliance were to be discussed with the relevant staff member, although it did not state who would do this and by when.
- Staff completed Adults at Risk training every two years, which included Mental Capacity Act 2005 and Deprivation of Liberty Safeguards awareness training. Staff we spoke with had an understanding of how this applied to patient consent but told us they implement the training infrequently as the majority of patients had capacity. As of March 2106, 91% of hospital staff had completed this training.
- Nursing staff documented on the front of the patient care pathway if there was a do not attempt resuscitation order in place or an advanced decision to refuse treatment and that they had seen the relevant document. This ensured staff respected the patients' wishes should they collapse and need emergency treatment.

Are surgery services caring?

Good

By caring, we mean that staff involve and treat people with compassion, kindness, dignity and respect.

We rated this service as good for caring because:

- All feedback from patients, both verbal and through patient surveys was positive. Patients felt staff took the time to listen to their concerns, provided clear explanations about their care and treatment and on the day of surgery provided care of a high standard. This included treating patients with dignity and respect, and in general maintaining privacy and confidentiality.
- Patients felt staff treated them as individuals and they, and those close to them, were involved in making decisions about their care. Staff considered patients emotional needs, not just their clinical needs.
- All patients we spoke with would recommend the service to friends and family and this was supported by data collected for the Friends and Family test.

Compassionate care

- All patients we spoke with were pleased with the quality of care they had received. They told us staff had made them feel at ease and had felt comfortable and relaxed prior to having surgery. Staff had spoken to them in a kind manner and treated them with dignity and respect. A patient told us 'staff are nice, helpful and friendly'.
- Staff ensured confidentiality and privacy by knocking before entering a patient's room and kept the door closed while providing care. A patient told us and we observed staff introducing themselves when they met a patient for the first time. Patient names were displayed (initial and last name) on the door of their room and on the whiteboard at the nurse's station, which was visible to patients and visitors. Staff told us they gained verbal consent to display this confidential information; there was also a section in the patient pathway to obtain their consent.
- In the second operating theatre, a window in the door looked into the scrub room The window was not frosted, which prevented patients' privacy and dignity being maintained as people in this room could see any surgery taking place. We raised this with the executive director and they took immediate action. A consultant also raised concerns around privacy and dignity for patients as theatre staff sometimes used this same door to enter and exit the theatre, rather than going through the anaesthetics or recovery areas.
- In the Patient Led Assessment of the Care environment (PLACE) audit for February 2015 to June 2015, the hospital scored below the England average for privacy, dignity and wellbeing, with a score of 80% compared to the England average of 87%.
- We saw notices on display in the pre-assessment waiting area and on the wards advising patients to let staff know if they wished for a chaperone during their appointment.

Requires improvement

Surgery

- The hospital collected Friends and Family test for all patients. This was analysed on a daily, monthly and rolling basis. Data from the previous day was shared at the daily meeting for senior staff.
- Data for April 2016 showed, 99.7% of inpatients would recommend the service to a friend or family member. Data was also analysed by patient category with 99.6% of insured and self-pay recommending the service and 100% of NHS funded patients.
- From April 2015 to April 2016, 100% of NHS funded patients would recommend the service and between 95%-100% for insured and self-pay patients. The hospital also asked all patients to rate the quality of care, with scores consistently achieved of 80% or above for excellent care, the remainder rated their care as very good.

Understanding and involvement of patients and those close to them

- Patients told us all staff had given clear explanations, in sufficient detail for each stage of their care and treatment, from initial consultation through to discharge. They had been given written information to support the discussions that had taken place. Patients valued seeing the physiotherapist during the pre-operative assessment, so they understood the exercise programme they needed to complete after their surgery.
- Staff were clear about the risks and benefits of the planned treatment and patients understood how their recovery would progress. Patients told us staff had made them aware of any costs they may incur.
- We did not have the opportunity to speak with any carers or family members during our visit. However, with the patients' permission they could attend appointments and be present during their stay in hospital.
- We observed staff explaining any tests or observations to the patient prior to completing them.
- Patients told us they appreciated the time staff spent with them to answer any concerns they had. They had found it helpful seeing the anaesthetist and consultant prior to having surgery.

Emotional support

- Staff in all areas showed sensitivity and support to patients and understood the emotional impact of them having to be admitted for surgery.
- The specialist cancer nurse accompanied the consultant endoscopists when telling patients they had cancer. This ensured patients and relatives had immediate access to support and information about the next steps.
- We observed a theatre team providing additional reassurance for a patient who was anxious about their surgery.
- A patient commented how staff attended to their needs but also reduced their anxiety prior to surgery by talking and laughing with them about 'every day' things.
- The hospital had open visiting hours on the ward so relatives and carers could visit at any time to offer support.
- Patients were able to telephone the ward after discharge, for further help and advice on their return home.

Are surgery services responsive?

Good

By responsive, we mean that services are organised so that they meet people's needs.

We rated this service as good for responsive because:

- The hospital and local clinical commissioning groups worked together to plan and deliver surgical services to meet the needs of local people.
- Admissions were pre-planned so staff could assess patient needs prior to treatment. This enabled staff to provide care to meet their specific needs, including cultural, language, mental or physical needs.
- The service had strict selection criteria to ensure only patients whom the hospital had the facilities to care for were referred. Patients told us the whole process from booking their initial appointment, to being discharged post-surgery was efficient and well organised.
- Discharge arrangements were planned but flexible, and care was provided until patients could be discharged safely.

- The hospital dealt with the majority of complaints promptly, and there was evidence that the complaints were discussed amongst staff. Complaints were used to improve the quality of care.

However,

- The hospital failed to meet the 18 week referral to treatment time indicator for NHS patients from September 2015 to January 2016.

Service planning and delivery to meet the needs of local people

- The hospital worked with the local Clinical Commissioning Groups to plan services for NHS patients and participated in the NHS e-Referral Service. The service allows NHS patients requiring an outpatient appointment or surgical procedure to choose both the hospital they attend and the time and date of their treatment. Through this initiative, the hospital was able to provide a selection of NHS services including ear, nose and throat (ENT) surgery, hip and knee surgery, and hernia repairs.
- The provider was registered with various insurance companies, providing access to treatment for patients who had private healthcare insurance. Additionally, patients could opt to pay for treatment themselves. BMI Healthcare had recently introduced a card which allowed patients to spread the cost of their treatment over 12 months.
- The service admission criteria ensured only patients for whom the hospital had facilities to care for were referred. Patients admitted had a low risk of complication and their post-surgical needs could be met through ward-based nursing care.
- There were no facilities for emergency admissions; commissioners and the local NHS trust were aware of this.
- The provider had plans to develop an ambulatory care service at the hospital for patients who did not require a full ward admission. An ambulatory care service allows patients to be treated in hospital without the need for an overnight stay. It ensures patients receive timely access to treatment and releases inpatient beds for those who require an overnight stay.

Meeting people's individual needs

- Information on patients' additional needs was recorded by nursing staff during the patient's pre-assessment. They gave patients information leaflets about their planned procedure or treatment during their appointment or the hospital sent the leaflets to patients with their outpatient appointment letter. The patient information leaflets were written in English but could be provided in other languages or formats. During pre-assessment the nurse asked patients if they needed an interpreter for their stay in hospital.
- Patient-led Assessments of the Care Environment (PLACE) are a collection of assessments, used to measure the quality of the patient environment for NHS patients. The hospital's PLACE score, for the suitability of the environment for a patient living with dementia, was 75% from February to June 2015. This was lower than the England average (81%).
- The service had not employed any specialist dementia nurses or had a dementia lead, however 89% of staff had completed mandatory dementia training (as of March 2016). Also, the ward sister had received in-depth dementia training awareness and stated clinical staff would come to her if they had concerns about a patient. The hospital rarely admitted patients living with dementia due to the set admission criteria.
- In the assessment from February to June 2015, the hospital scored 86% for ward food, which was slightly below the England average (93%). During our inspection, patients we spoke with praised the quality of the food and were impressed with the choices available. The service provided alternative menu options when patients had special dietary requirements, for religious or cultural reasons.
- The layout of the hospital meant that all areas were accessible for people in a wheelchair, however the entrance to the pre-assessment clinic was only just wide enough and there was only a small waiting area once nursing staff had called a patient through from the main waiting room.
- On Chalfont ward, patients had to access three patient rooms via a slope. This was of concern for any patients with mobility difficulties or a visual impairment.
- In the Patient-Led Assessments of the Care Environment (PLACE) from February to June 2015, the hospital scored 89% for the condition, appearance and maintenance of

the wards. This was slightly lower than the England average (92%). We spoke with three patients on Chalfont ward who commented on the outdated decoration in their rooms.

Access and flow

- Both private and NHS patients were admitted on a planned basis for elective surgery, and staff provided care in a timely manner.
- From April 2015 to March 2016, the hospital admitted 6,998 inpatient and day cases, of which 16% were NHS funded. The hospital monitored the percentage of NHS patients admitted within 18 weeks of their referral as part of their quality report to the CCGs. It is expected that 90% of NHS patients will receive treatment within 18 weeks. The hospital did not achieve this 90% indicator from September 2015 to January 2016, with compliance ranging from 82% to 89% during this time. The hospital did not explain why they had not achieved the indicator. However, NHS patients on both the inpatient and day case ward praised the speed at which they could access surgery at the hospital.
- The hospital did not have a waiting list for private patients requiring surgery. Patients were offered treatment according to their availability, taking into consideration the clinical urgency for the surgery and the need for a 'cooling off' period following consultation.
- The operating department followed a planned programme of activity from Monday to Friday, with Saturday operating sessions available on request. The hospital allocated theatre time to consultants on a sessional basis unless there was a clinical requirement to provide an ad hoc session, for example a return to theatre.
- There were morning, afternoon and evening operating sessions. The evening session ran from 6pm to 8pm and included both inpatients and day cases. Theatre and ward staff told us the evening surgery session sometimes overran, with patients returning to the ward after 9pm. Key performance indicator data for the first week of August 2016 theatre data showed, four patients were reported to return to the wards after 9pm, out of a possible 75 admissions. Occupancy rates on both wards meant that any day case patient who required an overnight stay could do so. If a patient required or requested an overnight stay, staff recorded this as an incident.
- Consultants, or if unavailable the resident medical officer (RMO), authorised the discharge of patients from the hospital. This meant patients could be discharged out of hours if they wished.
- The pre-assessment nurse covered discharge planning during pre-assessment to determine not only how many days patients would be on the ward but also whether patients were likely to require additional support at home once discharged.
- Staff communicated planned changes to the surgical lists via the administration team. The hospital required consultants to give five days notice of any changes to the list so the hospital could ensure enough staff were working. Senior managers discussed this, with consultants who regularly did not comply with this standard.
- From April 2015 to March 2016, the hospital reported cancelling ten procedures for non-clinical reasons. The hospital was not able to confirm how many patients were offered another appointment within 28 days of the cancelled appointment. There was no assurance how the hospital assessed if improvements could be made to limit cancellations as it did not monitor and analyse this information.

Learning from complaints and concerns

- Staff followed the BMI Healthcare 'Complaints policy' (2015) which provided staff with a clear process to investigate, report and learn from complaints. The policy was up to date and was based on recommendations made by national reports and enquiries, with a focus on patient safety.
- From April 2015 to March 2016, the hospital received 57 complaints; one complaint was referred to the Ombudsman for an independent review. The Executive Director had overall responsibility for all complaints. The Quality and Risk Manager tracked complaints and assigned each complaint to the relevant head of department for investigation.
- Complainants received an acknowledgement of their complaint within two working days; however, we found

that not all complaints were investigated within the corporate policy time frame of 20 working days. Twenty complaints were recorded on the hospital complaints tracker in May 2016, seven investigations were delayed at stage one (internal investigation). The hospital sent holding letters to inform patients if there was a delay in sending a formal response. A delay most commonly occurred when information was required from a consultant. The Director of Clinical Services reminded consultants to respond quickly to requests for information at the Medical Advisory Committee (MAC) meetings.

- There were procedures for sharing and learning from complaints across the hospital. Complaints were discussed at a senior level bi-monthly at the MAC meeting and Clinical Governance meeting, monthly at the Heads of Department meeting, weekly at the Executive Team meeting and at the daily communication meeting. Ward meeting minutes also showed evidence of staff discussing complaints and then implementing change. For example, at the June 2016 ward team meeting staff were reminded to access patient pain levels at every point of contact following a complaint about limited pain relief. In contrast, theatre staff said they received little feedback once reporting a complaint, although how often this occurred is unclear. If complaint feedback is not received it can result in limited learning and action from patient feedback at departmental level.
- At the December 2015 MAC meeting, it was reported that the hospital had received an increase in complaints from patients relating to unexpected financial costs. In response to this patient feedback, the hospital had produced a leaflet outlining the costs specifically relating to treatment at BMI The Chiltern Hospital. Patient cost information had also been placed in the waiting areas and consulting rooms.
- Patients said they were not aware of the complaints procedure, but said they would be happy to raise concerns if they had any. We saw comment boxes in pre-assessment and on the wards for patients to leave feedback cards but did not see specific leaflets on how a patient could make a complaint.

Are surgery services well-led?

Requires improvement

By well-led, we mean that the leadership, management and governance of the organisation assure the delivery of high-quality person-centred care, supports learning and innovation and promotes an open and fair culture.

We rated this service as requires improvement for well-led because:

- Governance processes were not always effective in monitoring the quality and safety of the surgery service at departmental level but this information was monitored by the hospital.. Information on performance, risks and incidents was shared with senior staff and regional teams but this information was not consistently shared with frontline staff.
- Although audits were completed, there no delegated person to ensure any required actions were completed or learning shared with staff. There were no formal written action plans to support completion of outcome from audits.
- Practices were taking place in the operating department that were not reflective of corporate polices or current national guidance. There was no hospital oversight of this. Across the hospital, there was a lack of monitoring of compliance with policies.
- Managers and staff did not use the hospital risk register effectively to identify and manage risks within the service. There was no risk register for each department. Some key risks within surgery were not included on the hospital risk register.
- The lack of a consistent and experienced theatre manager to lead and manage the operating department had resulted in no-one taking clear accountability and responsibility for the quality and development of the service.
- There was limited evidence of the monitoring patients outcome data locally to monitor the quality of the surgery service at the hospital.
- Staff felt unable to raise concerns via the whistleblowing process for fear of being identified.

- There was little engagement with patients, other than the use of patient surveys.

However:

- There was a corporate vision in place, supported by a hospital business plan. Senior managers were aware of the key risks that may affect them achieving the vision; although, there was no local vision or strategy for the surgical service.
- Staff across the service felt supported by their manager and valued the support of their team particularly during the number of changes in senior management. They had confidence in the new executive director, who was visible and staff felt able to raise concerns with them. Heads of department found the daily senior team meeting an effective way to share key information with them.
- The hospital had recently improved how it engaged and sought feedback from staff, also, a new awards scheme had been introduced to recognise the work and commitment from staff

Vision and strategy for this core service

- BMI Healthcare had a corporate vision 'to deliver the highest quality outcomes, the best patient care and the most convenient choice for our patients and partners as the UK leader in independent healthcare'. Senior managers were aware of this vision.
- The new hospital executive director, who had been in post for three weeks, had introduced the '6Cs' as a way of supporting staff to achieve the corporate vision. The '6Cs' help staff to focus on six key areas; care, compassion, competence, communication, courage and commitment. There had not been sufficient time for staff to adopt this new approach but they were aware of it.
- There was a hospital business plan in place to support the achievement of the corporate vision. This included aims and objectives and any challenges to achieving the aims, particularly the financial impact.
- However, there was no local vision for the surgery service, wards or theatres, to show how these services aligned with the corporate vision or to show how they wished to develop.

Governance, risk management and quality measurement

- Governance systems were in place at the hospital but these lacked detail and monitoring at departmental level to ensure local management of quality and safety. Practices were taking place in the operating department that were not reflective of BMI Healthcare corporate policies or national guidance, designed to keep patients and staff safe.
- Scrub practitioners were undertaking a dual role without the required risk assessments and policy being in place. This did not follow the corporate 'Policy for management of operating sessions for elective scheduled surgery' (2016). Theatre staff acting as a surgical first assistant were not identified on the rota, were not an additional member of the surgical team and could not provide evidence of completed competencies. This did not follow the recommendations of the Perioperative Care Collaborative (PCC) position statement on 'Surgical first assistant' (2012) or the BMI Healthcare 'Policy for the provision of surgical first assistants' (2013). The hospital could not provide audit evidence to show how it monitored practice against these particular hospital policies. There had been no detailed internal or external review completed of the operating department to provide assurance of quality and compliance with corporate and national standards.
- Although the hospital were up-to-date with the administrative checks for consultant practising privileges, they were behind on the biennial review of clinical work for 135 consultants. This did not follow BMI Healthcare 'Practising privileges policy' (2015) and raised concerns again about monitoring compliance with policies.
- The hospital also utilised the corporate clinical audit calendar which highlights audits to be completed on a monthly basis. We were told there was also a comprehensive integrated audit programme which incorporates both non-clinical and clinical audits conducted by corporate team specialists. The BMI hospitals quality account provided to us showed some patient outcome data for national reported information

were compared organisational wide and with national outcomes. However, there was a lack of information on how the hospital monitored clinical outcomes for patients.

- Whilst audits were completed and actions identified, there was no person identified as being accountable for sharing the results and learning to ensure the information reached relevant staff groups. There were no formal action plans. In the operating department, compliance with the World Health Organisation surgical safety checklist was audited but there was no evidence how the hospital shared the results with staff.
- Senior managers had not given sufficient priority to the investigation and closure of incidents. There were 105 outstanding at the time of our inspection (across the two locations managed by the one team), although the management had since addressed this. Systems and processes to keep patients safe were not being adhered to and prompt action taken to address any risks.
- There were no departmental risk registers for the operating department. There was a hospital wide risk register; this listed the top concerns and risks. The register was not always reflective of concerns raised by staff, such as the laminar airflow system in theatre one and the lack of hand washing sink on Shardeloes ward. This posed a risk that senior management did not have an overview of all risks relating to the delivery and management of services. However, minutes from clinical governance meetings showed senior staff discussed some risks relating to individual departments and action taken.
- There was a governance structure in place. Hospital sub-committees reported to the clinical governance committee and medical advisory committee (MAC). Senior leaders then reported to the corporate BMI Healthcare regional and national clinical governance structure. Outcomes from the clinical governance meetings were shared at the heads of department meetings; although, minutes from departmental meetings did not show this information always being shared with frontline staff.
- Agendas and minutes for meetings followed a standardised format, with actions listed, who was accountable for the action and by when. We saw from minutes of the clinical governance meetings that staff discussed complaints and incidents, including any learning and trends related to these events. They also discussed audits, policy reviews, updates from clinical committees and any external guidance or new legislation.
- Staff told us they found the daily 'huddle' a useful way of communicating information across the hospital. Senior staff and heads of department discussed daily activity, incidents and complaints at these meetings.
- The hospital had recently set up a theatre user group and defined the terms of reference; the group had not yet held any meetings. Its purpose was to maximise theatre efficiency and consider the quality and standards of the service, reporting to the MAC and hospital clinical governance committee. This group intended to review the National Safety Standards for Invasive procedures document and develop local policies to deliver safe care for patients.
- The medical advisory committee (MAC) had a role in granting, reviewing and renewing consultants practising privileges. They held meetings once a quarter, with minutes showing they discussed for example, complaints, hospital activity and practising privileges. We reviewed the minutes for the last three meetings and these did not contain discussions for medical staff due a biennial review.

Leadership of service

- An executive director had overall accountability for this hospital and two other locations, which were part of the same area group. There was an operations manager and a director of clinical services who took responsibility for these respective areas at the hospital.
- Staff raised concerns about the number of changes in senior management during the last 18 months. They felt this had affected the development and management of services at the hospital including the surgery service. They were though positive about the recently appointed executive director, who they felt was visible and took the time to listen to their concerns. Staff were hoping for a period of stability so the hospital could focus on improving the quality of the service they offered to patients.
- There had been two theatre managers in the last 12 months, which had a further impact on theatre staff due

to lack of consistent and sustained leadership. There were staff acting up to these roles or providing day to day management but they did not have the experience and capacity to effectively lead and challenge concerns about the service. However, theatre staff did feel well supported by the Director of Clinical Services during this time.

- Departmental managers found it difficult sometimes to complete the administrative aspects of their role. They had raised their concerns but told us the corporate team had declined their request for additional administration time. The senior management team told us administration time has been allocated to roles following careful analysis of the processes departmental managers are asked to complete.
- Staff told us the roles and responsibilities of the clinical lead were not clearly defined and they often raised concerns with the Director of clinical services instead.

Culture within the service

- Staff told us despite all the recent changes, they enjoyed coming to work. They commented on the strong team work and how the positive feedback from patients had helped during all the changes. Staff were flexible in the hours they worked to meet the needs of the service and patients. They felt valued and well supported by the senior staff at the hospital.
- However, staff did raise concerns, particularly in the operating department how the service at times ran to meet the needs of the consultants. This impacted on theatre session start and finish times. Staff would change their hours to ensure patients were seen but felt the hospital management needed to better manage and challenge the performance and approach of some consultants.
- Staff told us they found it difficult to whistle blow due to the small number of staff at the hospital. They felt there was a risk of identification if they raised a concern, even though they could raise this anonymously via an online form or to a central BMI Healthcare email address. Staff did not have confidence in the process and told us they had chosen not to raise concerns.
- The hospital was working towards a more open culture and there was a focus on the needs and experiences of patients, however, at times staff told us the culture felt financially driven, rather than patient centred.
- There were higher than average staff turnover rates (75%) in the operating department, from April 2015 to March 2016, for operating department assistants and healthcare assistants, however, the rate was 0% for theatre nurses. On the wards, turnover averaged 29% for all grades of nursing staff. Sickness rates over the same period were very variable both for staff in the operating department and on the wards, there was no consistent pattern, with sickness rates ranging from 0% to 30%. The hospital were reviewing the pay rates for permanent staff to see if changes could be made to improve staff retention and reduce agency staff costs.

Public and staff engagement

- The hospital had recently introduced a number of new schemes to recognise and acknowledge the contribution made by staff and seek their feedback. The hospital also regularly reviewed the feedback received from patients.
- The hospital on a weekly basis awarded the staff member who had best demonstrated the '6Cs', based on nominations from other staff at the hospital. There were also plans to introduce more social events for staff to reward the whole team for their hard work.
- A number of staff commented on the 'open door' policy of the new executive director and director of clinical services and felt able to raise concerns. The senior management team met with department leads at the daily 'huddle' and monthly managers meetings. The executive director planned to attend the first part of each department's monthly team meeting, so staff could raise concerns directly with them.
- Information was cascaded to staff through newsletters, emails and staff noticeboards.
- The results from the 2015 staff survey, showed an engagement score of 43 out of 100 compared with 51 in 2014. The response rate was 55%. The higher the score, the more satisfied staff are who work at that location. Feedback comments from staff were mainly around equity of pay, low morale lack of consistent senior leadership and the appearance of the hospital. We

asked the hospital for their action plan in response to the staff survey results, they did not provide one. However, the executive director had begun to address some of the concerns raised by staff.

- The hospital asked patients for feedback using the Friends and Family test, which they analysed on a daily and rolling month basis. A patient had been involved in the design of the new bathrooms to ensure they met the needs of patients with a disability.
- The hospital also held a monthly customer experience meeting. There were no patients as members of the group to seek their views and take action in response to suggestions made, even though the group identified one of its purposes was to 'understand situations from the customer's perspective'. Service improvement had occurred as a result of learning from verbal comments and the hospital now had a rolling programme in place for modernisation of patient rooms, which included replacement of beds and mattresses.

Innovation, improvement and sustainability

- The senior management had identified key areas for development to either sustain, improve of develop the services they provided for surgery patients.
- This included a new air-handling unit for the central sterile supplies department to ensure safe storage of equipment, an upgrade of the recovery area in the operating department and the purchase of camera stacks for theatre.
- The senior management had long-term plans to develop the orthopaedic service to increase the number of referrals and develop their ambulatory care service to reduce the need for patients to stay overnight. In the future, they hoped to run more nurse-led clinics.
- The hospital had an on going refurbishment programme. Three staff commented on the hospital looking more presentable for patient and visitors. They valued the new executive director taking prompt action to improve the appearance.

Requires improvement

Outpatients and diagnostic imaging

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

Information about the service

Outpatient services at The BMI Chiltern Hospital include services from 27 different specialities including orthopaedics, dermatology, ophthalmology and cardiology. A diagnostic imaging department is also available, which provides x-ray, ultrasound scans, Computerised Tomography (CT), Magnetic Resonance Imaging (MRI), bone density scanning, and mammography. There is was a separate physiotherapy department.

The Chiltern Hospital is part of the BMI South Buckinghamshire Hospitals group. The senior management is shared between this hospital and two other services. We inspected one of these services, The Shelburne Hospital at the same time as The Chiltern Hospital. There are similarities in our findings and the content of both reports due to this and the overall management of the hospitals being the same.

The outpatient department have eight consulting rooms, which are used for any speciality, and three rooms in a separate area for consultations by ear, nose and throat consultants. The department also has one audiology room. Consultants lead all clinics with support from registered nurses and health care assistants. Minor operations had been performed in a dedicated room in the outpatients department until recently. At the time of our inspection the minor operations room was out of service and these procedures were performed in the endoscopy suite.

The majority of patients were seen in outpatient clinics Monday to Friday, with some evening and weekend clinics. The outpatient department held 52,769 appointments from April 2015 to March 2016, 20,832 of these were first attendances and 31,937 were follow-up appointments.

Patients attending the outpatient department were either NHS funded, self-funded or used private medical insurance. The hospital had recently stopped seeing children under the age of 18.

The diagnostic imaging department consisted of x-ray rooms, a mammography room, an ultrasound room, bone density scanner, CT and MRI scanner. The department also had mobile equipment for use in other areas, for example theatre. CT scans were available 9am to 5pm, MRI scans 8am to 8pm and general x-rays 8am to 9.30pm Monday to Friday.

The physiotherapy department had six treatment rooms, a traction room, a hand therapy room, gym and hydrotherapy pool.

During our inspection, we visited the outpatient, physiotherapy and diagnostic imaging departments. We spoke with eight patients and 16 staff including nurses, healthcare assistants, physiotherapists, radiographers, receptionists and administrative staff. We observed staff providing care to patients, reviewed three patient records and analysed data provided by the hospital before and after the inspection.

Requires improvement

Outpatients and diagnostic imaging

Summary of findings

We rated this service as requires improvement because:

- The incident reporting system used by the hospital at the time of the inspection was not robust. There was a delay in the investigation and closure of incidents. Staff had reported, although the hospital addressed the delay after the inspection. There was a lack of assurance who had oversight for timely investigations and that the hospital had implemented any learning quick enough to ensure patient safety. Managers and staff could not accurately describe the trends of incidents or learning in their department and staff did not always receive feedback on incident reports.
- The diagnostic imaging department could not provide assurance staff always practised within Ionising Radiation (Medical Exposure) Regulations (IRMER). In the diagnostic imaging department, staff did not always correctly document patient safety and identification checks prior to carrying out a radiation scan. A consultant did not document dosage levels when using the image intensifier in theatre although the hospital had written to the consultant three times there was no evidence of improvement.
- There was new management across departments who were still familiarising themselves with the service, departments and hospital. The outpatients department had recently appointed a new manager who had not yet commenced in post and the outpatient manager was acting up as manager in an interim role. At the time of our inspection, managers did not demonstrate an understanding of the risks or clear oversight of the governance processes to monitor the quality standards of the service.
- There was no departmental risk register and therefore the hospital could not provide assurance that departments managed key concerns in a timely way. The hospital risk register did not reflect the risks at a department level and was not in sufficient detail to outline how risks were monitored and by whom.
- Not all staff completed mandatory training appropriate to their role. Not all staff knew how to recognise a child or adult at risk of abuse. The hospital had not provide safeguarding children training level two to some members of staff as required by their own corporate policy.

However:

- Staff treated patients with dignity and respect and provided emotional support throughout their treatment. Staff helped patients to understand their condition or treatment by giving written information after their treatment and allowing time to ask questions. Patients could request to have a chaperone present during their examination or consultation if needed.
- The diagnostic imaging department had access to a Radiation Protection Advisor and Radiation Protection Supervisor. The department displayed radiation hazard signs appropriately and access to controlled areas was secure.
- The hospital met the NHS referral to treatment (RTT) indicator and gave patients a choice of appointments at times that suited their needs.
- Staff valued the new hospital director and told us they had made a positive impact on the hospital. Staff worked well together across multidisciplinary teams to ensure services met the needs of patients.

Requires improvement

Outpatients and diagnostic imaging

Are outpatients and diagnostic imaging services safe?

Requires improvement

By safe, we mean people are protected from abuse and avoidable harm.

We rated safe as requires improvement because:

- Although we saw posters encouraging staff to 'pause' to complete patient safety checks prior to carrying out a radiological scan, we found staff did not always correctly document they had carried out these checks. An audit of imaging request cards showed staff did not document they had completed the checks in 72 out of 100 patients.
- The incident reporting system used by the hospital at the time of the inspection was not robust. There was a delay in the investigation and closure of incidents, although the hospital addressed the delay after the inspection. There was a lack of assurance who had oversight for timely investigations and that the hospital had implemented any prompt learning to ensure patient safety. Managers and staff could not accurately describe the trends of incidents or learning in their department and staff did not always receive feedback on incident reports.
- In the outpatient department, each consulting room had access to a call bell but staff could not demonstrate how to use these in an emergency and did not know if the call bells worked. There was no evidence of regular testing.
- Although staff received adult safeguarding training, staff did not receive safeguarding children training appropriate to their role and did not always have sufficient knowledge on how to recognise a safeguarding concern. Staff did not always know who the safeguarding lead was. Departments did not display safeguarding escalation flowcharts.
- Although the hospital had met the mandatory training target for most modules, a significant number of staff had not completed practical manual handling training which could pose a risk to staff and patient safety.
- In the outpatient department, although risk assessments had been completed in 2013, there was no evidence of a full review after this date.

However:

- There was a nominated Radiation Protection Supervisor (RPS), who had received appropriate training. Staff had good communication and support from the Radiation Protection Adviser (RPA) and a current RPA audit and report.
- The hospital complied with safety measures to monitor staff exposure to radiation such as providing appropriate personal protective equipment and personal dosing badges. The diagnostic imaging department displayed appropriate signage on x-ray doors to prevent people entering. The Magnetic Resonance Imaging (MRI) and Computerised Tomography areas had restricted access.
- We observed the outpatient, diagnostic imaging and physiotherapy department was visibly clean and staff adhered to infection control policies and procedures such as using personal protective equipment and being 'bare below the elbow'.
- The hospital held up-to-date records for all equipment in the physiotherapy, diagnostic imaging and outpatient department. The diagnostic imaging department had a clear process in place for repairing essential equipment such as the CT and MRI machines.
- All outpatient services had good systems in place to ensure medicines were stored appropriately and securely.
- The hospital had business continuity and major incident plans in place should a significant event occur at the hospital or in the local area. Staff knew what to do in the event of a fire and held regular fire drills.

Incidents

- Staff knew how to report incidents using the hospital paper based incident reporting system. Incidents were then uploaded to a central database, by a member of the quality and risk team. The hospital planned to introduce electronic reporting of incidents in October, with training for staff starting in August. There was a

current risk of the quality and risk team not uploading information correctly due to being unable to read the hand written forms and they did not actually witness the incident

- At the time of our inspection, there was a delay in closing a total of 105 incidents across this hospital and a second hospital managed by the same team. The quality and risk team had to chase managers to complete investigations so they could record the outcome and close the incident. The senior management told us they had closed 100 of these incidents by 8 August 2016. The remaining five were within the 20-day timescale for the relevant department to investigate and report on the learning and outcomes. We had concerns the backlog had delayed the hospital applying learning and action, with a potential impact on safe care and treatment for patients. Managers could not accurately describe the trends relating to incidents in their department and could not give examples of where learning from incidents had improved clinical practice.
- Departments discussed incidents in a daily communication meeting, but staff could not always describe the learning from these. Staff also told us they did not always receive individual feedback when they had reported an incident.
- From April 2015 to March 2016, staff reported 207 clinical incidents across all outpatient services. This made up 55% of the hospital's clinical incidents for this period. In the same period, the departments also reported 12 non-clinical incidents, which made up 13% of the hospital's non-clinical incidents.
- In the diagnostic imaging department, staff could discuss their responsibility for reporting incidents about the Ionising Radiation (Medical Exposure) Regulations 2000 (IRMER). The hospital told us they did not have any IRMER incidents from April 2015 to March 2016.
- The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of 'certain notifiable safety incidents' and provide reasonable support to that person. In all outpatient services, staff had a basic understanding of the principles of duty of candour

Cleanliness, infection control and hygiene

- All the waiting areas and consulting rooms we visited were visibly clean and tidy.
- Patients and staff had access to hand sanitiser points at reception and in frequent locations across all the outpatient services. This promoted good hand hygiene practice.
- In the outpatient department, each consulting room had a cleaning schedule. However, we observed staff had not always completed this on a daily basis. It was not clear on the cleaning schedule if rooms had been in use on these days.
- The hospital employed an outside contractor to carry out legionella testing across all hospital departments.
- Members of the physiotherapy team checked temperature, PH and chlorine levels of the water in the hydrotherapy pool twice a day. We saw records in the physiotherapy department confirming this practice. Staff also sent pool water samples to the microbiology for further analysis.
- In diagnostic imaging, we saw staff completed cleaning schedules. Radiographers took responsibility for cleaning equipment after each use. Equipment used for invasive procedures were decontaminated in a suitable way.
- Staff in the outpatient department told us they carried out regular infection control and prevention audits. The hospital provided data showing the outpatients department and diagnostic imaging achieved 92% compliance and physiotherapy achieved 100%. Staff could not describe any action taken, or learning from these audits.
- All consulting rooms had sharps bins available for the safe disposal of needles. We observed sharps bins had been correctly signed on assembly and staff ensured these were not overfilled in line with best practice for health and safety.
- Staff had access to personal protective equipment (PPE) such as gloves and aprons in all outpatient areas to ensure their safety when carrying out procedures. We observed single patient use plastic covers for equipment such as jaw x-ray machines in diagnostic imaging to prevent cross infection between patients.

Requires improvement

Outpatients and diagnostic imaging

- Staff in all outpatient services adhered to the 'bare below the elbow' guidance, which allowed for thorough hand washing and reduced the spread of infection between patients and staff.
- Some consulting rooms had carpeted flooring. The hospital planned to replace this as carpets posed an infection control risk. We observed the outpatient department had recently replaced carpet in the corridor with wooden flooring.
- The hospital provided Infection Prevention and Control (IPC) training for staff depending on their role. The IPC basic awareness training had been completed by 88% of eligible staff, 76% of eligible staff had completed the IPC in healthcare training and 77% of eligible staff had completed the high impact, care bundles and Aseptic Non Touch Technique (ANTT) training.

Environment and equipment

- Equipment across all outpatient services was visibly clean. We observed equipment with labels showing last service and review date. All equipment also had an asset number to allow tracking and maintenance of the item. We found some equipment that was out of service and not labelled to inform staff not to use it. However, all staff knew the equipment was not to be used.
- In the outpatients department the minor operation room was out of service due to a fault with the airflow system. This was included on the hospital risk register but the outpatient sister was not aware this had been added. In diagnostic imaging, the fluoroscopy equipment was broken and not labelled to prevent staff using it. Although there was a risk assessment in place, this had not been updated to show the equipment was out of service and not labelled. Staff told us they had made all staff aware not to use this equipment but there was a risk that new staff or bank staff would not be aware of this. Staff in the outpatient department and diagnostic imaging told us equipment required updates in their areas. The hospital had recognised this and reflected it in their quality improvement action plan and capital expenditure budget.
- Senior staff in the outpatients department did not recognise specific environmental and equipment risks within the service. Although risk assessments had been written in 2013, there was no evidence of a full review in 2014 or 2015.
- In the outpatient department, each consulting room had access to a call bell but staff could not demonstrate how to use these in an emergency or provide evidence of regular testing. We asked staff to test this during our inspection, the staff member performing the test did not know if the call bell worked and staff hearing the call bell were not sure how to respond.
- Resuscitation equipment was clean, well maintained and ready for use in an emergency. Staff kept a log of daily checks; this was complete and up to date. In hydrotherapy, a stretcher was available to transfer patients out of the pool area in an emergency. Staff also had access to a technician and engineer should any maintenance issues arise.
- The hospital accessed a Radiation Protection Advisor (RPA) from an external company who completed equipment safety and paperwork audits. The hospital also had a Radiation Protection Supervisor (RPS) on site that was responsible for ensuring the diagnostic imaging department was complaint with Ionising Radiations Regulations (1999). All the staff we spoke with had knowledge of the RPS and their role.
- Staff in the diagnostic imaging department carried personal dosing badges, which recorded their exposure to radiation. The department monitored this for all staff at three monthly intervals.
- Staff had access to PPE such as lead coats and aprons. We observed staff carried out a yearly audit to ensure PPE was in good working order and not damaged.
- The diagnostic imaging department displayed radiation hazard signs outside all x-ray rooms and only authorised staff could access the Magnetic Resonance Imaging (MRI) and Computerised Tomography (CT) areas using a keypad entry system.
- Equipment reports for diagnostic imaging had been completed and kept up to date. The department had a clear process in place for repairing vital equipment. During our inspection, staff had identified a fault with the CT scanner and an engineer was on site to fix the equipment. We observed a clear record of the equipment signed out to the engineer and then back to the hospital once work was completed.

Medicines

Requires improvement

Outpatients and diagnostic imaging

- Medicines were stored safely across all outpatient services. In the outpatient department, staff kept all medicine cupboards locked and the nurse in charge held the key. Staff kept medicine fridges locked and checked and recorded temperatures daily to ensure medicines were kept at the correct temperature.
- Staff placed medicines required by consultants in clinic in a sealed blue bag and locked them in individual cabinets in the consulting rooms prior to the start of the clinic. The nurse is charge held the key and opened the cabinet when requested.
- Prescription pads were also stored in locked cabinets and signed in and out for each clinic. The hospital monitored the use of prescriptions by individual consultants.
- In diagnostic imaging, staff kept contrast in a locked warmer and keys were stored in a key safe within the CT and MRI viewing room. The code for the key safe was only available to radiographers.
- Staff disposed of used contrast medication syringes in a box designed for this purpose as most syringes still contained some contrast medication. Staff kept the box in a locked room and only authorised staff could gain access.
- When patients required contrast by injection, two members of staff were present and emergency medication was available for use in the case of a severe allergic reaction. Staff told us they would call the Resident Medical Officer (RMO)and an emergency ambulance if a patient suffered a severe allergic reaction to the contrast injection. Staff gave patients having a scan with contrast an information sheet with advice about the side effects and how to contact the department if needed.
- The diagnostic imaging department had a patient group directive (PGD) for hyoscine butylbromide. The PGD was authorised by the senior pharmacist and consultant radiologistin line with legislation. The PGD was current and had a review date of March 2018. A PGD provides a legal framework that allows registered nurses and radiographers who have completed appropriate additional training and signed the PGD to administer a specified medicine(s) to a pre-defined group of patients, without them having to see a doctor.

Records

- The hospital stored patient's medical records at another local BMI site. A driver transferred notes to the hospital for outpatient clinics and staff stored these securely in the outpatient department until needed.
- Consultants took responsibility for holding their own patient records in the outpatient department. Staff told us secretaries ensured this information was available in the hospital medical records.
- Staff spoke positively about the medical records service and told us they had no difficulty in obtaining notes for clinic. Staff told us if a patient booked an appointment at short notice, they would contact medical records and arrange for administrators to fax notes to the hospital. A secure fax was available on site.
- The hospital's radiological images were stored on a nationally recognised Picture Archiving and Communication System (PACS). The hospital also had the same information system as the local acute NHS trust hospital for patient population records and radiological reporting. The diagnostic imaging department could also provide and request patients' radiological examinations electronically from other hospitals. Access to these records meant patients who had previously had radiological examinations in the NHS did not need them repeated, and so were not exposed to unnecessary radiation procedures
- We reviewed the physiotherapy records audit completed in March 2016, which showed the department was compliant with all standards apart from keeping the referrer up to date with the patient's progress and reviewing patients who exceed six sessions. There was no action plan documented on the audit to show how staff planned to address this.

Safeguarding

- Staff told us they completed safeguarding children and vulnerable adults modules in their mandatory training. Hospital records showed 92% of staff had completed level one safeguarding children training and 91% of staff had completed level one safeguarding vulnerable adults training. This met the hospital target of 85%.
- The BMI policy for safeguarding included what action staff should take if they had concerns a patient had undergone female genital mutilation (FGM).

Requires improvement

Outpatients and diagnostic imaging

- We were told by senior staff in April 2016 BMI introduced training package on their e-learning system, which introduced the different levels of training to bring this in line with the intercollegiate document with the four different levels of training being provided. We were told prior to April 2016 all staff at the hospital were trained using one training module that would have covered the aspects required for level one and level two safeguarding children training.
- Information provided by the hospital indicated that only staff in a management or supervisory role were required to undertake level two safeguarding children and adults training and 96% of staff in this group had completed training. However, the BMI Safeguarding Children policy states that all staff who have some degree of contact with children, young people and/or parent or carers should complete a minimum of level 2 safeguarding training. The policy takes this requirement from the intercollegiate document Safeguarding children and young people: roles and competencies for health care staff (2014). This meant all staff caring for adult patients who have children required level 2 safeguarding children training. The service therefore did not provide its staff with safeguarding training that met the requirements of its own corporate policy.
- The hospital provided a training session on protecting people at risk of radicalisation in line with the Government Prevent strategy, 91% of staff had completed this training.
- The diagnostic imaging, outpatient and physiotherapy departments did not display clear information for staff on how to escalate a safeguarding concern.
- Staff we spoke with demonstrated some basic understanding of safeguarding issues but did not know how to recognise more complex or less obvious signs of potential abuse. The hospital had a nominated lead for safeguarding children and adults. However not all staff knew who this was and told us they would inform the consultant if they had a safeguarding concern. This could lead to staff not following the hospital safeguarding process or a delay in referring the concern to the lead for safeguarding.

Mandatory training

- Staff completed a number of mandatory training modules. This included, display screen equipment, infection control, basic life support, Control of Substances Hazardous to Health (COSHH), fire, equality and diversity and children and adult safeguarding.
- Staff received training through the BMI online learning package (BMiLearn), face to face and practical sessions.
- As of April 2016, compliance with mandatory training for staff working at the hospital was inconsistent. The hospital target was 85% compliance, this had been achieved for 16 of the 50 courses. Courses which were less than 50% compliant included patient moving and handling (47%).
- There was a role specific mandatory competency programme in place for staff in the diagnostic imaging department. This included plain film processes, MRI, CT scanning and ultrasound. We looked at a random sample of staff competencies and these were all completed and in date. Staff also completed training to give intravenous contrast via a pump. All seven members of staff required to administer contrast had completed this training. Four members of staff had also completed additional training to allow them to deliver pump teaching sessions to other staff.

Assessing and responding to patient risk

- Staff in the diagnostic imaging department told us they completed a six-point check prior to performing a radiological scan to ensure the correct patient received the correct scan. We saw audit results from May 2016 which highlighted staff did not correctly document they had completed this check for 72% of the 100 records reviewed. A staff member told us they discussed the audit results at a team meeting but could not provide evidence of this. We did observe posters encouraging staff to 'pause' to complete checks before performing scans.
- Staff in the outpatient, diagnostic imaging and physiotherapy department knew how to recognise and respond to patients who became unwell.
- The hospital employed Resident Medical Officers (RMO) who were on call at all times and based at the hospital. The RMO's were trained in advanced life support and European Paediatric Advanced Life Support (EPALS). They provided support to the outpatient staff if a patient

became unwell. Patients who became medically unwell in outpatients would be transferred to the inpatient ward or to the local acute NHS Trust in line with the emergency transfer policy

- Hospital records showed 80% of clinical staff had completed adult basic life support training and 71% of eligible staff had completed adult intermediate life support. The hospital did not provide a breakdown of training figures by department so it is not possible to identify the significance of these results for outpatient services.
- In the hydrotherapy pool, staff we spoke with had a good understanding of emergency protocols. We observed an emergency button in the pool area and staff wore an emergency button around their neck to summon help in an emergency.
- The hydrotherapy department had an emergency evacuation plan and staff received yearly training in emergency procedures and pool evacuation.
- Staff could access advice from the Radiation Protection Advisor (RPA) by telephone and email. We saw an example of where this had taken place two weeks prior to our visit and staff told us they received a response within two days.
- The imaging department had a list of all professionals who had authorisation to request a radiation scan. Nursing staff with authorisation to request a radiation scan had additional training in line with IM(ME)R guidelines. This meant diagnostic imaging staff could ensure all staff making imaging requests had appropriate training and authorisation to do so. Staff told us they felt confident to challenge requests if they felt they were incorrect or inappropriate.
- We saw the most recent RPA audit report completed in May 2015. This highlighted a consultant not documenting use of the image intensifier in theatre in line with IR(ME)R guidelines. Managers had written to the consultant on three occasions without any improvement. The manager was new in post and could not tell us the actions or learning around this incident. During our unannounced visit, the manager told us the hospital had employed an assistant practitioner for theatres to ensure consultants carried out the correct documentation and the department would re-audit this area to ensure compliance.
- Staff in the diagnostic imaging department told us they completed pregnancy checks for all women aged between 16and 55 prior to any radiation scan. We saw evidence staff had completed these checks during our inspection. We also observed signs in the department asking women to inform the radiographer if they may be pregnant.

Nursing staffing

- There are no national guidelines on safe staffing levels for the outpatient department. Outpatient and diagnostic imaging staff told us they had sufficient numbers of staff to meet the workflow and patient needs in a safe manner. The outpatient manager told us they did not have a formal system in place for planning staffing.
- At the time of our inspection, the outpatient department manager told us they had three registered nurse vacancies and two health care assistant vacancies across the three sites they covered. The department filled these shifts with their own bank staff.
- In the outpatient department, from May 2015 and February 2016 the use of bank nurses and healthcare assistants was above the average for independent hospitals. The rate of bank registered nurses was between 39% and 57%. For health care assistants in the outpatient department this was between 14% and 17%.
- The diagnostic imaging department manager was responsible for the imaging department across two BMI sites. They told us they had 12 members of staff including part time and bank staff. At the time of our inspection, the department had one vacancy for a radiographer for 30 hours per week, which was covered by the use of bank staff. The manager told us staffing was safe on every shift.
- The physiotherapy department employed 21 permanent members of staff, which equated to 11.7 full time equivalent posts. The hospital had a budget for 12.5 full time equivalent members of staff therefore the service was one part time member of staff short. The hospital employed bank staff to provide cover for the service.
- Staff teams had daily communication meetings to share important updates, such as changes to planned clinics or staffing for the day.

Medical staffing

Requires improvement

Outpatients and diagnostic imaging

- There was sufficient consultant staff to cover outpatient clinics, including Saturday clinics. Consultants agreed clinic dates and times directly with the outpatient administration team.
- Staff told us they found medical staff supportive and could seek advice when needed.
- The hospital employed a Resident Medical Officer who provided medical support to the outpatient, physiotherapy and imaging departments.

Major incident awareness and training

- The hospital had local and corporate business continuity plans for use in events such as a power failure or adverse weather conditions.
- There was a corporate 'Major Incident' policy for staff to follow should a significant event occur at the hospital or in the local area.
- A hospital-wide fire alarm test took place on a weekly basis. Each area had fire check cards, which prompted staff to complete checks of each area in the case of evacuation due to fire.

Are outpatients and diagnostic imaging services effective?

By effective, we mean that people's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on best available evidence.

We inspected but did not rate effective as we do not currently collate sufficient evidence to rate this.

- Staff in all outpatient services had training and competencies appropriate to their role and this included additional skills such as cannulation. Staff reported they had regular appraisals and the hospital placed this as a high priority for their development.
- Staff in diagnostic imaging and physiotherapy department had a clear knowledge of evidence-based treatment such as diagnostic reference levels and good practice on managing hydrotherapy pools. Although the outpatient sister participated in the BMI user group, there was no evidence learning from this group had been used to change clinical practice in the department.
- The hospital participated in some national patient outcome audits such as the patient reported outcome measures programme (PROMS) and recently joined the private health information network (PHIN).
- There was good multidisciplinary team working across all departments and provision for patients to access diagnostic imaging and outpatient consultant clinics within the same appointment.
- Staff received training on consent and obtained consent to care and treatment in line with legislation and guidance including the Mental Capacity Act 2005.

However:

- In the diagnostic imaging and physiotherapy department, audits had highlighted areas where staff did not always follow policy and guidance. There was no evidence managers tracked progress to improve this or shared learning with staff.
- The hospital had a policy and system in place for granting of practising privileges for medical staff wishing to work at the hospital. There was a backlog in completion of the required biennial clinical reviews for 135 medical staff for assurance on local clinical performance.

Evidence-based care and treatment

- In diagnostic imaging, staff and managers had a good knowledge of Ionising Radiation Regulations 1999 and the Ionising Radiation (Medical Exposure) Regulations 2000 (IRMER). The department maintained records of equipment servicing and had access to qualified specialists. However, not all staff and consultants complied with local policies and procedures for using equipment.
- Although IR(ME)R audits such as image quality and request cards were undertaken in line with national guidelines, Staff could not describe learning or changes in practice from audits. We saw records of these audits, which had clear outcomes, and proposed actions however, there was no evidence the department had put these into practice.
- Local diagnostic reference levels (DRLs) were in use in the imaging department. DRLs ensure a patient does

not receive an unnecessarily high dose of radiation. The department audited DRL's regularly and we saw evidence of these during our inspection. Staff displayed DRL's on the wall in each room for guidance.

- The physiotherapy department followed The Chartered Society of Physiotherapists guidelines on good practice in hydrotherapy.
- The outpatient sister attended the BMI outpatient user group. This group met quarterly to share best practice across the organisation. The outpatient sister could not give examples of how learning from this group led to changes in practice within the department.

Pain relief

- The outpatient department did not have a pain management policy or protocol in place at the time we visited. This posed risks that patient's pain may not be recognised and managed appropriately and in a consistent way.
- Staff told us they would call the Resident Medical Officer (RMO) or the patient's consultant if a patient displayed signs of pain before or after a procedure.

Patient outcomes

- The physiotherapy service reported on the patient reported outcome measures programme (PROMs) using the national quality of life questionnaire (EQ-5D-5L). The results showed that patients received effective treatment as the majority of patient's health outcomes improved.
- At a corporate level the provider was working with the Private Health Information Network (PHIN). PHIN planned to provide information for the public from April 2017 on 11 key performance measures, so a patient could make an informed choice where to have their care and treatment for providers offering privately funded healthcare.
- The diagnostic imaging department carried out regular image quality audit, which could also form part of staff performance management if required.
- The diagnostic imaging department did not currently take part in the Imaging Services Accreditation Scheme (ISAS), however the manager told us they had plans to gain accreditation following a trial in another BMI hospital

Competent staff

- Patients told us that they felt staff had the appropriate level of skill to provide the care they needed. Staff across all outpatient services gave us examples of training courses they had attended to develop their professional skills and experience.
- In the current year from October 2015 to July 2016, 79% of nurses and health care assistants in the outpatient department had received an appraisal. The hospital had a target to complete 100% of appraisals by September 2016. Staff told us they had regular appraisals and they felt the hospital placed a high priority on this.
- Diagnostic imaging bank staff, who did not routinely work at the hospital, always worked with an experienced BMI Chiltern Hospital staff member.
- Radiographers performing scans using contrast had completed a nationally recognised cannulation course and completed supervised practice by a radiologist to pass their competency assessment. Staff updated their competency assessments and undertook supervised practice every year.
- Radiographers also had competency assessments for the equipment they used. We looked at a selection of these, which were complete and up to date.
- Senior management completed a number of checks prior to granting consultants practising privileges at the hospital. The term 'practising privileges' refers to medical practitioners being granted the right to practice in a hospital. In order to maintain their practising privileges consultant medical staff were required to supply copies of current insurance, a disclosure and barring scheme check, their registration, last appraisal for their main place of work and evidence of completion of the required mandatory training. The hospital were up-to-date with these annual checks but they were behind for the review of clinical performance that took place biennially with the Medical Advisory Committee (MAC), in keeping with the BMI Healthcare 'Practising privileges policy' (2015). The policy contained a standard agenda that the MAC should adopt which included biennial review of practising privileges. We reviewed the minutes for the last three meetings and these did not contain discussions for medical staff due a biennial review.

Requires improvement

Outpatients and diagnostic imaging

- There were a total of 135 medical staff who were due a biennial review, seven reviews were significantly out of date 1 from 2007, three from 2009, one from 2010 and two from 2011. Six of the seven medical staff were undertaking clinical work at the hospital. There was no assurance that the hospital were actively monitoring the local clinical performance of staff who held practising privileges for the hospital. We discussed this with the executive director who was accelerating the reviews, with the aim of being up-to-date by the end of October 2016 .
- However, we did see in the minutes from the MAC meetings that the group had reached decisions to grant or stop practicing privileges and appropriate action taken, where the MAC had identified concerns about performance or conduct.

Multidisciplinary working

- From the care we observed, there was effective team working, with strong working relationships between all staff groups**.**
- Departments worked closely to ensure patients did not have to make unnecessary visits.
- Staff told us radiologists had a good working relationship with consultants. Radiologists contacted the patient's consultant directly if they found abnormalities on scans or x-rays.
- The hospital had a service level agreement with the local NHS trust for patients who required emergency treatment that the hospital could not provide.
- The hospital ran a breast clinic where patients could see their consultant, have a mammogram and biopsy in one visit. Results were available electronically for consultants to view in the clinic.

Seven-day services

- The hospital held the majority of outpatient clinics Monday to Friday, with clinics running until late in the evening. The department worked flexibly, with clinics also held on Saturdays.
- The diagnostic imaging department had appointments from 8am and 9.30pm Monday to Friday. At other times there was an on call service to provide emergency cover for thewards. The diagnostic imaging manager told us they had plans to extend the opening hours to include a Saturday clinic.
- The physiotherapy offered clinics to outpatients Monday to Thursday from 8am to 8pm, Friday 8am until 4.30pm and Saturday 11.30pm until 4.30pm.

Access to information

- Staff spoke positively about the medical records service and told us they had no difficulty in obtaining notes for clinic. Staff told us if an appointment was booked at short notice, they would contact medical records and administrative staff would fax notes to the hospital. A secure fax was available on site.
- The hospital's radiological images were stored on a nationally recognised Picture Archiving and Communication System and had the same Computerised Radiology Information System as the local acute NHS trust hospital for patient population records and radiological reporting.
- Staff we spoke with reported timely access to blood test results and diagnostic imaging. Results were available for the next appointment or, for certain clinics, during that visit, which enabled prompt discussion with the patient on the findings and treatment plan.
- We reviewed all incidents occurring in the outpatient department from August 2015 to July 2016. Seven of these related to medical records not being available for clinic. We observed that in most cases, staff had prepared a new set of notes but on two occasions, consultants saw patients without their medical records. There was no action plan in place to address this.
- Outpatient consultations within the hospital were consultant-led. All patients attending a clinic had a GP referral letter. The outpatient administration staff monitored this process.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff received information about the Mental Capacity Act 2005 and associated Deprivation of Liberty Safeguards in their mandatory Adults at Risk training. Hospital

records showed 91% of staff had completed safeguarding vulnerable adults level one training and 96% of staff had completed safeguarding vulnerable adults level two training

- Staff received training on consent and 93% of staff had completed this training. Staff sought verbal consent from patients for general x-ray and outpatient procedures carried out. The consultants sought written consent for minor operations.
- The hospital did not carry out consent audits for patients undergoing minor operations in the outpatient department.

Are outpatients and diagnostic imaging services caring?

Good

By Caring, we mean that staff involve and treat people with compassion, kindness, dignity and respect.

We rated 'caring' as good because:

- Staff interacted with patients in a friendly and supportive manner, treating them with dignity and respect throughout their treatment or appointment.
- Patients had access to chaperones during consultations and departments clearly displayed signs in waiting areas and consulting rooms.
- Patients told us they were given time to ask questions and understood their condition and treatment plan.
- Staff provided emotional support to patients throughout all outpatient services.

Compassionate care

- Staff across all outpatient services treated patients with compassion, dignity and respect. All the patients we spoke with praised the staff highly for their caring and attentive manner. We received comments such as; 'the best thing about the hospital is the staff, they are so lovely and welcoming'' staff are very kind' and ''the staff are very professional and caring'.
- Staff interacted with patients in a friendly and supportive manner. For example, we observed a group hydrotherapy session where the physiotherapist gave individual help and encouragement to all the patients.
- We observed staff treating patients with dignity and respect. For example, staff in the diagnostic imaging department provided women undergoing mammograms access to half gowns and explained the procedure before patients got undressed to maintain their privacy and dignity. The hydrotherapy and diagnostic imaging department also offered single cubicles for patients to change.
- Patient Led Assessments of the Care Environment (PLACE) for February to June 2016 showed the hospital scored 80% for privacy, dignity and wellbeing, which was slightly lower than the England average of 87%. PLACE assessments assess the quality of the patient environment against set criteria.
- All outpatient services displayed signs in the reception area and in consulting rooms offering patients a chaperone.
- The hospital took part in the Friends and Family Test (FTT). There was no breakdown of these figures displayed therefore it was not possible to identify the significance of these figures with regard to outpatient services. The results for the hospital showed from October 2015 to March 2016 100% of patients were either 'likely' or 'extremely likely' to recommend the hospital to their friends and family apart from February 2016, this was 94% and lower than the England average of 100%. The response rate was between 20% and 64%.

Understanding and involvement of patients and those close to them

- We observed a staff member discussing the warning signs of an allergic reaction to contrast with a patient. The information was clear and concise and included how to obtain further advice. We reviewed records documenting patient telephone calls to the department for advice. Staff had dealt with the enquiries appropriately and provided a follow up call one to two days later.
- All patients we spoke to told us they had a clear understanding of the next steps in their treatment, for

example, if they required another appointment or more tests. Reception staff assisted patients to make follow up appointments and all patients knew how they would receive details of their appointment.

Emotional support

- Staff showed a clear understanding of the importance of providing emotional support to patients. Staff gave us examples of when carers had accompanied patients during their procedure and they had taken additional time to provide reassurance to patients who were anxious.
- In the outpatient department, a breast care nurse specialist attended patient consultations to provide support to patients who may be receiving bad news.
- Patients had a clear understanding of their condition and proposed treatment plan. Patients told us staff used clear explanations and gave them time to ask questions about their treatment. Patients received written information about their condition or procedure during consultations if required.

Are outpatients and diagnostic imaging services responsive?

Good

By responsive, we mean that services are organised so that they meet people's needs.

We rated 'responsive' as good because:

- The hospital planned outpatient services to meet the needs of patients, offering good access to appointments at times that were convenient to them.
- There was evidence of learning and action taken in response to complaints.
- Staff provided additional support to patients living with dementia or disabilities including prioritising them when waiting for clinic appointments.
- Outpatient facilities met the needs of all patients providing ample seating, magazines and access to hot drinks. The outpatient department had made provision for disabled access toilets and baby changing facilities.
- The hospital provided text reminders for patients giving details of their appointment.
- Patients had minimal waiting times and staff informed them if there was a delay or cancellation.

However,

- The diagnostic imaging department changing rooms were small and did not allow patients enough room to change comfortably.
- The hospital did not send out written information to patients explaining their outpatient treatment or procedure. Some patients raised this as an issue during our inspection.

Service planning and delivery to meet the needs of local people

- The outpatient and physiotherapy department planned services around the needs and demands of patients. Appointments were available Monday to Friday on Saturdays to accommodate patients with commitments during the working week.
- The diagnostic imaging department offered appointments Monday to Friday but did not offer a weekend service to outpatients. The manager recognised this and told us plans were being developed to offer a weekend service.
- The outpatient areas were bright and welcoming with ample seating provision. Hot drinks were available in the main outpatient reception for all patients. The hospital provided magazines and free internet in all outpatient areas.
- The hospital was well signposted and had ample parking for all patients.
- We observed staff directing and assisting patients to the department they required. The hospital also had clear signage directing patients to hospital departments.

Access and flow

- Patients made appointments through the national enquiry centre, with the hospital directly, by GP referral or through the consultants own secretary. Patients told us the appointments system was easy to use and they could make appointments at a time that was convenient to them.

Requires improvement

Outpatients and diagnostic imaging

- Patients we spoke with reported good access to appointments and at times that suited their needs.
- The hospital met the NHS referral to treatment (RTT) indicator. From April 2015 to March 2016 the hospital obtained 95% to 99%, this was higher than the NHS target of 92%. The RTT indicator shows the amount of patients accessing treatment within 18 weeks of referral.
- The hospital sent out reminders about appointments by text message. Patients told us they found this helpful, however the text message did not state which hospital they needed to attend. This could lead to confusion and some patients had attended appointments at the wrong hospital.
- Patients told us they had minimal waiting times, usually attending their appointment within a week of referral. Reception staff told us that they made urgent appointments within two days. We spoke with one patient who was able to book an appointment on the same day.
- At the time of our visit, the CT scanner had broken down. Staff telephoned patients individually to inform of the cancellation and rescheduled appointments within two days.
- The clinics we observed ran to schedule. Staff told us they would keep patients informed if delays occurred however, there was no formal system to do this.
- The outpatient department did not carry out audits on how long patients had to wait in the department for their consultation. The outpatient sister told us the previous outpatient manager had completed audits but she did not have sufficient time due to clinical duties.
- The hospital monitored patient who cancelled or did not attend (DNA) their appointment. The DNA rate for diagnostic imaging was 3.8%, for physiotherapy 2%. We requested DNA data for the outpatients department but the hospital did not provide this.The cancellation rate for diagnostic imaging was 9.6%, for physiotherapy 7.2%. The hospital did not provide a breakdown of whether the appointments were cancelled by patients or by the hospital. We requested cancellation rate data for the outpatient department but the hospital did not provide this.
- The hospital ran a breast care clinic where patients had a consultation, mammogram or ultrasound and biopsy if required on the same day. Patients received the results of their scan on the same day so they did not have to attend another appointment.

Meeting people's individual needs

- Staff recognised the need to support people with complex or additional needs and made adjustments wherever possible for example prioritising patients living with dementia or learning disabilities. However, staff noted there were rarely patients who had complex or additional needs.
- The hospital provided dementia awareness training for staff as part of mandatory training. Hospital records showed 87% of staff had completed this training but commented they saw very few patients living with dementia.
- The outpatient department did not have a formal system of recording or highlighting patients who have additional needs. One member of staff told us it was possible to place a note on the patient's record but this did not always happen.
- Patient Led Assessments of the Care Environment (PLACE) for February to June 2015 showed the hospital scored 75% for dementia, which was slightly lower than the England average of 81%.
- The hospital provided disabled toilet facilities which contained an emergency pull cord should patients require urgent assistance. The hospital also provided baby changing facilities.
- The changing cubicles in diagnostic imaging were small and did not allow patients sufficient room to change comfortably. We saw there was a slightly larger room for patients with disabilities, however; this did not allow room for a wheelchair.
- Staff in the physiotherapy department recognised many of their patients had limited mobility. We saw staff assisting patients for example when entering the hydrotherapy pool. However, some physiotherapy patients told us the seating was low which made it uncomfortable to sit on when they were recovering from surgery.

Requires improvement

Outpatients and diagnostic imaging

- The hospital had a hearing loop installed in the main reception for patients with hearing impairments.
- The hospital provided some information leaflets on general health and wellbeing and diagnostic imaging procedures. Patients told us they did not receive written information about their procedure or treatment prior to their appointment, which sometimes meant they did not feel fully prepared.
- All written information, including pre-appointment information and signs were in English. These were not available in other formats such as other languages, pictorial or braille. A translator service was available on request.

Learning from complaints and concerns

- Staff told us managers shared learning from complaints for example, patients had complained about not understanding all the costs involved in their treatment. At the time of our visit, we saw posters and information cards explaining costs of treatment displayed in all outpatient services.
- A manager in diagnostic imaging told us about a complaint they were dealing with at the time we visited. The manager had spoken directly with the patient, apologised and invited them to a meeting to discuss their concerns.
- We did not see any information about how to make a complaint displayed in the outpatient, physiotherapy and imaging departments and this information was not contained on the BMI Chiltern Hospital website. Patients told us they had not received written information about how to make a complaint and would ask hospital staff for information if they needed it. We were told by senior staff information on how to make a complaint was available.

Are outpatients and diagnostic imaging services well-led?

Requires improvement

By well-led, we mean that the leadership, management and governance of the organisation assures the delivery of high-quality person-centred care, supports learning and innovation, and promotes an open and fair culture.

We rated 'well-led' as requires improvement because:

- There was new and interim management across diagnostic imaging, physiotherapy and the outpatients department.Managers were still familiarising themselves with the service and the hospital and did not demonstrate a clear understanding of the risks or oversight of the governance processes to monitor the quality of service. There hospital risk register did not reflect all risks at a department level and there was no clear documentation on how risks were monitored or by whom.
- One consultant was consistently not recording dose levels in line with IRMER guidelines. Although previous managers had written to the consultant on three occasions there was no evidence this issue had been escalated to senior management or the Medical Advisory Committee (MAC).
- Although the hospital had completed annual checks of consultants insurance and registration, they were significantly behind with the review of clinical performance. A total of 135 medical staff were due a biennial review, seven of these were significantly out of date.
- The hospital held regular hospital governance meetings and undertook clinical audits. However, there was no evidence that managers shared learning from hospital governance meetings or department audits with staff to ensure clinical practice improved.
- In the outpatient department some aspects of staff management were not always recognised, for example

the importance of regular one-to-one meetings and performance management. Staff had escalated safety issues of lone working in the evening but had not received feedback.

- Although the outpatient and diagnostic imaging manager planned to grow their services they did not have a clear vision or strategy for how they would achieve this. There were no clear development or business plans in place to support this.

However,

- Although the executive director had only been in post for four weeks, staff and managers felt they had made a positive impact on the culture of the hospital.
- Staff could describe the vision, values and strategy for the hospital. The hospital had processes in place to share key messages with staff on a daily basis and staff spoke passionately about the care they provided to patients.
- The Medical Advisory Committee (MAC) carried out their roles and functions appropriately.
- The diagnostic imaging department displayed local rules in every x-ray room.

Vision and strategy for this this core service

- The BMI corporate vision was to deliver the highest quality outcomes, the best patient care and the most convenient choice for patients. The senior management had implemented a local vision for the hospital based on a care, compassion, competence, communication, courage and commitment. The staff we spoke with knew about the vision for the hospital.
- The hospital had a strategy to improve and grow some areas of the business including outpatient, diagnostic imaging and physiotherapy by introducing new physiotherapy services and promoting the new MRI unit. The diagnostic imaging manager told us they had a strategy to grow the service and gave examples, such as opening at the weekend. However, there was no evidence in place to support this. The outpatient sister told us they wanted to grow the service but had no clear examples of how they would do this. The staff we spoke with during our visit did not have knowledge about the vision and values of the department.

Governance, risk management and quality measurement for this core service

- There was a governance structure in place. Hospital sub-committees reported to the clinical governance committee, which fed into the medical advisory committee (MAC). Senior leaders then reported to the corporate BMI Healthcare regional and national clinical governance structure. Outcomes from the clinical governance meetings were shared at the heads of department meetings; although, minutes from departmental meetings did not show this information always being shared with frontline staff.
- The hospital held regular governance and health and safety meetings attended by the senior management team and heads of department. We saw evidence of minutes showing the meetings discussed clinical issues and actions to resolve these.. High level governance issues raised in the hospital governance meetings were escalated to the MAC.
- The hospital had a risk register in place, which included actions for senior hospital managers. However, we did not see evidence that department managers used the register as a means of escalating issues. The risk register did not track monitoring of risks and assign it to a specific staff member.
- At the time of our inspection, the outpatient sister was acting as the interim outpatient manager until the new manager took up the post and did not demonstrate an understanding of the risks or clear oversight of governance procedures to monitor the quality standard of the service.
- Staff had access to policies and standard operating procedures for radiological examinations. Local rules (local instructions relating to radiation protection measures for the service) were on display in every x-ray room. This meant staff had guidance on best practice to perform radiological examinations.
- The Radiation Protection Advisor (RPA) audit highlighted an issue with a consultant not always documenting the doses of radiation used when using equipment in pain clinic. The audit stated managers had written to the consultant on three occasions with

no improvement. The diagnostic imaging manager could not provide evidence of sharing this with staff or improvement. There was also no evidence this issue had been raised to senior management or the MAC.

- The hospital had completed annual checks of insurance and registration for consultants but they were behind for the review of clinical performance that took place biennially with the Medical Advisory Committee (MAC), in keeping with the BMI Healthcare 'Practising privileges policy' (2015). The policy contained a standard agenda that the MAC should adopt which included biennial review of practising privileges. We reviewed the minutes for the last three meetings and these did not contain discussions for medical staff due a biennial review.
- There were a total of 135 medical staff who were due a biennial review, seven reviews were significantly out of date 1 from 2007, three from 2009, one from 2010 and two from 2011. Six of the seven medical staff carried out clinical work at the hospital. There was no assurance that the hospital actively monitored the local clinical performance of staff who held practising privileges for the hospital. We discussed this with the executive director who was accelerating the reviews, with the aim of being up-to-date by the end of October 2016.
- However, we saw minutes of the Medical Advisory Committee (MAC) meeting, which covered areas of good practice and risk and included outpatients. There was also evidence the MAC had reached decisions to grant or stop practicing privileges and appropriate action taken, where the MAC had identified concerns about performance or conduct.

Leadership of service

- At the time of our visit, the diagnostic imaging and physiotherapy manager were both new in post and still familiarising themselves with the service, departments and hospital. Staff spoke highly of them and felt positive about the changes they would implement.
- In the outpatient department it had been acknowledged that a new manager was required and had been appointed. The outpatient sister was acting up to this role in the interim.However, we did not see evidence of consistent leadership for example recognising the need for one-to-one meetings with staff and performance management. Although staff spoke highly of the outpatient sister and recognised the challenges within her role, staff commented they found the lack of structure in the outpatients department challenging.
- Staff in all outpatient services told us there had been a number of management changes in the hospital recently. However, all staff spoke positively about the new executive director. Staff told us they were approachable and understood the work of each department.
- Staff and managers across all outpatient services told us they had seen an increase in complaints from patients about charges for treatment. The hospital had recognised this and displayed posters and leaflets giving information about charges for treatment. All the patient's we spoke to told us they had information about the charges for their treatment.

Culture of service

- Staff spoke passionately about the standard of care they delivered to their patients.
- Although the hospital had undergone a number of senior management changes staff commented this had been a positive change and managers commented they could see positive changes in morale within their teams.
- The hospital did not always consider the safety and wellbeing of staff in the outpatient department. Staff told us they would be the only registered nurse on duty between 9pm and 10pm on some occasions and felt this was unsafe. Staff told us they had escalated it to managers but did not know of any actions taken to resolve this. The department could not provide a risk assessment for this.
- The sickness rate for nurses and healthcare assistants was higher than the national average in October 2015 and January to March 2016. The hospital did not provide data for sickness rate from April to September 2015 or November and December 2015.
- The turnover rate for nursing staff in the outpatients department was 40% from April 2015 to March 2016. This was significantly higher than the national average. There was no turnover of healthcare assistants in the outpatients department from April 2015 to March 2016.

Staff engagement

Requires improvement

Outpatients and diagnostic imaging

- The hospital held a daily communication meeting at 9am to update senior staff on current issues for that day such as complaints, incidents, staffing and workload. Each department then held a department communication meeting to share these messages with staff.Staff spoke positively about the meetings and felt they were kept up-to-date on key issues. For staff unable to attend the hospital provided a daily printout, which we saw was placed on the departmental notice board.
- The hospital identified a 'behaviour of the week' based on the hospital values and encouraged staff to nominate colleagues who had demonstrated this behaviour. Each department displayed this on their communication board. There was also an 'Above and Beyond' award scheme in place, whereby patients could nominate a staff member or staff could nominate colleagues for an award. Winners received awards in categories such as outstanding care, innovative thinking, amazing support, true inspiration, brilliant leadership.
- The diagnostic imaging manager had started a weekly communication letter to the team. This highlighted key issues within the department and praised individual staff for positive contributions they had made.
- The hospital also took part in the staff FTT. The results showed that 68% of staff were either 'likely' or 'extremely likely' to recommend the hospital to their friends and family. This was slightly lower than the BMI national average of 70%.
- The results from the 2015 staff survey showed an engagement score of 43 out of 100 compared with 51 in 2014. The response rate was 55%. The higher the score, the more satisfied staff are who work at that location. Feedback comments from staff were mainly around equity of pay, low morale lack of consistent senior leadership and the appearance of the hospital. We asked the hospital for their action plan in response to the staff survey results, they did not provide one. However, the executive director had begun to address some of the concerns raised by staff.

Public Engagement

- The hospital took part in the Friends and Family Test (FTT). There was no breakdown of these figures displayed therefore it was not possible to identify the significance of these figures with regard to outpatient services.
- The hospital also held a monthly customer experience meeting. There were no patients as members of the group to seek their views and take action in response to suggestions made, even though the group identified one of its purposes was to 'understand situations from the customer's perspective'.

Innovation, improvement and sustainability

- Staff in the diagnostic imaging department, told us the department was due to be refurbished and extended. At the time we visited, the department did not have any formal plans in place and the project was awaiting approval.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

- The provider must ensure that all staff acting as a surgical first assistant have been assessed as competent for the role. In addition, the evidence of completed competencies and log of cases should be available in accordance with the BMI Healthcare Surgical First Assistance policy.
- The provider must ensure it completes regular reviews of compliance with BMI Healthcare policies, with action taken for areas of non-compliance, including the renewal of practising privileges.
- The provider must ensure that staffing levels in theatres are in line with current national guidance and the BMI Healthcare policy.
- The provider must ensure when staff are undertaking a dual role this is supported by a local policy and risk assessment.
- The provider must ensure staff in the operating theatre fully comply with the Five Steps to Safer Surgery at all times.
- The provider must ensure there is robust monitoring of the safety and quality of the surgery service at a local level, with risks identified and timely action taken to manage the risks.
- The provider must ensure the hospital risk register reflects the current risks faced by the hospital and in sufficient detail to show how they are monitoring the risks.
- The provider must ensure there is robust monitoring of the safety and quality of the outpatients and diagnostic imaging service at a local level, with risks identified and timely action taken to manage risks.
- The provider must ensure that all incidents are monitored at each hospital and individual clinical location to be able to identify trends.

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Action the provider SHOULD take to improve

- The provider should ensure a trend analysis of all incident reports is completed, with action plans devised as a result.
- The provider should ensure all patient chairs have a wipeable surface to ensure they can be appropriately cleaned.
- The provider should ensure all floors in the operating department are kept clear so they can be cleaned and there are no trip hazards to staff.
- The provider should ensure all areas in the operating department meet fire safety regulations.
- The provider should ensure all patient care records are completed in full, by the multidisciplinary staff providing care and treatment
- The provider should ensure all staff are up-to-date with all of their mandatory training.
- The provider should ensure all staff complete safeguarding children training appropriate to their role.
- The provider should ensure all the key recommendations of the Perioperative Care Collaborative Statement on Surgical First Assistants have been considered, with action taken as indicated.
- The provider should ensure patient surgical outcome data is shared and discussed at relevant departmental meetings so changes can be made to practice where necessary.
- The provider should ensure for all audits there is a clear action plan, with accountability for completion of any actions, by an agreed date.
- The provider should ensure all theatre staff receive an annual appraisal.
- The provider should ensure formal written on-call arrangements are in place for all relevant teams.

Outstanding practice and areas for improvement

- The provider should ensure the gastroenterologists explain to patients the need for possible transfer to the NHS hospital should complications from the procedure occur.
- The provider should consider arranging an external review of its theatre service to seek an independent review of the standards of the service.
- The provider should consider reviewing the layout of the changing rooms in diagnostic imaging to ensure it meets the needs of all patients.
- The provider should consider displaying safety thermometer information in all clinical areas as considered best practice.
- The provider should train staff in line with the BMI Safeguarding Children policy. All staff who have some degree of contact with children should complete a minimum of level 2 safeguarding training.
- The provider should consider formalising arrangements for diabetic specialist nurses from the NHS to assess and treat patients at both the Chiltern and Shelburne hospitals.

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
Diagnostic and screening procedures Surgical procedures	Regulation 17 HSCA (RA) Regulations 2014 Good governance Regulation 17 (1)(2)(a)(b)(f) **How the regulation was not being met:** • Practices were taking place in the operating theatres that were not reflective of corporate policies and procedures. Scrub practitioners were undertaking a dual role without a local policy or risk assessments in place to support this. The potential risk to staff and patients was not being assessed or managed. Staff in the operating theatre were not fully complying with the Five Steps to Safer Surgery to reduce the risk of harm to patients having a surgical procedure. • The required documentation for staff acting as a surgical first assistant was not recorded and kept in the operating department as stated in BMI Healthcare policy. • There were no regular audits to monitor compliance with corporate policies. • Governance processes to assess and monitor service quality and risk were not embedded at a local level. The hospital risk register was not in sufficient detail to show how risks were being monitored and by whom. It did not contain all the risks for the surgical service or the outpatient and diagnostic imaging department.

Regulated activity	Regulation
Surgical procedures	Regulation 18 HSCA (RA) Regulations 2014 Staffing

This section is primarily information for the provider

Requirement notices

Regulation 18 (1)(2)(a)

How the regulation was not being met:

- The operating department was not always staffed in line with national guidance from the Association for Perioperative Practice or BMI Healthcare policy.
- Staff in the operating department were acting as a surgical first assistant without having completed a competency based assessment as required by BMI Healthcare policy and national guidance.