BMI The London Independent Hospital

Quality Report

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

Ratings

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

Summary of findings

Letter from the Chief Inspector of Hospitals

The BMI The London Independent Hospital is an independent acute hospital located in Stepney Green, east London. It is operated by BMI Healthcare Limited.

There are a total of 69 inpatient and day care beds and 20 outpatient consulting rooms. There are four operating theatres, five critical care beds, a cardiac catheterisation unit, a JAG accredited endoscopy suite, physiotherapy department and diagnostic imaging.

We inspected surgery, critical care and outpatients. The inspection was carried out on 24 and 25 June 2019 and was unannounced.

We inspected services using our comprehensive inspection methodology. To get to the heart of patients' experiences of care and treatment, we ask the same five questions of all services: are they safe, effective, caring, responsive to people's needs, and well-led? We rate services as outstanding, good, requires improvement or inadequate.

We spoke with 42 members of staff including nursing, healthcare assistant and medical staff specific to each area inspected, managers, cleaners, receptionists and physiotherapists. We reviewed the healthcare records of 22 patients and spoke with 16 patients and relatives. We checked items of clinical and non-clinical equipment. We looked at information provided by the hospital.

Services we rate

Our rating of this hospital improved. We rated it as good overall. All three core services were rated good in all domains where we have a duty to rate.

We found the following areas of good practice across all services:

- Staff understood how to protect patients from abuse and the service worked well with other agencies to do so.
- Staff used equipment and control measures to protect patients, themselves and others from infection. They kept equipment and the premises visibly clean.
- The design, maintenance and use of facilities, premises and equipment kept people safe.
- Staff completed and updated risk assessments for each patient and removed or minimised risks.
- The service had enough nursing and support staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment.
- Staff kept detailed records of patients' care and treatment. Records were clear, up-to-date, stored securely and easily available to all staff providing care.
- The service used systems and processes to safely prescribe, administer, record and store medicines.
- The service managed patient safety incidents well. Managers investigated incidents and shared lessons learned with the whole team and the wider service.
- The service provided care and treatment based on national guidance and evidence-based practice.
- Staff gave patients enough food and drink to meet their needs and improve their health. They used special feeding and hydration techniques when necessary.
- Staff assessed and monitored patients regularly to see if they were in pain and gave pain relief in a timely way.
- The service made sure staff were competent for their roles.
- Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients' consent.
- Staff treated patients with compassion and kindness.
- Staff provided emotional support to patients, families and carers to minimise their distress. They understood patients' personal, cultural and religious needs.

Summary of findings

- Staff supported and involved patients, families and carers to understand their condition and make decisions about their care and treatment.
- The service took account of patients' individual needs and preferences. Staff made reasonable adjustments to help patients access services. They coordinated care with other services and providers.
- Waiting times from referral to treatment and arrangements to admit, treat and discharge patients were in line with national standards.
- It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff.
- Leaders had the integrity, skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff.
- The service had a vision for what it wanted to achieve and a strategy to turn it into action.
- The service had an open culture where patients, their families and staff could raise concerns without fear.
- Leaders operated effective governance processes throughout the service and with partner organisations.
- Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact.

We found areas of practice that require improvement:

Surgery

- At the last inspection hand hygiene audits showed variable results for bare below the elbow and for hand hygiene at appropriate times. At this inspection although we found good practice and audit results that showed good hand hygiene, we also observed instances where hand hygiene standards were not being maintained. In theatres we observed excessive glove usage with minimal hand hygiene taking place between glove changes. In the anaesthetic room we observed instances where staff were not decontaminating their hands after patient contact. In pre assessment we observed an occasion where a member of staff did not use alcohol gel or wash hands prior to applying gloves and did not wash hands post procedure.
- Information was collected for monitoring ongoing harm free care. However, this information was not on display to patients.

Outpatients

- Although the service generally controlled infection risk well, compliance levels with hand hygiene and bare below the elbow standards were low. Hand hygiene audits for January and February 2019 found that compliance rate was 32% and 29% respectively. The department had an action plan in place.
- The treatment room did not meet all the environmental requirements set out in the BMI policy Surgical Procedures in Outpatients, due to a lack of ventilation and the presence of a suspended ceiling. An appropriate local standard operating procedure was in place to mitigate the risk.

Critical Care

- At the last inspection the intensive treatment unit did not have a follow up clinic where patients could reflect upon their critical care experience and be assessed for progress. The service still did not have a follow up clinic for patients following discharge from the hospital. This was not in line with Guidelines for the Provision of Intensive Care Services which state that patients discharged from ITU must have access to a follow up clinic.

Nigel Acheson
Deputy Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Surgery	Good	We rated this service as good because it was safe, caring, effective, responsive and well led. We found good practice in all areas.
Critical care	Good	We rated this service as good because it was safe, caring, effective, responsive and well led. We found good practice in all areas.
Outpatients	Good	We rated this service as good because it was safe, caring, responsive and well led. We found good practice in all areas. We do not rate effective in outpatients.

Summary of findings

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Good

BMI The London Independent Hospital

Services we looked at:
Surgery, critical care and outpatients.

Summary of this inspection

Background to BMI The London Independent Hospital

The BMI The London Independent Hospital is an independent acute hospital located in Stepney Green, east London. It is operated by BMI Healthcare Limited.

There are a total of 69 inpatient and day care beds and 20 outpatient consulting rooms. There are four operating theatres, five critical care beds, a cardiac catheterisation unit, a JAG accredited endoscopy suite, physiotherapy department and diagnostic imaging.

Services are provided to insured, self-pay private patients and to NHS patients through both GP referral and contracts.

The main service provided by this hospital is surgery. Where some of our core service findings also apply to other services, we do not repeat the information but cross-refer to the service level report.

Our inspection team

The inspection team was made up of a CQC lead inspector, three CQC inspectors, and a range of specialist advisors with expertise in the areas we were inspecting. The inspection team was overseen by a CQC inspection manager and a CQC head of hospital inspection.

Why we carried out this inspection

We carried out this inspection as part of our independent hospital inspection programme. We also followed up findings from our previous inspection in 2016.

How we carried out this inspection

To get to the heart of patients' experiences of care and treatment, we ask the same five questions of all services: are they safe, effective, caring, responsive to people's needs, and well-led? Where we have a legal duty to do so, we rate services' performance against each key question as outstanding, good, requires improvement or inadequate.

Information about BMI The London Independent Hospital

The hospital provides a wide range of services. Surgical services are a significant proportion of hospital activity and all ward and day care beds were surgically based.

Surgery was provided for adults in four theatres. Each had specific use dependant on the environment and available equipment of each. There were two laminar flow theatres, one non laminar flow used for cardiac and general surgery and one theatre used solely for dental surgery. Surgical activity included gastroenterology, general surgery, gynaecology, ophthalmology, oral and maxillofacial, orthopaedic, pain management, plastic, reconstructive and cosmetic, urology and vascular.

Summary of this inspection

There were two surgical wards that accommodated a total of 33 patient bedrooms. They were located on one floor, adjacent to theatres. The day surgery unit contained 18 beds and five ambulatory care chairs in a separate area within the day care suite.

was opened if capacity could not be managed on the two wards. The day care unit was opened an average of three days per week.

Between January and December 2018 there were 10,467 theatre visits.

The critical care provision was made up of a five bedded intensive therapy unit (ITU). The ITU had two individual side rooms and three pods. The pods are semi-permanent structures used to divide the ward area into separate individual spaces resembling rooms. Patients could be admitted directly to the ITU, post-operatively from theatres, or from the wards. The ITU saw patients across a range of medical and surgical specialities.

There were 1,825 level two and level three critical care bed days available in the hospital from April 2018 to March 2019. Of these 665 level two critical care bed days were used, while 126 level three bed days were used. The unit started submitting data to the Intensive Care National Audit and Research Centre (ICNARC) in January 2016.

Outpatient services are delivered from 20 consulting rooms, a treatment room and phlebotomy room. Consultants see patients across a broad range of specialties supported by a team of nursing and healthcare assistant staff. There is multidisciplinary team support that includes pharmacy, physiotherapy, phlebotomy and an onsite pathology laboratory.

From April 2018 to March 2019 there were a total of 34,735 patient attendances in outpatients.

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

Good

We rated safe as good because:

- There was good compliance with the World Health Organisation Five Steps to Safer Surgery checklist.
- The service controlled infection risk well. Staff kept equipment and the premises clean. We found the wards, day unit, theatres and the recovery area clean and hygienic.
- The service provided mandatory training in key skills to all staff and made sure most staff completed it.
- Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.
- There was an improved reporting culture which had led to more incidents being reported. Staff were encouraged to raise incidents for learning and improving outcomes for patients.
- Staff completed and updated risk assessments for each patient and removed or minimised risks. Staff identified and quickly acted upon patients at risk of deterioration.
- The service used systems and processes to safely prescribe, administer, record and store medicines.
- The hospital completed audits of infection control practices and produced specific action plans for improving practices throughout the hospital.
- Emergency equipment such as a resuscitation trolleys and crash bags were available. Staff checked resuscitation equipment daily.
- The service had enough staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment.
- The service managed patient safety incidents well. Staff recognised incidents and near misses and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service.

However:

- We observed some instances where hand hygiene standards were not always being maintained. In theatres we observed excessive glove usage with minimal hand hygiene taking place between glove changes. In the anaesthetic room we observed instances where staff were not decontaminating their hands after patient contact. In pre assessment we observed an

occasion where a sister did not use alcohol gel or wash hands prior to applying gloves and did not wash hands post procedure. In outpatients hand hygiene audits for January and February 2019 found that compliance rate was 32% and 29% respectively. The department had an action plan in place.

- Information was collected for monitoring ongoing harm free care. However, this information was not on display to patients.
- The treatment room did not meet all the environmental requirements set out in the BMI policy Surgical Procedures in Outpatients due to a lack of ventilation and a suspended ceiling. However, an appropriate local standard operating procedure was in place to mitigate the risk.
- Adult and children safeguarding policies were in place which outlined staff responsibilities should they have any safeguarding concerns. The adult safeguarding policy was currently under review as it was out of date (November 2018).

Are services effective?

Good

We rated effective as good because:

- The service provided care and treatment based on national guidance.
- Staff assessed and monitored patients regularly to see if they were in pain. Staff assessed patients' nutritional states and food and drink was provided to meet their needs.
- Managers monitored the effectiveness of care and treatment and used the findings to improve them.
- The service made sure staff were competent for their roles.
- Surgery lists, including Saturday lists, were supported by multidisciplinary teams. There was effective multidisciplinary working across teams within the hospital.
- Staff gave patients practical support and advice to lead healthier lives. On all pathways, patients were asked about health lifestyle.
- Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients' consent.
- The service submitted data to the Intensive Care National Audit & Research Centre (ICNARC) for all patients treated within the intensive care setting. This meant care delivered and patient outcomes were benchmarked against similar units nationally.
- Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. Staff were aware of their responsibilities to patient consent, including in relation to the MCA and DoLS.

Summary of this inspection

Are services caring?

Good

We rated caring as good because:

- Staff treated patients with compassion and kindness. Patients we spoke with said that staff were caring and told us their privacy and dignity was respected. During the inspection we saw staff treating patients with dignity, compassion and respect.
- Staff provided emotional support to patients, families and carers to minimise their distress. Patients said that staff were quick to respond to questions about pain relief and other medical concerns.
- Staff supported and involved patients, families and carers to understand their condition and make decisions about their care and treatment.
- The service had a satisfaction survey by which patients could feed back their thoughts about the service. The results and trends were discussed and reviewed at the monthly patient experience committee and, when needed, improvement actions were agreed.
- Staff provided reassurance and support for patients throughout their care. Staff demonstrated a calm and reassuring attitude to put patients at ease.
- We spoke with two family members of patients on the critical care ward. Family members were positive about the care the patients received and stated that staff members were professional and welcoming.

Are services responsive?

Good

We rated responsive as good because:

- The service planned and provided care in a way that met the needs of local people and the communities served.
- Waiting times from referral to treatment and arrangements to admit, treat and discharge patients were in line with good practice.
- The service took account of patients' individual needs. Individualised care was provided at every stage of the patient pathway.
- There were a variety of leaflets available explaining many health conditions and could be printed off in several different languages. Staff had access to interpreters for patients whose first language was not English.
- The service provided food that catered to dietary requirements and cultural preferences.

- People could access the service when they needed it. Patients told us that appointment choice was flexible and sufficient for their needs.
- The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with all staff. All complaints were reviewed at the weekly complaints meeting that monitored the progress of complaints responses to ensure compliance with the complaints policy.

However:

- The outpatient area had step free access and was accessible to individuals using a wheelchair. However, during our last inspection it was found that the reception desk within outpatients was not lowered to take in to account the needs of wheelchair users, and this remained the same during this inspection. The desk was due to be reconfigured and relocated as part of a five year refurbishment plan.
- A recurrent theme in the complaints received within outpatients was in relation to waiting times for consultant clinics once at the hospital and clinic cancellation. The department had started to record lateness and cancellations to see where any patterns emerged, however data provided by the hospital showed that this was still a challenge.
- The critical care service did not have a follow up clinic for patients following discharge from the hospital. This was not in line with Guidelines for the Provision of Intensive Care Services which state that patients discharged from critical care services must have access to a follow up clinic.

Are services well-led?

Good

We rated well led as good because:

- Leaders had the integrity, skills and abilities to run the service. Staff felt supported by local leadership and considered the senior leadership team to be visible and approachable.
- There were systems and process in place that adequately identified and minimised risk. Risk registers were sufficiently added to, reported on and actioned.
- Managers at all levels had the right skills and abilities to run a service providing high-quality sustainable care.
- The hospital had a vision for what it wanted to achieve and workable plans to turn it into action.
- Managers promoted a positive culture that supported and valued staff. Staff were engaged in quality measures and had opportunities to be involved in service development.

Summary of this inspection

- The hospital used a systematic approach to continually improving the quality of its services. There was a good system of governance in place.
- The hospital had a number of meetings and systems in place to provide engagement opportunities both for patients and for staff.
- The hospital measured patient satisfaction results using friends and family recommendations. Where individual staff were mentioned in patient feedback for providing good care this was recognised by managers.
- Staff we spoke with told us that there was a no blame culture, and that they felt valued and respected.

Detailed findings from this inspection

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Surgery	Good	Good	Good	Good	Good	Good
Critical care	Good	Good	Good	Good	Good	Good
Outpatients	Good	N/A	Good	Good	Good	Good
Overall	Good	Good	Good	Good	Good	Good

Surgery

Good

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

Are surgery services safe?

Good

Our rating of safe improved. We rated it as **good.**

Mandatory training

- **The service provided mandatory training in key skills to all staff and made sure most staff completed it.** The hospital set a target of 90% for completion of mandatory training. A breakdown by department showed that theatres had an overall compliance rate of 89.8%. Some staff showed as 100% compliant while others were below the target completion rate. Pre op assessment, day care and wards showed an overall compliance rate of 92%.
- In theatres, some modules such as consent (100%), dementia awareness (100%), infection prevention and control awareness part 1 (100%), and adult basic life support (100%) were above the target compliance rate. However, others such as patient moving and handling was at 78% and introduction to WHO safety checklist was 88.5% and were below the target rate for completion.
- Adult immediate life support (ILS) was at 59%. Training dates were booked for all non compliant staff for dates between June and September 2019. We were provided with an update following further training that confirmed the compliance rate was at with the final courses booked in August and September for full compliance.
- Face to face training was done for some courses, such as for basic and immediate life support. Theatre healthcare assistants did BLS while trained staff did ILS. Mitigating factors for the low compliance rate was given that the service had been without an infection prevention and control lead for a number of months and that there was now a full time member of staff catching up with training. It was stated that the service had been without a trainer for moving and handling since the previous person left and the service was in the process of training another person.
- The theatre manager told us that a number of staff were sent for adult immediate life support (includes BLS) training on 24 June 2019 which was not yet reflected on the system. We saw evidence of training programmes to demonstrate this.
- Care and communication of the deteriorating patient was 54.5%, and a number of staff were booked on this to attend in July. In order to increase compliance the theatre manager had applied for a half day a month for staff to conduct blocked training, this was already approved but the specific days had not yet been identified.
- Training was primarily delivered by e-learning modules. This was a platform for staff to complete their mandatory training online and for the compliance to be monitored by management. Staff were sent generated email reminders when mandatory updates must be completed.

Safeguarding

- **Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.** BMI policies outlined responsibilities and procedures for safeguarding adults and children.

Mandatory training and local safeguarding flow charts ensured staff knew how to respond to signs or allegations of abuse. Training modules included safeguarding adults to level 3 and safeguarding children to level 3. There was a new face to face training module in place for safeguarding adults level 3 being rolled out to managers. In theatres, training in safeguarding children level 2 was at 100% and safeguarding vulnerable adults level 2 was also 100%. On the surgical wards compliance was 93% and 100% respectively.

- The safeguarding of potentially vulnerable adults was part of the pre assessment process where support needs were identified. For instance, because of dementia, if people lived alone and whether they had the support they needed. Physical assessments picked up anything such as marks, evidence of falls or skin integrity. Concerns were escalated to line managers before the patient had left so that a second assessment could take place if needed. We were given a recent example of a vulnerable person that resulted in contact being made with the local safeguarding team who confirmed they were known to social services. The director of clinical services was a member of a multi-borough safeguarding committee and worked in partnership with a key member of the safeguarding team as a link worker.

Cleanliness, infection control and hygiene

- **The service controlled infection risk well. Staff kept themselves, equipment and the premises clean. They used control measures to prevent the spread of infection.** We found the wards, day unit, theatres and the recovery area to be visibly clean and dust free. All equipment had green 'I am clean' stickers on and were visibly clean. Housekeepers did all cleaning of rooms and communal areas. The housekeeping supervisor kept all schedules. Itemised schedules for the cleaning of all areas such as the treatment room, all occupied bedrooms, vacated rooms and toilets were in place. Areas were cleaned more than once at staffs' request. We were told that cleaners were able to call on additional resources when needed and sometimes 'double allocating' took place, where cleaning staff contacted the housekeeping manager for more support. Cleaning schedules for wards 3a and 3b showed that from 6.30am to 2.30pm there were two cleaners. From 3pm to 7pm, another two cleaners had a schedule for the same round. In theatres one cleaner worked 9pm to 5am and four cleaners were on at night. Industrial deep cleaning of theatres took place twice a year and housekeeping carried out deep cleaning twice a year too. Wards and other areas were deep cleaned twice a year.
- On the day unit, we observed curtains around beds with dates on. We were told that curtains were changed by housekeeping when required or every three months, whichever was sooner. All curtains we saw were clean and within this timeframe. The clean utility room was checked daily when in use. In the day unit which was used three times a week on average, flushing took place of all taps and toilets, flushed weekly, for 3 minutes. Cleaning schedules for machines, clinical room and resuscitation trolley were all checked daily.
- All reusable medical devices were sent to a decontamination centre located at another BMI hospital. We were provided with the policy the decontamination centre worked to, which demonstrated compliance with Department of Health (2010) The Health Act 2008. Code of Practice for the Prevention and Control of Healthcare associated Infection and Department of Health (2013) Choice Framework for Local Policies and Procedures (CFPP) 01-0. Management and decontamination of surgical instruments (medical devices) used in acute care. The decontamination centre was also accredited by the International Organisation for Standardisation (ISO). This certified the provision by an independent body of written assurance that the service met specific requirements.
- There was a dental list in theatre 4 and we observed staff washing their hands after glove removal. All staff were observed undertaking good hand hygiene. All items and equipment were cleaned after the patient's surgery was completed. Staff had to remove their hats when leaving the department to collect patients.
- In theatre 3, once the procedure was finished all the equipment was cleaned before the next patient was prepared. Waste bags were used one per patient. However, we observed excessive glove usage with minimal hand hygiene taking place between glove changes. In the anaesthetic room, we observed staff

were not decontaminating their hands after patient contact. In pre assessment we observed a member of staff who did not use alcohol gel or or wash hands prior to applying gloves or post procedure.

- The infection control lead nurse stated they were willing to challenge unacceptable behaviour.
- Surgical site infection rates (SSIs) were reported up to one year after having an implant and 30 days post operatively. Between January and December 2018 surgical site infection rates were recorded for the following procedures: Primary hip (0%), primary knee (0.6%), revision knee (0%), other orthopaedic and trauma (0.9%), spinal (0.04%), breast (0%), gynaecology (0.6%), upper GI and colorectal (0.1%) urology (0.1%), cardiothoracic (1.3%), cranial (0.07%) and vascular (1.2%).
- All hip and knee post-operative patients were called between 30 and 40 days to check on their condition regarding surgical site infection.
- The infection control lead told us the following audits were completed quarterly: hand washing, standard precautions, theatre asepsis, patient equipment and invasive devices. Audit headlines and the audits themselves were kept separately. The hospital were working to streamline all the audits. We were also told that the invasive devices audit had not been completed as there was a change in the audit rotation.
- The hand hygiene audit took place in March 2019 in recovery and checked 19 members of staff including medical, nursing and healthcare assistants, asking ‘hands' skin intact and in good condition, bare below the elbows' observed, hands decontaminated at point of care and correct six step technique used correctly’. Staff were checked at different ‘patient moments’ such as after patient contact, before aseptic task/procedure, before patient contact and after contact with patient surroundings/belongings. It showed an overall compliance rate of 89%. The same audit took place in theatres and showed a compliance rate of 91%.
- IPC meeting minutes for January and April showed attendance from IPC lead, consultant microbiologist, clinical services manager for theatres and recovery and the quality and risk manager. There were standard agenda items such as incidents, audits and surveillance. There were also updates on actions from members such as on infection rates and antimicrobial policy.
- The MRSA policy stated that patients would not be routinely swabbed. The decision to screen patients for MRSA was determined based on a 9 question questionnaire, if the patient answered yes to any of the questions they would be screened.
- All cardiac patients were screened for MRSA. In addition, Kuwaiti patients were screened for Carbapenem-resistant Enterobacteriaceae (CRE). CRE is a drug resistant organism. Observation of cardiac catheter laboratory pre assessment showed a tick list that highlighted infection control risks and identified when to screen, manage and treat patients. We were informed this was only used in cardiac pre assessment which had been under review since 2015. Staff had flagged this up with the infection control lead who had advised to continue using this document.

Environment and equipment

- **The service had suitable premises and equipment and looked after them well.** Entry to the theatre unit was secure, with swipe access for staff while visitors had to ring a buzzer for staff to come and give entry. Each theatre had specific use dependant on the environment and available equipment of each. Theatre 1 had ceiling mounted Laminar flow, suitable for orthopaedic and spinal decompression, spinal fusions as well as neurocranial surgery. Theatre 2 had ceiling mounted Laminar flow theatre suitable for major/minor orthopaedics, spinal decompression, major spinal fusions as well as neurocranial surgery and had a microscope set up ready for spinal or cranial surgery. Theatre 3 was non Laminar flow and was used for cardiac surgery as well as general surgery. Theatre 3 currently had the heart and lung machine set up and ready for any cardiac surgery emergencies from the cardiac catheter laboratory. Most gynaecology and general surgery cases were undertaken in this theatre. Theatre 4 was not suitable for open cases as the air changes do not meet the requirements associated with this type of surgery. As such theatre 4 was used only for non surgical dental extractions.

Good

Surgery

- The fabric of theatre three was observed as in good condition, with hand wash basins that were compliant with Health Technical Memorandum 64 (HTM64), which is a Department of Health publication that provides guidelines specifically for the health care sector.
- All patients that were observed had good venous thromboembolism control in the form of flotron boots or TED stockings, based on the length of the procedure and the needs of the patient.
- The resuscitation trolley was located in the recovery room. All items checked were in date. However, the sharps bin was located on top of the trolley. On the day surgery unit, the sharps bin was also located on top of the resuscitation trolley and had been used for a non resuscitation event. Ideally this should be used for resuscitation rather than for general use.
- The recovery room had a three bedded general anaesthetic area, with an area for local anaesthetic with sedation. We were told there were plans to make the recovery room bigger therefore the wall to theatre 4 will be removed to extend to recovery room.In the anaesthetic room, all the equipment we checked had been PAT tested. Fridge temperatures were checked and recorded daily and were consistent for June 2019.
- The cupboard and fridge were checked in theatre 1 and there was good stock rotation with all items in date.
- In theatres, a patient equipment audit took place in March 2019 and showed 16 standards audited that included 'cleaning schedule itemises all patient equipment within the department with timescales and responsibilities for cleaning', 'appropriate personal protective equipment is selected and worn for all cleaning activities' 'equipment storeroom in a good state of repair, clean, uncluttered and free of unnecessary items' and 'where I am Clean labels are used, the equipment cleanliness is checked in accordance with the cleaning schedule and labels are in date' and 'single use patient items are not cleaned and reused'. The audit showed a 94% compliance rate. The recovery patient equipment audit also took place in March 2019 against the same criteria and also showed a compliance rate of 94%.
- There were a number of orange lidded bins throughout the hospital that were due to be changed on 27 June 2019 to yellow lidded bins. This was in compliance with correct colour coding as orange lidded bins were for blood waste only.
- Wards 3a and 3b were adjoined surgical wards and accommodated a total of 33 patient bedrooms, located on one floor, adjacent to theatres. Both sides had a nursing station. The day surgery unit was opened if capacity could not be managed on the two wards. We were told the day unit was opened an average of three days per week.
- All patient bedrooms on the wards were single, en suite rooms with toilet and shower. Four rooms were equipped with bariatric shower units. There was a plan for all shower units to be walk in showers. This was part of a five year refurbishment plan to be completed by the end of 2021.14 of the ward bedrooms had now been updated with wall mounted washbasins external to the en suite and HTM64 compliant. The others were due to be installed by the end of the week, depending on the daily activity of the unit.
- The day surgery unit contained 18 beds in three bays of six beds. This used to be 21 but the last bay of three had been decommissioned for more than a year now due to the cramped nature of the layout. The space was small in the last bay of three, with access to two toilets and a storage room also located within the bay.
- All of the clean utility rooms and fridges were temperature monitored and within normal ranges. Both the rooms and fridges were monitored daily and were found to be within acceptable ranges. The ward did daily stock checking and ordered items as was needed such as for stockings, syringes, stents and disposable knickers. Rooms were also stocked routinely by the stores team as well as by night staff who checked on dates and replaced items that were out of date.
- The resuscitation trolley on the ward contained a new defibrillator which was replaced the week before our inspection. The trolley was checked every day and the seals on the drawers were broken every week to check contents and dates. Daily checks of equipment such as electrodes attached to electrocardiogram leads, defibrillator and pads and sharps bin were taking place.

Weekly checks were in place for other items such as laryngoscope, masks and oxygen tubing. Oxygen was securely attached to the trolley. All items had been regularly checked and were in date.

- The dirty utility room had waste segregated. The temperature was monitored daily and found to be within suitable range.
- Equipment on the wards was checked weekly by staff, such as weighing scales, scanners, IV drip stands, wheelchair, walking frame, vital signs and hoist. All had an up to date service sticker and green ‘I am clean’ sticker. All items had an asset number that linked to an equipment register held by estates that recorded PAT test and service due dates. We were told there were cleaning schedules for all equipment and all staff were responsible for cleaning.
- Daily checks on function and cleanliness of equipment in the store room was in place, such as the macerator and commodes. We were told that if any issues were found it was noted and reported. There was a maintenance team on site. Technicians for equipment (outsourced company) was also based on site. We were told that both gave quick responses.
- An estates and facilities environment and equipment checking audit took place in March 2019. It showed estates checking themselves against a set of 119 criteria that covered all aspects of estates and facilities. These were organised under the headings of: clearly delegated responsibility for facilities management and reporting in hospitals, general building and site maintenance, asbestos, electricity, ventilation, regular maintenance testing in accordance with requirements, security systems and arrangements, fuel tank, water, lighting, lifts, wiring, medical gases, patient equipment, gas and fire, windows, electro bio-medical equipment, external contractors managed, patient rooms maintained, purchase of fixed assets follows policy, assets held securely, maintained appropriately and accurately reported. Score 107/119; 90%.
- In pre-assessment, the bloods room and pre-assessment clinic room were clean and clutter free. All consumables were in date, with the exception of an adult oxygen mask in a grab bag in the bloods room, which expired in May 2019 which was brought to the attention of the nurse in charge. Pre assessment did not have its own resuscitation trolley. This was located next door within the day surgery unit and was shared between the two.
- The cardiac catheter pre assessment and laboratory were clean and clutter free. All consumables were in date.
- In pre-assessment the waiting room was clean and clutter free. There was a tea and coffee machine and water, free to patients and visitors.

Assessing and responding to patient risk

- **Staff completed and updated risk assessments for each patient. They kept clear records and asked for support when necessary.** Referrals came through an e-referral system which were triaged against a criteria that included co morbidities and a BMI of below 40 and whether the service could accommodate complex patients including those with complex social needs.
- Pre assessment also checked on whether a person lived alone, if there were existing care packages in place, co morbidities, medical history, dementia, anything that may require further support on discharge and notified social services of a patient's likely need for community care services after discharge.
- Patients were provided with individualised care plans for planned care and treatment. Patients undergoing surgery were assessed and provided with the support appropriate to their planned procedure to ensure their specific needs were met.
- Patient files for inpatient care included a number of assessments that incorporated assessement of patient risk. They included the long medication chart, the daily SBAR) handover that included a handover on medication, NEWS, fluids, diet, bowels open, urine output and number of days post op. This had been in place since February 2018 which we were told had greatly improved handover information and gave a good picture of a patient’s progress in addition to their progress notes.
- Assessment work books identified risk in a number of ways including through pre operative anaesthetic assessment, consultant notes, venous thromboembolism (VTE) risk assessment, food and fluid intake, national early warning score (NEWS), risk booklet

and additional clinical notes. Pre assessment pages were colour coded to indicate completion required by anaesthetist, operation suite and multidisciplinary team (nursing, physiotherapy, RMO).

- A documentation audit took place on the wards in June 2018. Patient notes were assessed against 40 standards that included checking on clinical risk assessments being in place. The check included a risk assessment for VTE, pressure areas, moving and handling, VIP score, bed rails, falls, nutrition and an infection prevention and control risk assessment, completed on admission. There was a compliance rate of 100% against the risk assessment section of the audit.
- Sepsis was assessed on return from theatre using NEWS scores. We were given a recent example by the sepsis link nurse where sepsis was suspected and quickly acted on with cannulation, antibiotics, oxygen and called the consultant (the Sepsis Six consists of three diagnostic and three therapeutic steps).
- There was a pre assessment matrix whereby different procedures were graded as to what type of pre assessment was needed. For instance, injections were categorised as needing telephone pre assessment, while complex needs were face to face. Non complex taking of bloods and swabs were healthcare assistant led clinics.
- Physiotherapy saw patients for pre assessment on the same day as the patient's other pre assessment appointments. On admission, the physiotherapist checked that everything was in place for discharge. The patient pathway was to be seen in pre assessment and then sent over to physio.
- If someone in pre assessment identified a need for an anaesthetist review they had to contact theatres to find one who is able to see a pre assessment patient. However, there was a new system about to commence, whereby anaesthetists were on an on call rota for pre assessment. There were triggers in the assessment such as co morbidities or a high BMI that required anaesthetist input.
- Patients received a pre assessment health questionnaire prior to pre-assessment, which were also available on clipboards if they had forgotten the form. Patients undergoing local anaesthetic procedures had a telephone pre-assessment undertaken by a nurse who asked about any co-morbidities and changes in health since their consultation. All other surgical patients were pre-assessed in person. All cardio patients were pre-assessed. The hospital's RMO clerked the patient on admission to the ward. Consultants were available via telephone to answer any queries from the RMO. When in operation, the cardiac catheter laboratory had a resuscitation team on standby.
- The service used the World Health Organisation (WHO) surgical safety checklist and '5 steps to safer surgery'. The WHO safety checklist audit encompassed a combination of theatre list samples. The audit was organised in to sections of: observational, sign in, time out and sign out. There were 32 standards audited in total that included: 'Did the patient confirm:- identify, site, procedure, consent?' and 'sign in section signed, sign in section timed', 'surgeon, anaesthesia professional and nurse have all verbally confirmed: a) patient b) site c) procedure'. The March 2019 audit showed 30 patient records were sampled. Scores showed 24 of the 30 sampled patients marked as 100% compliant against the checklist. All others scored in the 90%s.
- In theatres, we observed good adherence and consistency to following the World Health Organisation (WHO) surgical safety checklist and '5 steps to safer surgery'. Staff were fully engaged with the process and were paying attention during checklist. We observed the dental list in theatre 4. Time out was done at the end of the case. There was an onscreen x ray of the tooth to be extracted throughout the procedure to help ensure that the correct tooth got extracted. The WHO checklist was completed. In theatre 3, we observed VTE prophylaxis was in place, fluids were administered but temperature was not monitored as it was a short case. Sign out was completed when the case was finished. Aspects of the checklist were observed but not all stages. We observed sign in, time out and sign out although we were not present to witness team brief or debrief.
- A documentation audit took pace on the wards in June 2018. Patient notes were assessed against 40 standards that included has the WHO checklist been completed: (patient confirmed identify, site, procedure, consent, evidence that the site was marked, anaesthesia safety

check, pulse oximetry check, allergies, aspiration risks, risk of blood loss, all team members introduced themselves). There was a compliance rate of 100% against the WHO documentation section.

Nursing and support staffing

- **The service had enough nursing staff, with the right mix of qualification and skills, to keep patients safe and provide the right care and treatment.** It was reported that a nursing dependency and skill mix planning tool was used as a guide to support trained professionals to exercise their judgement and ensure the right staff are on duty at the right time and with the right skills. The tool was populated five days in advance so that staffing levels could be reviewed and planned in a timely manner.
- It was reported that there was an average of 0.1% unfilled shifts between January and March 2019.
- On site we were told that the labour standard tool was used to assess staffing need by day care procedure. For instance, joint injections were calculated with a length of stay of one to two hours, whereas an epidural was calculated at two hours, which increased to six hours for removal of prosthesis from breast and eight hours for total thyroid lobectomy. Staffing need was based on this total. There was no staffing establishment for day care as such but staffing numbers were assessed, based on the previous year's activity and numbers. Monthly figures were also used and based on complexity and activity from last month.
- The ward labour tool was also used for inpatients. There were four levels, including complex, and patients were assessed by procedure complexity. This enabled the service to flex up and down with staffing numbers and planning took place a week in advance.
- For the wards and day care, there were currently 25 nurses and ten healthcare assistants in post, with five nurses and four HCAs on the bank. The staffing need was managed through bank staff and regular staff doing extra shifts which we were told was manageable.
- When staff left, a request to fill that vacancy was made and sent for approval. Once approved the advert went out and the recruitment process commenced. There were currently three HCAs and one nurse waiting to start. There were three further vacancies that had been approved to go to advert. The staff turnover last year was four nurses and two HCAs.
- We were told that recruitment of experienced scrub and anaesthetic staff was a challenge which was mitigated by good leadership and the provision of agency staff where required. In theatres, there was a staffing establishment of 14. For operating department practitioners (ODP) and healthcare assistants in theatres there was an establishment of 17. Between April 2018 and March 2019 staff turnover in theatres was 42% following a senior person leaving and recruiting others. On site, we were told there was a current vacancy rate of four. There were three trained staff and one healthcare assistant on duty in each theatre. There were six nursing bank staff and one bank HCA on duty at the time of our inspection covering short fall. We observed the dental list in theatre 4 (tooth extractions). There were four patients on the list all under local anaesthetic. Staff comprised of one charge nurse, two scrub nurses, one healthcare assistant and one surgeon. In theatre 3 there were three scrub nurses, one healthcare assistant, one anaesthetic nurse and one ODP making a total of six staff, so within safe practice as prescribed by The Association for Perioperative Practice(AfPP) who recommends two nurses and one healthcare assistant as a minimum.
  The pre-assessment unit was staffed by a team of five; two sisters and three healthcare assistants. The cardiac catheter pre assessment and laboratory were staffed by three nurses; a sister, senior nurse and nurse manager. There are no physiotherapy staff within the pre-assessment team. However, patients could be sent to the outpatients physiotherapy team after their pre-assessment or a physiotherapy assistant could attend the pre-assessment. This was only done for certain cases, where a physio input had been determined as necessary at the clinical consultation.
- There were 16 housekeeping staff including two team leaders.

Medical staffing

- **The service had enough medical staff, with the right mix of qualification and skills, to keep patients safe and provide the right care and treatment.** Medical cover for inpatient beds was

provided by the resident medical officer (RMO). RMOs worked to a system whereby they were on duty one week followed by a week off. There were two RMOs in post, provided by a medical staffing agency. If one was on leave another was provided by the agency. RMOs were responsible for the wards and inpatients and were bleeped if needed to attend outpatients. They were able to call the consultant on call for further advice. Staff told us this system worked well. We were told the medical staffing agency representative visited the hospital last week to check that everything was working to the team's satisfaction and gave an update on a replacement for one RMO who was leaving. The agency had a clinical team who could be contacted if there were any questions regarding clinical competency. We were told this had not occurred. If there were incidents then the team would email the agency to keep them advised. Renewal and updating of mandatory training was organised and managed by the supplying agency and shared with the hospital as completed. RMOs were also included in the mandatory resuscitation scenarios.

- We were told that RMOs were expected to get the required amount of rest, both during the day and for an uninterrupted period during the night. This was closely monitored through regular contact with the doctors by the doctor's agency and through a more formal programme of feedback. The hospital also monitored this via the ward manager and ward team, with any concerns fed back to the director of clinical services. If there were multiple call outs during the night the RMO was given protected time away from the department in their dedicated living space. The director of clinical services had daily contact with the RMOs during the rounding.
- There were a total of 299 doctors and dentists with practising priveleges. It was reported that the process for ensuring that consultant's credentialing documents were in place had been strengthened to ensure safe consultant practice.Consultant credentialing compliance was reviewed on a monthly basis and any non-compliant consultants were temporarily suspended until all associated paperwork was completed and returned. We were told that as a result, temporary consultant suspensions were regularly in place but no permanent suspensions had taken place during the last year. Currently six consultants were under temporary suspension awaiting submission of outstanding paperwork.
- All new applications for consultant practising privileges depended on completion of an application and provision of evidence of all relevant clinical experience relating to the practice.We were told that all prospective consultants must provide a number of supporting documents including; Curriculum Vitae, certificates of qualification, annual appraisal, GMC specialist register registration and medical indemnity certificate.A short business case was also completed by the consultant as part of the pre-application process. Upon receipt of all documentation the executive director will interview the applicant and make an individual decision on whether to progress the Consultant's application for Medical Advisory Committee submission. Successful applications are progressed to the medical advisory committee (MAC) to be fully ratified with a specific review by the speciality lead. References and immunisation status will be requested and an enhanced DBS will be performed if the consultant is approved at the hospital MAC.

Records

- **Staff kept detailed records of patients' care and treatment. Records were clear, up-to-date and easily available to all staff providing care.** Paper notes were used. For day care patients there was one folder for medical notes. If patients stayed overnight a nursing folder was made up. These were colour coded yellow and black. There were also electronic records for e-discharge and blood results. Notes we reviewed were legible, dated and signed.
- We were told that historically, notes availability for both clinics and admissions were a daily issue affecting the ability for safe and effective care. Over the last 18 months, an expanded medical records store had been created to meet the needs of the service, with over 18,000 notes now archived in line with the retention of records policy. An e-tracker system had been implemented to track notes across the departments. We were told there had been zero patients cancelled in the last 6 months due to notes availability.

- A documentation audit took place on the wards in June 2018. Patient notes were assessed against 40 standards including general questions, whether clinical risk assessments were in place, has the WHO checklist been completed and are prescription charts correct. A total of 40 files were checked with an overall compliance rate of 95%. Some of the general item questions scored 83% each thus lowering the average that scored 100% in the other sections. The general standards that scored 83% were: notes secure within the file and filed in order, was there a copy of the registration form, copy of the booking form, next of kin details recorded, GP details present, copy of the GP referral, relevant consultant clinic notes available, does every page have a unique identification (name, address, DOB, Hospital number), is documentation legible.

Medicines

- **The service followed best practice when prescribing, giving, recording and storing medicines. Patients received the right medication at the right dose at the right time.** A history of medications was learned in pre assessment and patients were asked to bring all current medications with them. The hospital dispensed medications for inpatient use but the service asked to see each patient's medication so that current medications could be verified against what was learnt during the pre assessment and triage of patient information. If a patient did not have current medications at home or a supply they were given a prescription for a week's supply or for whatever was needed following patient assessment. Private patients were given medication or private prescriptions. Medications were given to NHS patients. This was part of the contractural agreement with NHS organisations, to provide one week's supply and sometimes two, to take away for home use. The patient's GP was liaised with to inform them of what was being provided.
- In theatre 2, stock rotation occurred in the drugs cupboard and fridge. There were no medications past expiry dates seen. The controlled drug (CD) book was checked and all items had been signed. All CDs had been checked twice daily except on one occasion where they were only checked once. In theatre 3, CD drugs were checked twice daily and all items were signed for. In recovery all medications in the drug cupboard were in date and there was stock rotation.
- In the anaesthetic room, stock rotation was observed among fridge items. Drugs in the cupboard were also stock rotated. However, one item had expired in March 2019 which was brought to the attention of the lead nurse. The CD book and cupboard were checked. We found that CDs given were signed for and drugs were checked at least twice daily. All items were stored above ground level to aid effective cleaning.
- Controlled drugs audits took place in both theatres and recovery in March 2019 against a set of 39 standards under the headings of: security of stock, CD stock holding is appropriate and recording of stock. The compliance score for theatres was 100% and for recovery it was 100%.
- A documentation audit took place on the wards in June 2018. Patient notes were assessed against 40 standards that included two pharmacy standards: was the pharmacy prescription chart completed with allergies and was the pharmacy prescription chart completed with details of weight. There was a compliance rate of 100% against the pharmacy section.
- An audit of pharmacist interventions for March 2019 showed there were 81 patients seen by pharmacy over the period of a week, resulting in 68 pharmacist interventions including from dispensary, in departments, for outpatient prescriptions and 'to take away' prescriptions.
- The pharmacy department was open from Monday to Friday from 9am to 6pm and from 9.30am to 12.30pm on Saturdays. There was a 24-hour on-call service for clinical queries, ordering emergency stock out of hours, controlled drugs requirements and out-of-hours service for medications to take away. The on call pharmacist was contacted via the on-call rota directly or by switchboard.

Incidents

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

the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support. There were zero Never Events at the hospital between January and December 2018. The service reported 282 relating to surgery and surgical inpatients over the same period. The clinical governance report for April 2019 shows a breakdown of all incidents for the month and a comparative analysis for the year. March 2019's breakdown shows out of 47 'patient events', there were six with low harm, three with moderate harm and zero with severe harm or death. 33 were reported with no harm. Incidents were categorised in to themes. There were nine cancelled operations, two incidents categorised as surgical complications and one re admission within 28 days. There were three reported under 'unplanned transfers/re-admission or returns to theatre' with action taken stated. This included root cause analysis in one case.

- There was a serious incident in April 2019, where during a planned procedure for aorto - bifemoral bypass, a patient died following an intra-operative haemorrhage. The hospital took appropriate action that included immediately notifying the coroner and family, with no inquest required and Duty of Candour applied. The consultant was suspended, pending outcome, from completing any complex vascular surgery which was agreed by the medical advisory committee chair and the NHS trust they also worked for were notified. The investigation involved independent consultant review and an independent investigator was appointed to carry out a level III investigation. The draft root cause analysis investigation was due to be reviewed by the corporate senior clinical review board. Once completed this will be distributed for learning.
- The senior leadership told us that a more open and transparent culture had meant a better reporting culture. Staff were encouraged to raise incidents without cause for concern and for learning and improving outcomes for patients. This was now covered within the new staff induction programme. In June 2018, 24 incidents were reported which was now up to an average of 70 in last three months (76 in May 2019).
- One example of incident reporting impacted on the decision to introduce security. We were told it was made clear to staff of the need to report security incidents if they wanted things to change, as it gave quantifiable information which in turn secured funding for security presence.
- We were told that a current trend of incidents was around late finishes in theatre. This had become part of a drive towards reducing late finishes and identifying surgeons who overrun. We were told that currently the late running rate was 3% and the hospital was working to get it down to 1%.
- We came across some good examples where learning from incidents had been embedded in practice. Incidents were recorded of patients coming in to theatre not shaved and were an infection risk. As a result, a process for marking the area for shaving on the day of theatre had been introduced. This process had been in place since April 2019. All staff were aware of this through meetings and discussions of incidents in team meetings.
- We were told that when an incident was put on to the online reporting system, the department lead receiving the report would discuss the incident with the person who reported it. For instance, if theatres reported that a patient had not been sufficiently prepared for surgery, which was looked at in terms of how much support was needed to properly prepare the patient. We were also told there used to be a higher number of medication errors but following lessons learnt, there was now a system of first, second, and third error, where each nurse knew how many errors they have had and what support and supervision was needed, so that improvement plans could be put in to place. This had significantly lowered the number of drug errors. Over a six month period two years ago medication errors were counted at eight. In the most recent six month period this had fallen to just two.

Safety Thermometer

- **The service used safety monitoring results well. Staff collected safety information and shared it with staff, patients and visitors. Managers used this to improve the service.** Safety thermometer information was collected and uploaded on to the NHS system for falls, urinary tract infection, infection, catheter, venous thromboembolism and prophylaxis. We were told that safety thermometer information was

not used as a tool to manage patient safety as the data applied only to NHS patients. The service utilised a range of datasets to oversee all of our patients: private, self-pay, international and NHS funded care. This was because NHS and private patients were not distinguished between in terms of management of safe patient care.

- There were a range of datasets and assurances in place to manage patient safety. There was a twice daily 'comm cell' meeting each day that every department reported verbally on activity, safe staffing levels and any incidents or safety concerns.
- The quality dashboard was presented at the monthly governance committee meeting. Pressure ulcers and falls were listed on the dashboard and discussed at the meetings to ensure appropriate oversight and actions as necessary. Venous thromboembolism (VTE) compliance was subject to quarterly audits and any incidents of VTE were reported on the risk reporting system and subject to investigation. Very few patients had indwelling urinary catheters due to the patient mix. All microbiology results were monitored by the infection control lead. There were zero hospital acquired pressure ulcers in the last 12 months, 6 patient falls (0.046% of admissions) and no VTE over the same period. However, this information was not on display to patients.

Are surgery services effective?

Good

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

Evidence-based care and treatment

- **The service provided care and treatment based on national guidance and evidence of its effectiveness. Managers checked to make sure staff followed guidance.** Evidence based practice and National Institute for Health and Care Excellence (NICE) guidelines were implemented to ensure effective outcomes. NICE guidance was monitored through the clinical governance committee. Minutes from the monthly clinical governance committee showed NICE compliance and practice updates as a regular agenda item. For instance, recent minutes (January, February, March 2019) showed the group currently monitored compliance and updates for the following good practice guidance for the treatment of chronic obstructive pulmonary disease MIB161, renal replacement therapy and conservative management NG107, decision-making and mental capacity NG108, urinary tract infection (lower): antimicrobial prescribing NG109, prostatitis (acute): antimicrobial prescribing NG110, percutaneous insertion of a temporary heart pump for left ventricular haemodynamic support in high-risk percutaneous coronary interventions IPG633, Urinary tract infection (catheter-associated): antimicrobial prescribing NG113, tofacitinib for moderately to severely active ulcerative colitis TA547 and heavy menstrual bleeding: assessment and management NG88. Decisions were made regarding whether guidance was relevant to the service, named individuals were identified to review specific guidance and report back and new guidance was being identified for individuals to report back on.
- A documentation audit took pace on the wards in June 2018. Patient notes were assessed against 40 standards that included checking on clinical risk assessments being in place. The check included a risk assessment for venous thromboembolism,pressure areas, moving and handling, VIP score, bed rails, falls, nutrition and for an infection prevention and control risk assessment, completed on admission. There was a compliance rate of 100% against the risk assessment section of the audit.
- Evidence based care and treatment was provided through following of national guidance such as NEWS and the World Health Organisation (WHO) checklist for safer surgery. Patient documentation, such as treatment plans, risk assessments and observational charts followed national guidance such as the Royal College for Nursing standards. A documentation audit took place on the wards in June 2018 where patient notes that included effective use of a risk assessment for venous thromboembolism, pressure areas, moving and handling, visual infusion phlebitis (VIP) score tool, bed rails, falls, nutrition and for an infection prevention and control risk assessment, completed on admission. There was a compliance rate of 100% against the risk assessment section of the audit. It also checked that the WHO checklist been completed. There was a compliance rate of 100% against the WHO documentation section.

- All operating rooms met the Association for Perioperative Practice guideline for staffing.

Nutrition and hydration

- **Staff gave patients enough food and drink to meet their needs and improve their health. They used special feeding and hydration techniques when necessary. The service made adjustments for patients' religious, cultural and other preferences.** Nutritional state was assessed for each patient on admission using the Malnutrition Screening Tool (MUST). Food and fluid intake was monitored using food charts and fluid balance charts.
- Fluid balance chart including oral and intravenous were seen. This included total input and output when required for patients with complex needs.

Pain relief

- **Staff assessed and monitored patients regularly to see if they were in pain. They supported those unable to communicate using suitable assessment tools and gave additional pain relief to ease pain.** Pain advice booklets were given to patients for use post operatively and any issues are documented and discussed. Pain scores were documented in the patient health record and managed accordingly. The hospital also employed a nurse with responsibility for pain management care.
- In recovery, staff were asked about pain management and they stated that they used patient controlled analgaesia, as prescribed and other oral and intravenous analgesia. If they were concerned about pain they would speak to the anaesthetist.
- Pain management was managed by the patient's anaesthetist for surgical inpatients. For all other patients pain issues were managed by the RMO or the patient's own consultant was called to reassess patients and amend the medication prescription accordingly.
- In pre assessment we found that pain was assessed and all patients were provided with a guide to controlling pain. We were told that better pain management meant that patients were able to be discharged rather than have to stay overnight for pain management purposes.
- All day care and ward patients were seen on a daily pain round that commenced at 11am. This was carried out by the nurse lead for pain management, the pharmacist and RMO. Each patient was asked about pain and assessed alongside current pain scores. Patients could be referred to a pain consultant if needed.
- The pain round was now for everyone whereas, before January 2019, it was confined to complex inpatients. This was a result of patients calling to say they were in post operative pain and a complaint and lessons learnt.
- The pain lead carried out telephone follow up for pain patients following procedures or following discharge after 48 hours. Others with chronic pain were called weekly until medications for pain relief were reduced. The pain lead also advised GPs on medications for pain relief by sending emails to GPs. For more complex patients they advised GPs to refer to a pain consultant. Pain was also monitored with observation after surgery. Frequency depended on need and was between every 30 minutes to two hours. The pain lead was also referred to for advice.
- A pain relief audit took place on the wards in November 2018. 40 patient files were audited against a set of 18 standards that included: documented evidence regarding their pain in the patient care pathway, evidence what analgesia was taken, documented evidence that pain score assessed on the pain management care plan chart, has the patient been prescribed PRN analgesia, evidence pain levels were evaluated post analgesia, evidence the nursing team has assessed the patient pain levels frequently enough, evidence the patient was advised / prepared for their post-operative pain management at pre-assessment, did the patient need to contact the hospital / GP after going home regarding pain issues? The audit showed a compliance rate of 100% for pain management.

Patient outcomes

- **Managers monitored the effectiveness of care and treatment and used the findings to improve them. They compared local results with those of other services to learn from them.** Patient outcomes were measured in a number of ways.
- The process of registration had commenced for joining the National Breast and Implant Register. It was reported that limited activity was undertaken at the hospital and a full implant register was held onsite.

- Between January and December 2018, it was reported that 100% of patients admitted were risk assessed for venous thromboembolism. Zero cases of hospital acquired venous thrombosis and pulmonary embolism were reported over the same period.
- The hospital participated in national reported patient outcome measures (PROMs) for hip, knee and cataract surgery and were working towards EQ-5D, a patient-reported outcome measure that captured five dimensions of health related quality of life: mobility, self-care, usual activities, pain/discomfort, and anxiety/ depression.
- The hospital participated in the National Joint Registry (NJR) to collect information on orthopaedic joint replacement operations, monitor the performance of implants and the effectiveness of different types of surgery. The NJR monitor and report on outcomes. Individual consultant performance was reviewed to improve clinical standards and patient outcomes.
- The service was found to be an outlier for the NJR audit, published in 2018 for total knee replacement procedures. The service were complying with the terms of reference for the audit and working to identify the indications for primary surgery and any issues that may have arisen from this surgery, identify any patient related factors and co-morbidities which may have influenced further corrective or revision surgery and ascertain if any there were any learning or trends from this review and to make recommendations to improve outcomes where possible.
- The hospital benchmarked outcomes against other comparable services both internally through the BMI performance dashboards and national audit. We were told that heads of department reviewed outcomes and participated in audit. Poor outcomes were identified via benchmarking, incident reporting or complaints were investigated to ensure that lessons are learned.
- Patient Reportable Outcome Measures (PROMs) was used to calculate the health gains after surgical treatment using pre and post-operative surveys. Information was collected through self completed questionnaires. The hospital participated in hip and knee replacement surgery and cataract surgery PROMs.
- Patient Led Assessment of the Clinical Environment (PLACE) assessed the quality of the hospital environment including patient views on privacy and dignity, cleanliness, food and general building maintenance. This was scheduled for 27 August 2019.
- There were four Commissioning for Quality and Innovation initiatives (CQUINs) agreed with commissioners to promote improvement in patient care. This was a system introduced in 2009 to make a proportion of a healthcare provider’s income conditional on demonstrating improvements in quality and innovation in specified areas of care. The CQUINS were: improvement of staff health and wellbeing, antimicrobial resistance and sepsis, offering advice and guidance and NHS e-referrals.

Competent staff

- **The service made sure staff were competent for their roles. Managers appraised staff’s work performance and held supervision meetings with them to provide support and monitor the effectiveness of the service.** The staff appraisal year ran from November to October. In theatres, the appraisal rate was reported as 100% for operating department practitioners and healthcare assistants and 92% for nursing staff.
- The practice facilitator covered registered and non registered, clinical and non clinical, administrative and student nurses. They provided acute care competencies to registered ward staff on arrival when starting at the hospital. Theatre competencies were given to all theatre staff. It was down to line managers and senior sisters to follow up with compliance of competency workbooks.
- Some staff had participated in training additional to mandatory training that enhanced their competency in specific roles. For nursing staff, this included the anaesthetic practice course, circulating and scrub competencies, mentorship and recovery.
- Healthcare assistants were initially started on working towards a care certificate on commencement of employment. They were then able to complete the healthcare assistant versions of competency books. Associate nurse practitioners (ANPs) were trained to be scrub technicians to do scrubbing. These ANPs are

promoted to a band 4 after they complete their training and sign-off their competencies. BMI was funding these places and providing training. We were told that this enabled staff retention and career progression.

- It was reported that there was a weekly protected hour for healthcare assistants to meet with the practice facilitator to complete care certificate. However, other staff did not get protected time to complete training, so some clinical areas were not attending training due to area workloads. This was reflected in compliance with mandatory training and competencies.
- Each clinical area had a teaching liaison link role. Inhouse training for this was planned for July 2019.
- There was an online team teaching area that enabled management to monitor that competencies were being completed. An e-learning portal was available and updated regularly.
- Cardiac catheter laboratory pre-assessment nurses reported being offered learning opportunities within their team. These were organised by the consultants and consisted of study days at a local NHS trust and the attendance of seminars and conferences.
- The practice facilitator reported that individual team leads were able to make a referral if they felt staff needed more support or certain topics needed more intensive support. In relation to theatres and recovery training, all staff in this area were required to complete scrub competencies, recovery competencies and operating department practitioners competencies. These were given in the form of a workbook, which the completion must be supervised and signed off by a senior staff member or trainer. These were to be completed during a six month period of staff joining the department.
- Ward staff were given acute care competency workbooks and deteriorating patient workbooks to complete within six months of starting. These were the same as the theatres/recovery workbooks, but were tailored to surgical ward working.
- Staff development opportunities were provided through ‘BMI Learn’ Training Academy. BMI recently started in house teaching, whereas previously teaching sessions were held in other BMI locations or were provided by external agencies. They had recently started providing in house teaching sessions with topics tailored to specific areas, taught by London BMI staff and trainers.
- Some staff told us they undertook courses such as recovery and surgical courses and that refresher competency books were completed.
- The theatre department had a number of link practitioners such as for infection control, COSHH and practice development. We were told that that training for these roles was a combination of face to face and online competencies.

Multidisciplinary working

- **Staff of different kinds worked together as a team to benefit patients. Doctors, nurses and other healthcare professionals supported each other to provide good care.** Surgical activities were supported by multidisciplinary teams. There were specific teams working in areas such as pre assessment, the anaesthetic room, surgical wards, theatres and cardiac catheterisation unit. Teams included nurses, operating department practitioners, pharmacist, healthcare assistants, anaesthetists and surgeons.
- Physiotherapy saw patients for pre assessment on the same day as the patient’s other pre assessment appointments. patients can be sent to the physio team after their pre-assessment or a physio assistant attended pre-assessment. This was for certain cases, where physiotherapy input had been determined as necessary at the clinical consultation. On admission the physiotherapist checked that everything was in place for discharge.
- The way in which some disciplines supported patients had recently been rethought. If someone in pre assessment identified a need for an anaesthetist review they had to contact theatres to find one who was able to see a pre assessment patient. However, there was a new system about to commence, whereby anaesthetists were on an on call rota for pre assessment where there were triggers such as co morbidities or a high BMI. All day care and ward patients were seen on a daily pain round carried out by the nurse lead for pain

management, the pharmacist and RMO. Patients could be referred to a pain consultant if needed. This had been in place since January 2019. Prior to this, the pain round was confined to complex inpatients.

- We observed positive working relationships between disciplines. For instance, in the anaesthetic room there was a good working relationship among staff and open communication was observed.For the dental list in theatre 4 there was good working cohesiveness among the team and all the staff knew their roles.

Seven-day services

- **Key services were available to support timely patient care.** Normal working hours were 7.30am to 8pm Monday to Saturday. Saturday surgery lists were supported by multidisciplinary teams. Pre-assessment clinics were held every weekday from 8am to 6pm. The pharmacy department was open from Monday to Friday from 9am to 6pm and from 9.30am to 12.30pm on Saturdays. There was a 24-hour on-call service available. Medical cover for inpatient beds was provided by the resident medical officer (RMO). RMOs worked to a system whereby they were on duty one week followed by a week off. They were able to call the consultant on call for further advice.

Health promotion

- **Staff gave patients practical support and advice to lead healthier lives.** Lifestyle questions were all part of the pre and post operative assessments. On all pathways patients were asked about health lifestyle such as whether they smoked, how many units of alcohol they consumed and were advised about post operative care, diet and avoiding certain activities after their procedure. Lifestyle such as health and activity was asked about in pre assessment and how this may affect patients post operatively.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards.

- **Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients' consent.** Information was provided to patients prior to surgery to ensure patients fully understood any benefits and associated risks of the procedure. The consent form addressed the diagnosis, potential risks and benefits, the treatment team and patients' rights, ensuring that patients were fully informed and able to make decisions about their treatment options.
- There was a day care pathway form, which checked that all parts of the pathway had been followed. This included consent. The documentation audit carried out in June 2018 covered aspects of consent, checking on evidence of informed consent, has the consent form been signed, is it legible and was the consent signed before the day of procedure? In all 36 files that were audited it was found to all have been completed according to these questions. However, we reviewed patient files and found that some consent forms had been completed and some had not. We were told that in outpatient appointments, the consultant would agree or make a decision on the procedure to be carried out and seek consent from the patient, which was sometimes only verbal. Then on the day of the procedure the consultant would renew this consent with the patient. Some consultants completed the consent documentation with the patients on the day of procedure, prior to anaesthesia, while others chose to complete this in the outpatients' appointments and renew the agreement verbally on the day of procedure.
- Staff received training on consent, including the Mental Capacity Act (2005) and deprivation of liberty as part of their mandatory training. In theatres, the training compliance rate was 100% and on wards it was 95%. The BMI consent policy was in accordance with current legislation for patients who lacked mental capacity.

Are surgery services caring?

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

Compassionate care

- **Staff cared for patients with compassion. Feedback from patients confirmed that staff treated them well and with kindness.** We were told that patients were placed at the centre of everything and that importance was placed on delivering quality care that was respectful and responsive to individual patient preferences, needs and values.

Good

Surgery

- We were told that all new staff attend customer training as part of their induction programme to enable staff to understand patients' needs and expectations, the affect attitude has and apply effective communication.
- Between October 2018 and March 2019 there was an average friends and family test satisfaction rating of 96% from an average response rate of 12%.
- We spoke with one patient who was a choose and book patient. They were anxious prior to their procedure. They told us the anaesthetist had been kind, patient and reassuring. The patient stated they were happy with the service they had received from the hospital and staff, saying: "I have been treated well by everyone".
- We observed one patient awaiting dental surgery, who was very anxious. The staff including the surgeon had reassured the patient to allay their fears and anxiety.
- We spoke to one patient who had come for tooth extraction. They voiced their dissatisfaction with their NHS dentist. They had used choose and book and were very happy with the tooth extraction. We were told that they had experienced a good service from staff who were caring in their roles and communicated with them well.
- Patients had the option to visit and familiarise themselves with the cardiac catheter laboratory during the pre-assessment stage in order to put their mind at ease about forthcoming treatment.

Emotional support

- **Staff provided emotional support to patients to minimise their distress.** On the wards we were told that they helped patients to understand what was happening depending on their own individual need and this communication was key to caring. Where there were either pre or post operative patients, we were told that staff went around all patients daily to see if they wanted to discuss anything before or after their procedure. They were asked if they wanted them to inform their relatives or friends of anything and talked to patients to involve them in their care. We were told this was to let them know who was looking after them. All patients were brought to their room and informed if there were any delays.
- Family members were permitted to be with patients up to their surgery time and were allowed to be on the wards when the patient returned from surgery. Relatives were permitted to stay overnight where necessary. Fold up beds were available for relatives.

Understanding and involvement of patients and those close to them

- **Staff involved patients and those close to them in decisions about their care and treatment.** We spoke with one patient coming in for pre assessment, who told us they were always treated with dignity and respect. They told us that the nurse explained that their GP would receive copies of letters. The patient told us that staff were always clean and bare below the elbows. They told us that staff "Ae angels and couldn't be nicer to me" and that staff were always kind and caring. They told us they had completed the friends and family test a while ago but had not done one recently. They told us they would feel easy about talking to reception if they weren't happy with anything. They told us that staff always asked their opinion and involved them in their care. "Even the little things like what arm I want my blood pressure taken on".
- Patients could request a chaperone if necessary giving them access to emotional support prior to, during and immediately after an examination.
- In the pre assessment clinic we observed excellent interpersonal skills by a member of staff, who introduced themselves and confirmed the patient's identity; name and date of birth prior to doing anything. Consent was asked for before touching the patient. They explained the patient pathway; on the ward, on arrival on the ward, what happens, what to expect, who they will meet, what will happen and explained all that was done today would be repeated on their admission day. They explained painkillers and what to do and not do post operation. They explained the discharge summary procedure and that the GP would receive this. They had an excellent rapport with the patient that was caring and kind. An MRSA screen was taken due to the patient travelling abroad. The MRSA procedure was explained fully and a leaflet given on MRSA as well as a leaflet about their forthcoming procedure. Consent was explained. They explained fasting times, and the dressing change procedure.

Surgery

- Self pay patients were provided with a printed list of costs which they were asked to read and sign, ensuring patients had a greater understanding of the financial charges at the time of treatment.

Are surgery services responsive?

Good

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

Service delivery to meet the needs of local people

- **The hospital planned and provided services in a way that met the needs of local people.** The hospital offered elective surgeries to both NHS and private patients. There were a variety of surgical procedures available, including orthopaedic, ENT, general surgery, ophthalmology, pain management, and urology.
- There was a choose and book system in place for NHS patients, who were from the local catchment area of which a large proportion came for orthopaedic procedures. A physiotherapist saw orthopaedic patients for pre assessment on the same day as their other pre assessment appointments and assessed what support was needed for going home. On admission the physiotherapist checked that everything was in place for discharge. We were told that there was a good working relationship with the local social services team for patients who needed more support post procedure, and that processes were straightforward. Staff felt confident about working with them and the service did not experience delayed discharge for non medical reasons as a result of this partnership.
- There was a service level agreement in place with the local NHS trust for the provision of critical care services post surgery if required. There were critical care beds on site so this was intended as a back up plan. It had been used once in the last year.
- The hospital maintained good relationships with local safeguarding leads. The director of clinical services was a member of a multi-borough safeguarding committee and worked in partnership with a key member of the safeguarding team as a link worker.
- Telephone consultations were offered to avoid patients making unnecessary journeys to the hospital. The pain lead carried out telephone follow up for pain patients 48 hours post discharge. There was a pre assessment matrix that meant patients coming for different procedures were graded as to what type of pre assessment was required. Patients undergoing local anaesthetic procedures had a telephone pre-assessment undertaken by a nurse who asked about any co-morbidities and changes in health since their consultation. Injections were assessed as a telephone pre assessment, while more complex ones were face to face. All hip and knee post-operative patients were called between 30 and 40 days to check on their condition regarding surgical site infection.
- Senior managers reported a positive relationship with local NHS clinical commissioning groups and told us they were committed to driving improvement of the NHS standard acute contract and CQUINs which were reviewed and updated quarterly to review quality and performance.
- The hospital worked with the Private Healthcare Information Network (PHIN) where there was a reported move towards improved reporting of patient outcomes across the independent healthcare sector, enabling comparison with data available from NHS providers to assist with information transparency and, in turn, patient choice.

Meeting people's individual needs

- **The service took account of patients' individual needs.** The service identified patients who required specialist communication services and these were provided, for example interpreters where English was not a first language. In addition, a loop recorder was available on reception to support patients with a hearing impairment. Text messages were used to remind patients of their appointments.
- Individualised care was provided at every stage of the patient pathway. There was a pre assessment matrix which graded different procedures as to what type of pre assessment was needed. For instance, injections warranted a telephone pre assessment while complex ones were face to face. There was also bloods and swabs clinic which was led by a healthcare assistant for non complex patients. Physiotherapy saw patients for

pre assessment on the same day as the patient's other pre assessment appointments. All pre-assessment physiotherapy input was carried out by a physiotherapy assistant, with their recommendations then signed off by a registered physiotherapist. On admission, the physiotherapist checked that everything was in place for discharge where appropriate. In the pre assessment clinic we observed individual needs being assessed including blood pressure, weight, height, previous medicines, current and reasons for taking medicines, previous medical history, heart conditions and previous surgery. An MRSA screen was taken when travelling abroad was indicated.

- Patients with a learning disability were identified at triage. All patients with a learning disability were advised to bring a carer with them to support. Where staff had any concerns they would contact the director of clinical services.
- The day care pathway form checked that assessments of individual need had been completed for pre operative anaesthetic, consultant operating notes, daily medications chart, venous thromboembolism risk assesssment, consent, NEWS score, risk assessment booklet and additional clinical notes. File pages were colour coded in the corners for pre assessment by – anaesthetist, operating suite and MDT (nursing, physiotherapy and RMO).
- Patients on wards and the day care unit were routinely and regularly checked on to ensure they were not anxious about their procedure. There was a daily pain round and routine rounding for all pre and post operative patients.
- The pre assessment process identified individual support needs. Such as dementia, whether patients lived alone and whether they had the support they needed. Physical assessments also picked up evidence of falls and issues of skin integrity.

Access and flow

- **People could access the service when they needed it. Waiting times from referral to treatment and arrangements to admit, treat and discharge patients were in line with good practice.** We were told that NHS patients could easily access surgery services which were available on the national Choose and Book portal (eRS), which also gave patients a choice of appointment time. Private patients were able to book appointments through a centralised bookings team or through their website, which included a 'live chat' support function.
- The reservations team uploaded NHS referrals on to an initial BMI system in order for patient history and treatment record to be accessible for their triage assessment. There was then a separate BMI appointment system used for booking all patient appointments, outpatients appointments, pre assessment appointments, clinic appointments and physiotherapy appointments. The initial BMI system was then used again for bed planning and theatre planning. The two systems did not speak to each other so both were referenced to book appointments for procedures.
- We were told that the hospital adhered to a five day booking rule, which reduced the number of patients who were booked at short notice thus ensuring that teams could plan and undertake effective bed planning meetings (held weekly). The exceptions to the rule were due to short notice trauma or cardiac cases requiring an urgent timeframe. In such cases strict criteria must be met and signed off by the director of clinical services, the clinical services manager for theatres and the clinical services manager for Inpatients.
- Between January and December 2018 there were 10,467 theatre visits. During the same period there were five unplanned returns to theatre.
- All four theatres had hours of operation between 0730 to 2030hrs Monday to Saturday inclusive.
- Between March 2018 and February 2019, a breakdown of surgical activity was: injection(s) +/- aspiration, into joint, cyst, bursa with image guidance (1252), surgical removal of impacted/buried tooth/teeth (1046), facet joint injection (under x-ray control) - 5 or more joints (566), medial branch block (under x-ray control) 5 to 6 levels (332), multiple arthroscopic operation on knee (including meniscectomy, chondroplasty, drilling or microfracture) (259), facet or sacroiliac joint (RF) radiofrequency thermocoagulation, cryotherapy or phenol (including rhizolysis under image guidance) - 4 to 6 joints (256), hysteroscopy (including biopsy, dilatation, +/- cauterisation, curettage and resection of polyp(s) +/- Mirena coil insertion)(232), dorsal root ganglion block (local anaesthetic or neurolytic) (as sole

procedure) (196), facet joint injection (under x-ray control) - 3 to 4 joints (185), examination/ manipulation of joint under general anaesthetic +/- injection +/- arthrogram (as sole procedure) (170).

- On the day of our inspection there were 21 day case admissions, five new inpatient admissions and seven existing overnight patients making a total of 12 inpatients and 37 admissions all managed from the wards. The two surgical wards were adjoined and accommodated a total of 33 single rooms located on one floor, adjacent to theatres for easy access. The day surgery unit was opened if capacity could not be managed on the two wards. Capacity was known a week in advance and the day care unit was opened an average of three times a week. This included Saturdays when lists for surgery also took place.
- We were told that the average length of stay depended on patient need. This was on average three days for joint, five for spinal and complex surgery could be for one night. There was physio support and in pre assessment orthopaedic patients were seen by a physio to plan for discharge and for NHS patients, organise social services support in the community.
- Patients arrived on the ward pre procedure and were telephoned by the nurse if they did not arrive at their allotted time. If patients do not attend for their morning appointment in pre assessment, staff telephoned to see if they were able to fit into the afternoon schedule. Patients arrived depending on theatre list time and were informed in person if there was a delay in going to theatre. Any theatre delay was logged on to the incident reporting system. For more complex procedures such as arthroscopies, majors and gynaecological, appointment times for arrival were staggered but for lists such as pain management all patients arrived at one time.
- For theatre utilisation, a manager was currently doing a project to maximise utilisation. To try and minimise cancellation, patients booked for surgery were called the day before surgery to confirm attendance.
- The system for getting patients to theatre was that staff collect, walk in and walk out patients. Patients undergoing general anaesthesia would be collected from the ward. There was a remote 'walkie talkie' system whereby the porters were asked to collect the call slip and take it to the ward for the staff to bring the patient to the designated operating theatre. Trolleys were laid up in theatre on case by case basis.
- The dental list in theatre four and all local anaesthetic lists were considered as 'walk in and walk out' cases. The process was for the healthcare assistant in the theatre collect the patient from the lounge outside the theatre department. The patient was checked in by the charge nurse. At the end of the case the patient was given post-operative instruction by the surgeon and then accompanied by the healthcare assistant to the lift where the patient left for home.
- There were no outliers in the recovery room and staff stated that they did not have a problem with discharging patients after surgery.
- Over the last 12 months there were 228 cancellations on the day for non-clinical reasons (2.18%). The hospital analysed the information which was broken down to causes. 42% related to patients that did not attend. 16% were due to consultant factors such as overbooked lists or consultant sickness. 8% were due to a lack of anaesthetist. The remainder related to a number of factors that were all patient related. There were 33 cancellations on the day which related to cancellations for clinical reasons. We were told that the majority related to a lack of suitable pre-assessment or patients simply being unwell. There was an action plan in place to improve this.
- In the theatre department, software was used to inform the theatre utilisation tool to increase efficiency of the department. For on the day cancellations, a project team had been created to focus upon the volume of patient cancellations on the day with the aim to better understand the reasons behind the cancellations and be able to prevent cancellations. This was a key part of our 2019 clinical strategy.
- The referral to treatment (RTT) standard for NHS-funded patients was within 18 weeks (admitted pathway) of referral. Compliance against the 18 week target was broken down by surgical discipline such as urology, ophthalmology, oral, cardiothoracic and gastroenterology. The service set itself against a target compliance rate of 92% and was meeting this in most

cases including 100% in 8 of 18 disciplines. Neurosurgery fell below this standard most months. All were better than the national average of 72% of patients meeting the 18-week RTT.

- The electronic discharge system (e-discharge) enabled discharge summaries to go to the GP information system; in to a hub where it went on to the GP patient record. We were told that their GP received all copies of letters, including the discharge summary.

Learning from complaints and concerns

- **The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with all staff.** We were told that all complaints were directed to the executive director's office either by letter, telephone or through our dedicated email address for gaining patient feedback. Complaints were acknowledged within three working days by letter or email depending on the method of delivery. BMI Healthcare policy stated that responses be completed within 20 working days. All final responses were reviewed by the executive director and therefore have senior oversight from the outset. All complainants were given the option of a meeting with the executive director should they feel that their complaint hd not been fully resolved to their satisfaction or if they have further matters to discuss.
- Complaints and compliments were also discussed within the hospital at the daily 'comm cell' meeting attended by senior management and department representatives and immediate action needed could be taken.
- All complaints were entered onto the electronic incident reporting system. The complaints log for October 2018 to March 2019 gave a breakdown of all complaints within the hospital over the period, detailing the cause of each complaint and its outcome. The clinical governance report for April 2019 showed a breakdown of all complaints for the month and a running analysis for the year. Clinical complaints were categorised in to four areas; communication, treatment, consultant and clinical care. There were 53 complaints for the year running from April 2018 to March 2019, a rate of 0.4 per 100 admissions. Open complaints and significant complaints were tracked. Lessons learnt were also stated.
- We were told that patients were encouraged to speak with heads of departments and ward managers during their visit or admission in order to discuss any issues or concerns they may have Staff were encouraged to resolve any patient concerns in the first instance and to escalate matters to the appropriate manager if not possible. Staff told us that it was important to listen and understand any issues that patients brought to them in order to resolve any difficulties encountered. Patients told us they found all members of staff helpful.
- We were given an example of learning from complaints. As a result of a complaint and lessons learnt in January 2019, all day care and ward patients were now seen on a daily pain management round, whereas before it was confined to complex inpatients.
- As a result of a complaint regarding blood test charges for private patients the department had implemented a process whereby patients were provided with a printed list of costs which they were asked to read and sign, ensuring patients had a greater understanding of the financial charges at the time of treatment.

Are surgery services well-led?

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

Leadership

- **Managers at all levels in the hospital had the right skills and abilities to run a service providing high-quality sustainable care.** The organisational structure showed the senior management team comprised of the executive director, director of clinical services, quality and risk manager, director of operations, finance director and sales and marketing manager. There was a relatively new leadership team mostly recruited in the two years since the executive director had been inpost.
- There was a leadership structure within theatres. Each operating room had a designated charge nurse and all staff knew their role. The theatre manager worked closely with their entire team.
- The clinical services manager for inpatients used to also lead the pre assessment service but following some

reconfiguration of management arrangements they now covered the surgical wards and day care. Pre assessment was now led by their own specific lead nurse. This had been in place since January 2019.

Vision and strategy

- **The hospital had a vision for what it wanted to achieve and workable plans to turn it into action developed with involvement from staff, patients, and key groups representing the local community.** We were told the vision was to be the healthcare provider and employer of choice serving local communities in east London and Essex with a high standard of care.
- There was a strategy in place with clear vision and strategic goals that had been developed by the site leadership team, underpinned by a clinical and non-clinical five year plan with four key objectives: 1. To support quality care in the five core domains of safe, effective, caring, responsive and well-led through the quality improvement project, Timeliness, Outstanding, Quality (TOQ). 2. to promote quality patient care through a multidisciplinary team approach across a network of 30 integrated specialties, ensuring the right care and treatment was delivered by the right professionals, along the full patient pathway. 3. To promote patient and staff wellbeing and place them at the heart of everything and ensure these values were embedded in all aspects of the patient journey. 4. To promote, value and integrate patient and staff feedback. The executive director told us that they belived that being well led meant delivering on the five year plan.
- The clinical strategy was defined by eight objectives around ensuring that quality was at the heart of everything and to continuously improve the quality, safety and patient experience. The non clinical strategy stated a commitment to support these clinical areas.

Culture

- **Managers across the hospital promoted a positive culture that supported and valued staff, creating a sense of common purpose based on shared values.** We were told the hospital believed that being well-led was achieved through creating a culture where staff felt free to take responsibility, make decisions in the best interest of the patient and learn from every source to ensure patient care is constantly improving.
- The executive director told us that one challenge when they arrived was leadership teams working separately from one another. We were told that team working and the sharing of staff across departments had improved.
- We were told the executive director and director of operations were often working late, which was appreciated by the staff and allowed the leadership to be visible and support staff when incidents or events occurred out of normal working hours.We were told "It was common to hear staff say 'it's always been that way'; we have changed that attitude through proving we can make changes. If staff bring things to us, we will deal with it. Staff are therefore more likely to bring things to our attention". Staff told us that there was now more support from managers and communication was better and managers were more visible.
- We were told the aim was to promote an open, honest culture whereby staff and consultants can discuss hospital operational improvements through the various forums and meetings scheduled. The Freedom to Speak Up Guardian service had recently been launched to allow staff a confidential route to raising concerns and promote a safe culture.
- In theatres, staff stated that working here was like a family. Staff told us they felt well supported by the leadership. In one theatre staff we spoke with told us that it was a good place to work. A number of staff had been with the hospital for a long time. Staff were happy working within the department. We were told by other members of staff that the leadership were supportive of teams and morale was much improved.

Governance

- **The hospital used a systematic approach to continually improving the quality of its services and safeguarding high standards of care by creating an environment in which excellence in clinical care would flourish.** The hospital worked within the BMI Hospital Committee Terms of Reference, which allowed for the cascade of information from the executive team to the operations committee meetings

and departmental team meetings, to all members of the team at the hospital. We were told the approach was supplemented by frequent one to ones with and between individual members of the management team.

- Clinical quality and governance matters were reviewed by the medical advisory committee. The minutes and actions from these meetings, the clinical governance meeting and the various sub-committees were reported to the medical advisory committee and to the management team through the leadership committee.
- Senior management told us that the governance structure had been improved since the current executive director had been in post. There were no leadership meeting minutes. Now they were formally recorded and where each directorate provided a formal report for a set agenda. There was also an informal mid-month leadership meeting, in order to discuss matters to be raised at the next meeting and ensuring progress against the 'to dos' from the last board. Departmental meeting minutes took place every other month, which started in February. There was a grid of compliance to show that everyone had completed their departmental meeting. There was a structure to ensure that the meetings take place.
- The hospital leadership team met monthly as did the hospital and clinical governance committee. The medicines management committee, infection prevention and control committee, resuscitation committee and theatre user group all met quarterly.
- The operations committee, patient experience committee, safety, health and environment committee met monthly and the medical advisory committee met bi monthly.
- Minutes from the monthly clinical governance committee for January, February, March 2019 showed regular attendance by heads of departments and the quality and risk manager. Standing agenda items included reporting on the quality scorecards for infection control, patient experience, clinical effectiveness and safety. Risk management and patient safety was reported on under incident reporting, serious incident and inquests, RCA findings and learning, risk register, alerts, health, safety and environment updates. Complaints were reviewed, audits monitored and any departmental issues for escalation were raised. Subcommittee reports from resuscitation, transfusion, IPC, radiation protection and medicines management were reported on.
- The medical advisory committee met bimonthly. Minutes for September 2018, November 2018, March 2019 and June 2019 showed they were chaired by the medical director and attended by the executive director, director of clinical services, director of operations, quality and risk manager and 16 consultants from a range of disciplines. Consultant applications and practising privileges were reviewed. There were updates from clinical governance, director of operations, clinical director and executive director. The five year plan was discussed which included proposals for a private wing, front reception refurbishment, purchase of a second MRI Scanner, a proposal for a trauma centre.
- Theatre staff meeting minutes for January and February 2019 showed good multidisciplinary attendance from theatre manager, anaesthetists, theatre practitioners, theatre porters, healthcare assistants, operating department practitioners, administrator and central sterile services department technicians. Standard agenda items showed incidents and complaints were reviewed. Other standard items were infection prevention, quality, mandatory training, departmental update, hospital update, corporate update and a review of previous actions.

Managing risks, issues and performance

- **The hospital had effective systems for identifying risks, planning to eliminate or reduce them, and coping with both the expected and unexpected.** Ongoing events, incidents and daily issues of note were all brought to the two daily meetings that acted as a process for reporting, sharing and communicating live issues and to effectively manage risk. Daily 'comm cells', where held every day at 9.30am where a representative from each department attended. At 3pm a hospital safety huddle took place to ensure the same. Information from the meetings was fed back to teams by their representative, were available by email and placed on to 'hotboards' placed in every department.
- Senior managers told us that the most important factor for them was making sure that things were safe for patients and staff and that everything else followed that.

The executive director had taken a lead in making changes to safety and we were told there was now a sense of ownership of concerns and how to address them.

- An audit programme supported the hospital to ensure patient safety. Clinical audits were undertaken on a regular calendar and included infection control, WHO checklist, documentation, imaging specific and controlled drugs. Non-clinical audits were undertaken on a regular calendar and included financial, health and safety, information security and complaints. All audit results were discussed at the relevant hospital committee meeting to ensure that results were analysed, monitored and actioned.
- Incidents, near misses and complaints were monitored for trends and where required, improvements were actioned through action plans. Lessons learned were shared through the committee framework and cascaded to staff in departmental meetings. Implementation was monitored by the heads of department. There were dashboards to monitor our performance. These include a clinical, quality and risk, safety, health and environment, complaints and Information security incidents.
- The hospital operated a hospital risk register that was regularly reviewed and updated to ensure risks were monitored and appropriately managed. Heads of department managed departmental risk registers which fed into the hospital register. Governance and risk performance was discussed through the committee meeting structure including monthly heads of department, clinical governance, health and safety and medical advisory committees.
- The hospital's key risks and actions are circulated monthly via the executive director's staff newsletter.
- The audit schedule for 2019 showed a systematic approach to audit. Level 1 audits included the WHO observational audit, which took place every six months, with the last in March 2019 showing an overall compliance score of 99%, with the next planned for September. The infection prevention and control (IPC) observational audit took place quarterly basis and The infection prevention and control (IPC) observational audit took place on a quarterly basis and covered hand hygiene, patient equipment and standard precautions.

Level 1 also included IPC audits that encompassed hand hygiene, patient equipment, standard precautions, theatre asepsis and invasive devices. The most recent was in March 2019 and scores showed an average of 93% compliance. Antibiotic stewardship was scheduled to be audited every six months with the first planned for June 2019. IPC management was audited in May 2019 and showed a 100% compliance.

- Level 2 audits included annual audits on consent, recovery / anaesthesia audit, fluid management (peri-operative), consultant documentation and daily review. There were also level 3 departmental audits.
- A pharmacy audit schedule showed frequency of audits between October 2018 and September 2019. This included controlled drugs audit of each department annually, missed doses, antimicrobial stewardship, pharmacy department, medicine reconciliation, intervention monitoring, dispensing turnaround times and medication ward round observation audit all to take place twice yearly.
- The risk register covered top risks with dates for review and risk rating on risk register entry and current rating. There was an analysis of risks related to theatres within the risk register with four entries, all related to facilities and infrastructure with progress and completion stated.
- The senior management told us that current challenges were recruitment in theatres, management of pre assessment quality such as patients not being properly prepared for which there was an improvement plan, with new staff and a new lead.

Managing information

- **The hospital collected, analysed, managed and used information well to support all its activities, using secure electronic systems with security safeguards.** Controls were in place to mitigate risk to both patient safety and data protection, which included a number of BMI information governance policies and a four part mandatory training module, recently updated to comply with GDPR requirement. Information governance incidents were reported on to the risk management system.
- The reservations team had access to the NHS e-referral system and were responsible for the secure transfer of NHS patient information on to the BMI patient

information software, for the booking all patient appointments, outpatients appointments, pre assessment appointments, clinic appointments and physiotherapy appointments.

- The national enquiry centre for BMI booked self funded patient appointments, where patient information went straight on to the secure electronic system.
- All designated staff had access to patients' medical records which included assessments, tests results, current medicines, referral letters, consent forms, clinic notes, pre- and post-operative records.
- Consultants with practising privileges at the hospital were required to register with the Information Commissioners Office (ICO) as independent data controllers and were required to work to the standard set by the Information Commissioner, which included how patients' medical records were stored and transported.
- BMI had group policies and processes in place governing information governance, security and personal data protection. All data controller registrations for the processing of personal data were maintained in accordance with the requirements of the UK Information Commissioners Office. Policies were compliant with ISO/IEC27002 the Code of Practice for Information Security Management, with security risk management and regular independent auditing undertaken to satisfy these requirements. BMI maintained formal certification to ISO/IEC27001:2013 relating to the operation and management of its information security management system (Certificate Number: CI/144541S).
- BMI annually submitted and was compliant with the NHS HSCIC / NHS Digital Information Governance Statement of Compliance - IG Toolkit. BMI was also compliant with the Payment Card Industry Data Security Standard – PCI-DSS (PCI Security Standards Council).

Engagement

- **The hospital engaged well with patients, staff, the public and local organisations to plan and manage appropriate services and collaborated with partner organisations effectively.** We were told that effective two way communication played an important role in achieving good patient outcomes.
- The clinical governance report for April 2019 shows the patient satisfaction statistics for the month and a running analysis for the year. There were two types of patient satisfaction survey. The first was the typical friends and family test. The second, for inpatients, was more detailed which enabled the service to look closer at what experiences patients had. However, inpatients made up a very small proportion of the hospital activity being post surgical and / or criticial care patients. The clinical governance report detailed the top five most improved and the least improved scores compared with the same month a year ago. Significant improvement was identified in being informed of follow up telephone call, choice of food, asked if you had any communication needs, helpfulness of catering staff and overall impression of the service. The least improved five were diagnostic services, being kept informed of physiotherapy progress, the likelihood of post operative pain explained, the helpfulness of physiotherapy and being involved in the decision to treat. However, four of the five least improved items still had a satisfaction rate of above 90% as opposed to scoring 100% a year ago.
- The executive director read all of the daily feedback forms that had been completed by patients. If staff were mentioned positively by name then this was shared in the weekly newsletter. They also handed out a personal birthday card to every member of staff on their birthday and they got a free lunch on that day. There was a staff party held at a central London venue, attended by approximately 210 staff including 30 to 40 consultants.
- Senior management told us they were keen to instil a 'you said this, we did that', listening culture. We had sight of the notes of the June 2019 staff forum, which related either to staff survey result or to communicating changes and change plans to staff. We were told the results had now been shared with staff. All staff had been given a card with the four worst scores on, and invited to contribute an opinion on how to address the issues identified in the survey.
- Teams came together for meetings. Plus, there was a weekly staff newsletter for all staff, shared via email. Monthly team briefs for all staff took place and we were told a majority of staff attended. The executive director also conducted staff forums (BMisay) at which feedback on any corporate developments, hospital performance, people development/opportunities and our governance

framework. One member of staff told us, “we had the staff forum in June, there are three or four big seminars a year with the boss. We know what is happening. We are not left alone”.

- The Freedom to Speak Up Guardian service had recently been launched to allow staff a confidential route to raising concerns.

Learning, continuous improvement and innovation

- **The hospital was committed to improving services by learning from when things went well and when they went wrong.** Throughout our inspection we saw evidence of systems in place for continuously identifying, monitoring and improving services. Improvement and action plans were meaningful. The leadership team told us they believed that as a team they had demonstrated to the staff that poor practice can be addressed.
- Quality improvement projects were planned and underway in a number of subjects. The improvement intitiative was abbreviated as TOQ; ’time, outstanding, quality’. TOQ involved members of hospital staff in key areas of identified improvement to ensure feedback was received and the best improvement decisions were made for patients. Areas identified as TOQ project areas included security, call handling, e-discharge, theatre efficiency and equipment replacement.
- All hospital developments and quality enhancements were communicated through the executive director's weekly newsletter and the hospital hotboards that were now located in every department.
- Ongoing events, incidents and daily issues of note were all brought to the two daily meetings that acted as a process for reporting, sharing and communicating live issues and to effectively manage risk. Daily ‘comm cells’, were held every day at 9.30am where a representative from each department attended. At 3pm a hospital safety huddle took place to ensure the same. Information from the meetings was fed back to teams by their representative, were available by email and placed on to ‘hotboards’ placed in every department.
- Over the last 18 months an expanded medical records store had been created to meet the needs of the service, with over 18,000 notes now archived in line with the retention of records policy. An e-tracker system had been implemented to track notes across the departments. We were told there had been zero patients cancelled in the last 6 months due to notes availability and now the records service is identified as an exemplar within BMI.

Critical care

Good

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

Are critical care services safe?

Good

Mandatory training

- **The service provided mandatory training in key skills to all staff and made sure everyone completed it.**
- Staff completed mandatory training or provided evidence that it had been completed at another service. This included agency staff. The service provided training directly to nursing staff and allied health professionals, while some consultants and Resident Medical Officers (RMO) could complete training at another service and share the documentary evidence.
- Mandatory training modules was a mix of classroom delivered training and e-learning. Staff stated they felt this worked well and they were given adequate time to complete training.
- The mandatory training courses included resuscitation training, infection control, fire safety, complaints handling, safeguarding adults and children (both level two), moving and handling, conflict resolution, and information governance amongst others.
- The hospital and departmental targets for training were 90%. Completion rates for training in critical care were 100% for most mandatory training modules. However, the modules for documentation and legal aspects, basic life support, and blood transfusions did not meet the target at 85%. The lowest module was for immediate life support training which was at 50%. The service stated that the remaining staff whose training had expired were booked on to courses between July and September 2019. Following inspection, the service provided data to show ILS training was 90% compliant as of August 2019.
- Compliance for mandatory training was monitored by the clinical practice managers and practice nurse educator.

Safeguarding

- **Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse, and they knew how to apply it.**
- All staff had completed safeguarding adult and children levels one and two training. Staff had a good understanding of when they would need to report a safeguarding concern and what to look out for. Staff also completed modules on chaperoning, female genital mutilation (FGM), and PREVENT (Protecting people at risk of radicalisation)
- The director of clinical services was the safeguarding lead for the hospital, and their contact details was displayed on a noticeboard in the ITU. Staff were aware of this and of how to make a safeguarding referral if needed.
- We reviewed the hospital safeguarding policy, which detailed what to do in the event of a safeguarding concern and reflected the service's obligations under safeguarding legislation.

Good

Critical care

Cleanliness, infection control and hygiene

- **The service controlled infection risks well. Staff used equipment and control measures to protect patients, themselves and others from infection. They kept equipment and the premises visibly clean.**
- The ITU provided staff with personal protective equipment (PPE) such as gloves and aprons. Staff told us they wore PPE where necessary, and we observed all staff adhered to the 'bare below the elbows' protocol and use of PPE in clinical areas. Equipment was also checked and audited regularly.
- Cleaning schedules were used to monitor the completion of daily, weekly, and monthly infection prevention and control tasks. Cleaning was completed by a mix of service staff in clinical areas and by a third-party provider. We observed these tasks being carried out, such as cleaning of patient tables in diagnostic rooms and cleaning preparation trollies, and then being signed as completed.
- At the time of the last inspection we identified there were no designated hand wash sinks in the two side rooms on the ward, which meant staff washed their hands in patient basins. The service now had clinical hand wash basins in these rooms that were in line with best practice relating to hand hygiene protocols. Patients that used these rooms were not mobile and so did not use the sinks in the rooms.
- The hospital completed an annual audit of IPC practices within critical care services and used the results to inform an annual report. The report contained specific action plans for improving IPC practices throughout the hospital. Critical care leads also attended the quarterly IPC committee which reviewed performance in relation to IPC and progress against action plans.
- Waste was separated and disposed of in line with best practice guidance relating to clinical waste and sharps. Staff were informed of local arrangements relating to clinical waste disposal and sharps bins.
- The hospital had an up to date infection control policy and we observed good compliance in relation to the policy. This policy was updated regularly to reflect best practice.
- Hospital wards had a suitable control of substances hazardous to health (COSHH) policy and procedures in place for staff to follow. COSHH risk assessments were undertaken, and the service ensured compliance with COSHH arrangements through monitoring. For example, hazardous substances and materials were kept in secured areas only accessible by staff.
- There had been no incidents of health care acquired infection on the ITU during the reporting period. We observed the clinical and reception areas were clean and tidy. The service used stickers and cleaning schedules to identify when areas had been last cleaned.
- In the period between January and December 2019, the service reported no cases of Hospital acquired Methicillin-resistant Staphylococcus aureus (MRSA) or Clostridium difficile (C. difficile). Admissions to the critical care ward were assessed for MRSA and C. Difficile, and we saw this reflected in the patient records.

Environment and equipment

- **The design, maintenance and use of facilities, premises and equipment kept people safe. Staff managed clinical waste well.**
- There were three pods and two side rooms in the main ward area of ITU. Since the last inspection the ward had removed a bed space in the ITU as the space could not meet the building regulations for critical care services (HBN 04-02). The pod rooms had an integral air handling system to provide negative airflow where required (in the event of patients with potentially infectious diseases).
- Emergency equipment such as a resuscitation trolleys and crash bags were available. Staff checked resuscitation equipment daily in line with guidance from the Resuscitation Council.
- A charge nurse in ITU was responsible for checking equipment and reporting any issues. Staff responsible for this task were allocated time during their shift to deal with any issues.
- Entrances to the ITU were controlled by security card and visitors to the building were required to sign in.
- Clinical areas contained areas for staff to wash their hands before and after delivering patient care. The communal areas on the wards and bathrooms also displayed gel dispensers.
- We observed that electrical equipment displayed the electrical testing, and any equipment that required servicing was in date.
- Staff told us that the hospital was quick to address any environmental or equipment issues identified.

Good

Critical care

Assessing and responding to patient risk

- **Staff completed and updated risk assessments for each patient and took action to remove or minimise risks. Staff identified and quickly acted upon patients at risk of deterioration.**
- There were no reported incidents of venous thrombo-embolism (VTE) - a medical condition where blood clots develop in the veins - in the intensive therapy unit (ITU) between April 2018 and March 2019. A VTE risk assessment tool was included in the hospital prescription charts that were audited monthly by ITU. Compliance for patients being risk assessed for VTE was 100%. On inspection we viewed patient records and they demonstrated that all patients had undergone VTE assessments on admission.
- Staff used the national early warning scores (NEWS) system to asses and monitor deterioration in patients. We saw the NEWS form used by staff to monitor any deterioration in the patient's status, and observed staff discussing the NEWS score when deciding on care plans.
- The critical care service had pathways in place for patients at risk of deterioration. Staff we spoke with were aware of the actions taken when there were signs that a patient was deteriorating, and the pathways were posted on notice boards in the ITU. This included pathways for sepsis, resuscitation, and anaphylaxis.
- Patients at a higher risk of deterioration were cared for in a bay closest to the nursing station. This allowed for additional monitoring from staff in communal areas.
- When patients were escalated to the ward, the nurse in charge for the ward provided care for these patients. The clinical services manager acted as nurse in charge until additional staff could be brought in.
- An ITU RMO and senior ITU nurse provided a service similar to that which would normally be undertaken by an outreach team. They monitored and reviewed patients discharged from ITU and HDU for up to 48 hours following discharge. The team assisted patients with their care and treatment and escalated to the on-call critical care consultant if it was necessary.
- Management of sepsis was in accordance to the hospital's policy on sepsis recognition and management. Staff told us that they followed the United Kingdom sepsis trust guidance on the initial management of septic patients. The 'Sepsis Six' approach was used, and the sepsis pathway was visible on notice boards in the ITU. Sepsis Six is the name given to a bundle of medical therapies designed to reduce mortality in patients with sepsis.

Nurse staffing

- **The service had enough nursing staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed staffing levels and skill mix, and gave agency staff a full induction.**
- The hospital used a provider wide nursing tool to plan skill mix required against patient activity and complexity of need, including in critical care. The tool incorporated levels of care from zero to three with an allocated number of hours per patient per level. Staffing allocation was arranged seven days in advance to provide an overview and allow rotas to be rearranged if needed.
- Nursing provision in critical care was reviewed throughout the day. The clinical services manager and nursing staff identified if there was any need for additional staff, and this could be arranged with agency staff as necessary. Staffing was also discussed in the site safety huddles and communications daily briefing. There were 14 whole time equivalent (WTE) critical care nurses working in the ITU.
- Critical care leadership and nursing staff stated that nursing levels met the requirements of the Royal College of Nursing (RCN). A nurse to patient ratio of 1:1 was maintained for patients in the ITU in line with RCN guidance. A nurse to patient ratio of 1:1 was evident on inspection and was reflected in staffing rotas we reviewed. Nursing staff stated they felt there was enough staff to meet the needs of the ward.
- The hospital provided evidence for the use of agency nursing staff between April 2018 and March 2019 for inpatients wards (which included critical care). The average for the 12-month period was 9%, with a high of 18% in February and March 2019.
- The hospital's induction policy included the induction of agency staff. Agency staff underwent an induction to the unit, and senior nurses told us that where possible they used agency staff familiar with the ITU, as this helped to

maintain consistency of care. All new starters in critical care received a workbook for completion, which included familiarisation with ward practice, signing off competencies, and orientation.

Medical staffing

- **The service had enough medical staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed staffing levels and skill mix and gave locum staff a full induction.**
- The ITU was led by a consortium of six dedicated critical care consultants, who had a collective contract with the hospital to lead on the delivery of critical care. This contract included agreements around clinical availability, governance, and support for junior doctors. Both medical staff and the clinical services manager were positive about this model of medical staffing, and felt it worked well for the ITU.
- Consultants assessed all critical care patients within 12 hours of admission. A critical care consultant attended ward round everyday between 9am and 11am.
- Consultants were available on call to provide support to the Resident Medical Officers (RMOs) if needed. Consultants were required to live within a 30-minute journey time of the hospital and to be available to advise RMOs based on the on-call rota. Staff we spoke with stated they felt supported by the consultants and that there was consistent presence of medical leadership on the ward.
- The critical care RMOs were provided via a healthcare agency on long term contracts. The ITU had five RMOs who they worked with regularly. There was onsite critical care RMO cover 24 hours a day, seven days a week, and they attended the morning ward rounds with the ITU consultant. Consultant staff told us they were confident in the skills and experience of the RMOs, and felt they provided consistent delivery of care to patients.
- Prior to the commencement of their placement, RMO's were required to provide CVs including employment history, training certificates, qualification certificates (GMC), references and certificate of enhanced DBS to the hospital. Mandatory training was organised and managed by the agency and evidence shared with the hospital as completed. RMOs were included in mandatory resuscitation scenarios that were run in the hospital, and any areas for improvement were fed back to the agency.

Records

- **Staff kept detailed records of patients' care and treatment. Records were clear, up-to-date and easily available to all staff providing care.**
- Patient records we reviewed were in paper form. We reviewed four patient records and found them to be legible and comprehensively completed. All records had detailed notes of the patient care from different disciplines, treatment plans, completed risk assessments, and results of any diagnostic tests the patient had received.
- Patients' observation charts were kept by the patient's bedside or just outside their rooms, and staff would input data at regular intervals. Once completed for the day it would be filed in the patient's records.
- Health documentation was reviewed quarterly in critical care in 2018, with the ward achieving 100% completion in the most recent audit in December 2018. In 2019 the hospital audit programme identified documentation audits would be completed annually.
- Information governance was part of mandatory training for all staff. The hospital also had a management of health records policy detailing the process for managing and completing patient records. We observed staff adhering to best practice in relation to information governance and storing records securely.
- The hospital had a dedicated Medical Records Department with responsibility for filing, storing and maintaining medical record for patients. Staff within this department arranged for medical records to be readily accessible for patient care. We did not identify any concerns in accessibility of records while on inspection.

Medicines

- **The service used systems and processes to safely prescribe, administer, record and store medicines.**
- The hospital pharmacy was open from 9am to 6pm Monday to Friday, and also open on Saturdays between 9:30am and 12:30pm. There was a 24 hour on-call pharmaceutical advisory service via switchboard. The service also had a dedicated ITU trained pharmacist who attended the unit six days a week.

Good

Critical care

- We reviewed four medication charts and found them to be consistently and legibly completed. Staff documented information on patient allergies and patient risks as necessary. We found that prescription charts were legible.
- Medicines were administered and secured securely in accordance with the medicines management policy of the hospital. The service had access to a provider wide specialist pharmacy advisor who supported compliance with legislation and best practice.
- Controlled drugs were stored and managed appropriately. Drugs were kept in lockable wall units and staff performed daily checks of the controlled drugs to ensure they were accounted for.
- Medicines requiring cool storage were appropriately stored in refrigerators. Fridge temperatures, as well as the temperature in the medication room, were recorded daily.
- A summary of medication errors between December 2018 and March 2019 showed one medication error for the ITU of an incorrect dose. This incident was investigated and resolved as no harm.
- The pharmacy service for the hospital had a regular annual audit schedule running from October 2018 to September 2019. This included quarterly controlled drugs audits, twice yearly audits for missed doses, antimicrobial stewardship, and medicines reconciliation, and dispensing time turnaround times annually.
- In June 2018 a medicines reconciliation audit was completed in critical care, examining if reconciliation was completed within 24 hours of admission, if medicine's history for patients was completed, and if any allergies were recorded. The audit found 100% compliance in relation to these three areas on the ITU.
- Patients were assessed for any potential allergies to clinical equipment or medications on admission. We observed allergy assessments completed in the patient record.

Incidents

- **The service managed patient safety incidents well. Staff recognised incidents and near misses and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support. Managers ensured that actions from patient safety alerts were implemented and monitored.**
- There had been no 'never events' reported at the hospital from April 2018 to March 2019. Never events are serious incidents that are entirely preventable as guidance, or safety recommendations providing strong systemic protective barriers, are available at a national level, and should have been implemented by all healthcare providers.
- Between January to December 2018 there were 282 clinical incidents within surgery and inpatients (which included ITU). None of these incidents were categorised as severe harm.
- An incident reporting procedure was in place and staff knew how to report an incident. Staff told us they also received feedback from incidents reported that were investigated.
- The service held a daily briefing of staff and service managers from all departments to share information on incidents, transfers of patients, staffing issues and any other issues that may impact the delivery of care.
- There had been no notifiable safety incidents that met the requirements of the duty of candour regulation in critical care in the 12 months preceding this inspection. 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 were aware of the principles of duty of candour and when it would be applied. Staff also stated they felt encouraged to report incidents if they identified concerns. The incident policy reflected the hospital's requirement to be open and transparent with patients when there had been an incident and outlined the procedure by which patients would be involved or informed in the investigation process.
- The hospital incident policy described the process to be followed when investigating incidents. Incidents were investigated by a nominated individual and reviewed in governance meetings locally. We reviewed incident reports from the last twelve months and found them to be comprehensively investigated and reviewed.

Good

Critical care

Safety Thermometer

- **The service used monitoring results well to improve safety. Staff collected safety information and shared it with staff, patients and visitors.**
- The safety thermometer is a collection of data submitted by all hospitals which shows a snapshot of inpatients suffering avoidable harm, usually on one day each month. The safety thermometer allows teams to measure harm and the proportion of patients that are 'harm free' from pressure ulcers, falls, urine infections (in patients with a catheter) and venous thromboembolism (VTE), a blood clot which starts in a vein.
- The ITU displayed a quality and safety scorecard on the noticeboard. This displayed safety information for each month between May 2018 and April 2019. Within the timeframe the hospital reported six falls, two serious incidents, no hospital acquired pressure ulcers, and no VTEs. We reviewed patient records and found that they demonstrated patients had VTE assessments.
- The scorecard also presented quality and safety indicators for critical care such as readmissions to ITU. During the reported period, ITU had one unplanned readmission from the medical wards.

Are critical care services effective?

Good

Evidence-based care and treatment

- **The service provided care and treatment based on national guidance and best practice. Managers checked to make sure staff followed guidance. Staff protected the rights of patients' subject to the Mental Health Act 1983.**
- Care and treatment was delivered to patients in line with National Institute for Health and Care Excellence (NICE) and Royal Colleges guidelines. Staff followed national and local guidelines and standards to ensure effective and safe care. National best practice was reflected in the policies we reviewed.
- Staff assessed patients' needs and planned and delivered patient care in line with evidence-based, guidance, standards and best practice.
- Staff had access to the service's policies and guidelines via an intranet. Paper copies of local protocols and policies were also available to staff. All protocols and guidelines we reviewed were in date.
- Care was delivered in line with best practice for treating critical care patients. Patients were assessed on admission using the Glasgow Coma Scale and were monitored using the National Early Warning Score (NEWS). The service followed the Sepsis Trust guidance on the initial management of septic patients and used the 'Sepsis Six' approach as recommended to provide consistent care.

Nutrition and hydration

- **Staff gave patients enough food and drink to meet their needs and improve their health. They used special feeding and hydration techniques when necessary.**
- Staff made sure patients had support with nutrition and hydration to meet their needs. The ITU had access to a dietitian who could assess new patient's dietary needs as necessary. Staff told us that the dietician was available to provide advice and support if needed.
- We reviewed patient records on inspection and found that the nutritional needs of patients was monitored using the Malnutrition Screening Tool (MUST). Records reflected the use of fluid balance charts for each patient, as well as evidence of intravenous feeding when patients were not eating or drinking.
- We observed patients and visitors to the wards being offered refreshments by staff.

Pain relief

- **Staff assessed and monitored patients regularly to see if they were in pain and gave pain relief in a timely way. They supported those unable to communicate using suitable assessment tools and gave pain relief to ease pain.**
- We observed staff on the wards discussing pain management with patients. Patients stated that they felt their pain relief was discussed as part of their care, and we saw this reflected in the patient record.
- The ITU used a pain scale tool for assessing the patients need for pain relief. The pain scale was also available in Arabic for international patients and had a picture assessment tool for patients with communication difficulties.

- The hospital employed a nurse with responsibility for pain management care for inpatients. If this nurse was not available, pain management could be provided and administered by the available RMO.
- Post-operative patients were provided with a pain advice booklet with advice on what to do to manage pain following surgery.

Patient outcomes

- **Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for patients. The service had been accredited under relevant clinical accreditation schemes.**
- The service submitted data to the Intensive Care National Audit & Research Centre (ICNARC) for all patients treated within the intensive care setting. This meant care delivered and patient outcomes were benchmarked against similar units nationally. The hospital provided the most recent ICNARC report from August 2019 following inspection.
- The data from the ICNARC report showed that the service performed higher than the national average for similar services across all subcategories. This included infections acquired on the unit, out of hours discharges to the ward, unplanned readmissions, hospital mortality, and length of stay.
- There were no unplanned readmissions or inpatient deaths for patients on the ITU during the reporting period (between April 2018 and June 2018).
- The service conducted a regular programme of audits to evaluate the quality of care being received by patients. The results were reviewed in regular quality and safety meetings quality, and changes to service delivery were planned as necessary.

Competent staff

- **The service made sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and development.**
- At the time of the last inspection we identified that there was no formal educator on the critical care unit. The service now had a nurse in post with responsibility for monitoring mandatory training, ensuring staff competencies, and supporting staff development. Staff told us they were positive about the support and involvement of the practice educator.
- All staff received a local and corporate induction. Staff completed an induction and competency checklist when they first started which covered use of equipment, using the service's systems, departmental understanding, and clinical competency skills relevant to their job role and experience. Competencies were then signed off by the clinical and nursing leads.
- Staff were regularly assessed on competencies based on national competency frameworks for critical care, such as the core standards of The Faculty of Intensive Care Medicine. Any areas of positive performance and areas for development were recorded and action plans were put in place.
- Staff were required to provide evidence of their registration with the regulated body of their profession. We saw evidence of staff registration with the Health and Care Professions Council (HCPC) and General Medical Council (GMC). Staff were required as part of their employment to ensure they retained their registration and revalidated when it came close to expiry.
- Staff were able to access development opportunities and further training through the 'BMI Learn' Training Academy. Critical care staff told us that while they were encouraged to develop professionally they would like more opportunities for critical care training to develop in their roles.
- Overall staff performance was monitored and managed by the responsible Clinical Services Manager with support from the Human Resource (HR) advice team and HR Business Partner if necessary.
- The service supported staff to develop through regular, constructive clinical supervision of their work. Staff told us that they received an annual appraisal and found it useful to discussing their development goals. Data submitted by the service showed that, as of March 2019, 100% of inpatient nursing staff and healthcare assistants, including critical care staff, had received an appraisal.
- Managers made sure all staff attended team meetings or had access to full notes when they could not attend. The

Good

Critical care

ITU had a regular calendar of weekly and monthly meetings to monitor performance and staffing. Critical care staff also attended the hospital wide comms and safety huddles twice a day.

- The critical care ward used an RMO to provide a day to day medical presence on the wards. Consultants were positive about the quality of the RMOs that they worked with and stated there was a regular group of RMOs who consistently worked at BMI. CVs of RMOs were checked for competencies before their application to work on the unit was confirmed.
- The hospital provided staff with a continuity of care pocketbook, which contained quick guidance on certain policies and practices for staff to provide consistent care. This included instructions on hand hygiene, aseptic non-touch technique (ANTT), infection prevention and control, duty of candour, and safeguarding.
- The ITU met the Intensive Care Society standards for registered nurse work force. This included ensuring a dedicated clinical nurse educator for critical care nursing staff, all newly appointed nursing staff receiving a period of supernumerary practice, and a minimum of 50% of nursing staff possessing a post registration award in critical care nursing. New starters on the ITU received six to twelve weeks of supernumerary practice, and 71% of staff had completed a critical care course.

Multidisciplinary working

- **Staff of different disciplines worked together as a team to benefit patients. Doctors, nurses and other healthcare professionals worked together as a team to benefit patients. They supported each other to provide good care.**
- The critical care provision included the input of consultants, RMOs, nursing staff, physiotherapy and dietitian (as needed). Staff stated they had good working relationship as a critical care team and across disciplines. Staff stated they worked well together collaboratively, and this was supported by an effective and approachable manager.
- Staff held regular multidisciplinary meetings to discuss patients and improve their care. While on inspection we attended a safety huddle for staff across the hospital and found it well attended by staff from all disciplines.
- Critical care patients had access to multidisciplinary input to provide rehabilitative care as necessary. The critical care team worked with physiotherapists to meet rehabilitation needs in line with The National Institute for Health and Care Excellence (NICE) clinical guidance 83. On inspection we observed physiotherapists working with patients and discussing their care.
- A dietitian was available upon request to the ITU but was not based at the hospital site.

Seven-day services

- **Key services were available seven days a week to support timely patient care.**
- The hospital pharmacy was open from 9am to 6pm Monday to Friday, and also opened on Saturdays between 9:30am and 12:30pm. There was a 24 hour on-call pharmaceutical advisory service via switchboard. The service also had a dedicated ITU trained pharmacist.
- Consultant and junior doctor cover was provided 24-hours, seven days a week. Critical care staff also provided an outreach service to monitor patients discharged from critical care to the ward.
- Physiotherapy was available for patients between normal working hours, 9am to 5pm Monday to Friday.

Health promotion

- **Staff gave patients practical support and advice to lead healthier lives.**
- On inspection we saw leaflets that included advice on health promotion for all patients. This included advice on diet and nutrition, smoking cessation, wound management, and warning signs of acute illness.
- Hospital staff provided advice to patients on managing their care after discharge. We observed staff from different disciplines advising patients on how to maintain their recovery after they had left the hospital. Staff also encouraged patients to contact the ward if they had any questions.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- **Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patient's consent. They knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health. They used measures that limit patients' liberty appropriately.**

Good

Critical care

- The hospital had a policy in place for the management of patients under MCA and DoLS.
- Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. Staff were aware of their responsibilities to patient consent, including in relation to the MCA and DoLS. All staff completed a mandatory training module regarding consent.
- Staff clearly recorded consent to treatment in the patients' records as necessary. We saw examples of mental capacity assessments completed in patient records.
- Staff made sure patients consented to treatment based on all the information available. Staff told us that where patients did not speak English (for many international patients) they would not use family members to interpret on the patient's behalf and would instead arrange an interpreter.

Are critical care services caring?

Good

Compassionate care

- **Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.**
- During the inspection we saw staff treating patients with dignity, kindness, compassion, courtesy, and respect. Staff explained their roles to patients and put patients at ease during any interactions.
- We spoke with two patients in critical care during the inspection. Patients spoke positively about the care they received and how they were treated on the ward. Patients told us staff were respectful and provided them with space to ask questions about their care. Patients also stated that staff were professional and well informed about their treatment.
- Staff understood and respected the personal, cultural, social and religious needs of patients and how they may relate to care needs. The ward frequently admitted international patients, and this was taken into consideration when planning and delivering care.
- The service had a satisfaction survey by which patients could feed back their thoughts about the service. The results and trends were discussed and reviewed at the monthly patient experience committee and, when needed, improvement actions were agreed. We saw examples of the staff satisfaction survey on display on the ITU.
- The service provided data from the patient satisfaction survey between October 2018 and March 2019, which included critical care patients. The results showed that 95% of patients were 'likely to recommend the service to family or friends'. The response rate for this period was 20%.

Emotional support

- **Staff provided emotional support to patients, families and carers to minimise their distress. They understood patient's personal, cultural and religious needs.**
- Staff understood the impact that patients' care, treatment and condition had on wellbeing. Staff stressed the importance of treating patients as individuals and this was reflected in the interactions we observed.
- Staff provided reassurance and support for patients throughout their care. Staff demonstrated a calm and reassuring attitude to put patients at ease. We observed staff taking time to explain their treatment to patients and asking them if they had any questions about their care.
- Staff told us that they regularly assessed the patient's physical and emotional welfare and made referrals to the appropriate professionals when needed.
- The service did not provide bereavement or counselling services. Staff we spoke with stated they could arrange chaplaincy services for patients at the nearby Royal London Hospital, and the London Independent Hospital had a multi-faith prayer room on site.

Understanding and involvement of patients and those close to them

- **Staff supported patients, families and carers to understand their condition and make decisions about their care and treatment.**
- We spoke with two family members of patients on the critical care ward. Family members were positive about the care the patients received and stated that staff members were professional and welcoming. Family members also stated they were kept well informed of treatment plans.

Good

Critical care

- There was evidence of discussions of patient care with those close to them in the patient records.

Are critical care services responsive?

Good

Service delivery to meet the needs of local people

- **The service planned and provided care in a way that met the needs of local people and the communities served. It also worked with others in the wider system and local organisations to plan care.**
- The critical care service admitted international patients, particularly from Kuwait. The hospital had an international team based on site which liaised with the Kuwaiti embassy to arrange admissions and manage discharges for these patients.
- The international office arranged interpreters for patients when needed by the unit. Staff told us that the clinical services manager for the service also spoke Arabic, which helped with translation for patients from Kuwait or other Arabic speaking patients. The service could also provide information in other languages if needed.
- There was clear signage inside the main hospital building, which meant it was straightforward for visitors to locate the ITU.
- The provider's website provided useful information about the service, procedures that were provided, payment options, and the referral process.
- The service did not have bereavement or counselling services. Staff told us they could arrange chaplaincy services by contacting the local NHS trust as necessary, however there was no specific process in place for this. The service did have a multi faith prayer room for all patients on site.

Meeting people's individual needs

- **The service was inclusive and took account of patients' individual needs and preferences. Staff made reasonable adjustments to help patients access services. They coordinated care with other services and providers.**
- The service visiting hours were Monday to Friday 10am to 12pm and 2pm to 9pm on weekends. Staff told us visiting times were flexible and visitors could arrange to visit at a time outside the normal hours. Visiting times were clearly displayed on the unit in multiple languages
- The critical care service provided food that catered to dietary requirements and cultural preferences. Patients told us they were happy with the quality of the food that they received.
- At the time of the last inspection it was identified that the critical care provision did not have an outreach team. The ITU RMO and a senior ITU nurse followed up with patients who had been discharged from ITU to medical wards for up to 48 hours. Staff told us that they also provided support to the medical wards for patients at risk of deterioration as requested.
- Staff understood and applied the policy on meeting the information and communication needs of patients with a disability or sensory loss. A hearing loop was available for patients who were deaf or hearing impaired. Staff told us that patients with any communication difficulties would be provided with additional support, and that this had been facilitated for previous patients.

Access and flow

- **People could access the service when they needed it and received the right care promptly. The service admitted, treated and discharged patients in line with national standards.**
- The occupancy rate for ITU was 44% between April 2018 and March 2019. This was a decrease compared to the occupancy rate at the time of the previous inspection (57%). These rates did not go above the 70% occupancy rate recommended by The Royal College of Anaesthetists.
- The ITU was a mix of patients who had been referred directly to critical care, post-operative patients, and potentially patients from medical wards or outpatients with critical care needs.
- Managers and staff worked to make sure that they started discharge planning as early as possible. We reviewed patient records on the ward and found that discussions on discharge were proactive and included input from different disciplines.
- There were no out of hours discharge and no delayed discharges in ITU between April 2018 and March 2019. There were no unplanned readmissions to ITU or HDU during the same period.

Good

Critical care

- At the time of the last inspection the ITU did not have a follow up clinic where patients could reflect upon their critical care experience and be assessed for progress. The service still did not have a follow up clinic for patients following discharge from the hospital. This was not in line with Guidelines for the Provision of Intensive Care Services which state that patients discharged from ITU must have access to an ITU follow up clinic.

Learning from complaints and concerns

- **It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff.**
- Staff stated they would aim to resolve any patient complaints and concerns immediately. Staff were all aware of the complaints procedure and who had overall responsibility for managing the complaints process.
- There was a complaint management policy in place. The complaints policy differentiated between formal and informal complaints, with defined timescales for the provider to acknowledge and respond to formal complaints (acknowledged within three working days, responded to within 20 working days). The complaints policy also included reference to the service's responsibilities to duty of candour.
- All complaints were reviewed at the weekly complaints meeting held with the Leadership Committee and chaired by the executive director (ED). This meeting monitored the progress of complaints responses in relation to deadlines to ensure compliance with complaints policy. All final responses were reviewed by the ED.
- Patients had access to a local complaints process or raise a complaint with the overall all corporate provider. The complaints process included information about external independent adjudication services such as the Independent Sector Complaints Adjudication Service (ISCAS) and the Parliamentary and Health Service Ombudsman (PHSO). Patients we spoke with were confident they would be supported to make a complaint if needed.
- From April 2018 to March 2019 the hospital received 51 complaints (it is not stated how many of these applied to critical care). The service examined these complaints through the formal complaint’s procedure, and they were resolved without need for referral to ISCAS, the PHSO, or other independent adjudication. These complaints were investigated by an assigned member of staff, and we saw evidence of complaints and outcomes discussed in team meetings.

Are critical care services well-led?

Good

Leadership

- **Managers at all levels in the service had the right skills and abilities to run a service providing high-quality sustainable care.**
- Critical care had a clear management structure where the clinical services manager had responsibility for the day to day running of clinical areas. Staff knew the management arrangements and their specific roles and responsibilities.
- A supernumerary senior nurse was allocated as a shift coordinator for each shift. The shift coordinator provided clinical support to staff, as well as leadership for the delivery of care.
- We observed critical care staff interacting well with the ward leadership during the inspection. Managers and senior staff of the ward appeared to be approachable. Staff we spoke with were positive about the role of the Clinical Services Manager, and stated they felt well supported by the ward leadership.
- The nursing and medical clinical leadership teams worked closely together to plan and deliver care. Staff from both disciplines were positive about the working relationship on the ward.
- Resident medical officers said they were well supported by their consultants on the critical care unit. Consultants we spoke with were also positive about the support of their colleagues in critical care. The Medical Advisory Committee (MAC) approved new practising privileges for consultants.

Vision and strategy

- **The service had a vision for what it wanted to achieve or workable plans to turn it into action.**
- The London Independent Hospital had a clear vision and strategic goals, which was aligned to the BMI

Healthcare Corporate Vision. The hospital executive team had developed a clinical and non-clinical five-year strategic plan (with input from staff) with defined goals, starting from 2019.

- The hospital had a specific growth strategy for the intensive care unit (ITU). This included ensuring actions raised in the last CQC report were addressed, and eventual expansion and refurbishment of the ITU to include an additional bed.
- There were also specific clinical aims for the ITU and the critical care staff. This included ensuring that staff had the enhanced skills required to manage more complex patients, and that the ITU was established as part of nationally accredited programmes such as ICNARC.
- Staff told us that they were generally aware of the vision and strategy for the service, and that they would be kept informed on developments and consulted about any changes.

Culture

- **Managers across the service promoted a positive culture.**
- Staff we spoke with told us that there was a no blame culture, and that they felt valued and respected. We found that a positive working culture was embedded in the unit, and this was encouraged by supportive and available leadership.
- There was evidence of staff and teams working collaboratively to deliver good quality of care. We observed a safety huddle during the inspection and found this to encourage contributions from all staff attending.
- Staff were proud of the work they carried out. They enjoyed working at the service and were enthusiastic about the care and services they provided for patients.
- The hospital had implanted an action plan to meet the Workforce Race Equality Standard (WRES). The WRES examines an organisation's commitment to equality, diversity, and inclusion across nine key indicators. The hospital's staff survey included questions relating to WRES standards, and results had improved from 2017 to 2018. For example, in 2018 74% of respondents felt that the provider provides equal opportunities for progression or promotion of staff, compared to 57% in 2017.

Governance

- **The service systemically improved service quality and safeguarded high standards creating an environment for excellent clinical care to flourish**
- The ITU had clear governance structures in place. The ITU clinical services manager led a team of charge nurses and senior nurses. The ITU manager reported in to the director of clinical services.
- There was a robust corporate governance framework in place which oversaw service delivery and quality of care. The ITU held quarterly governance meetings, chaired by the director of clinical services, and attended by the ITU manager, the hospital quality and risk manager, ITU consultants, and other key critical care staff. Oversight of governance for the service was managed by the hospital quality and risk manager.
- We saw records of the last four governance committee minutes and saw they discussed complaints, incidents, key performance indicators (KPIs), training, subcommittees compliance, and any other clinical issues and audits. Actions to address concerns or outstanding issues were identified and monitored through the team meetings. The meetings were minuted for dissemination to other staff who were not able to attend.
- The service had effective systems to monitor the quality and safety of the ITU. The use of audits, risk assessments, quality indicators and recording of information related to the service performance was to a high standard. The service completed regular clinical audits and monitored KPIs, and adapted service delivery in response to the results.
- The provider disseminated information to staff in team meetings or through email. These included minutes of meetings, updated or new policies, changes in legislation or best practice, and service developments.
- Staff were clear about the governance structure in the organisation and stated they were confident the systems in place supported the delivery of clinical care.
- The Medical Advisory Committee (MAC) met every two months and reviewed matters relating to the delivery of clinical care across the hospital and new practising privilege applications from consultants. We reviewed minutes from the last four MAC meetings and found the meetings were well attended by consultants from each clinical area.

Good

Critical care

Managing risks, issues and performance

- **The service had good systems to identify risks, plan to eliminate or reduce them, and cope with both the expected and unexpected.**
- The hospital had a local risk register which included risks relating to critical care. We reviewed this register and found consistent evidence of action plans put in place to control or eliminate the risks.
- There were risks on the risk register that related to ITU and HDU. The risks were identified as insufficient investment in facilities and critical equipment, failure of medical equipment, skills of clinical staff, and failure to recruit appropriate staff. The clinical services manager also stated that one of the key risks to the service was the renegotiation of the critical care consultants' contract, which was currently taking place. We reviewed the mitigating actions in place to manage this risk found them to be sufficient to minimise the risk.
- The hospital had a risk management strategy which outlined the quality management system for clinical services managers across the different core services. The hospital had systems to monitor performance, including incidents reporting, clinical governance meetings, patient feedback, audits and staff appraisals. Performance was compared locally but also compared to other services owned by the corporate provider. These systems highlighted areas of good practice as well as opportunities for learning.
- The hospital's key risks and actions were circulated monthly via the executive director's staff newsletter.

Managing information

- **The service collected, analysed, managed and used information well to support all its activities, using secure electronic systems with security systems.**
- All staff demonstrated they could locate and access relevant information and patient records easily, which enabled them to carry out their roles. Senior staff informed us they were General Data Protection Regulation (GDPR) compliant and that patient information was managed in line with data protection guidelines and legislation. On inspection we observed staff compliance with information governance guidance.

Engagement

- **The service engaged with patients and staff to plan the delivery of services.**
- The hospital had a monthly patient experience steering group which discussed feedback from patient and how to improve the patient journey, which included critical care.
- Patient satisfaction was measured by a hospital survey of patients and their family members. Results from the patient satisfaction survey were discussed in local and hospital wide meetings.
- Critical care staff held weekly team meetings and monthly quality and governance meetings. Staff were informed in these meetings about changes to service delivery, areas of shared learning, and any quality or safety issues. These meetings were minuted for those unable to attend.
- Staff were engaged through the annual staff forum, which provided an opportunity to discuss the experience of working at the hospital. The hospital also conducted an annual staff survey and produced a staff newsletter.
- The executive director read all daily feedback forms that had been completed by patients. If staff were mentioned positively by name, then this was shared in the weekly newsletter. The hospital also handed out a personal birthday card to every member of staff on their birthday and they got a free lunch that day. There was an annual staff party held at a central London venue, attended by approximately 210 staff.
- The executive director conducted staff forums (BMisay) at which feedback on any corporate developments, hospital performance, people development/ opportunities and our governance framework.
- The Freedom to Speak Up Guardian service had recently been launched to allow staff a confidential route to raising concerns.

Learning, continuous improvement and innovation

- **The service was committed to improving services by learning from when things went well or wrong, promoting training, research and innovation.**
- The hospital's ran a programme of quality improvement initiatives called "Time Outstanding Quality (TOQ) projects". TOQ projects involved staff from across disciplines and areas of the hospital to make positive changes to the delivery of care through action plans. The results of TOQ projects were carefully documented

and reviewed at governance meetings. We found that critical care staff were included in hospital TOQ projects, such as the recent review of cancelled surgery appointments.

Good

Outpatients

Safe	Good
Effective	
Caring	Good
Responsive	Good
Well-led	Good

Are outpatients services safe?

Good

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

Mandatory training

- **The service provided mandatory training in key skills to most staff.**
- The hospital offered a comprehensive mandatory training package with modules including information governance, infection prevention and control, equality and diversity, safety, health and the environment children and adults safeguarding.
- Mandatory training was completed on the online electronic system within the hospital with some modules carried out face to face. The personal assistant to the executive director sent a monthly report to the clinical service managers. The report showed training compliance rates, and where training had or was near to expiring.
- Information provided by the hospital showed that in March 2019 the outpatients department were 92.6% compliant with their mandatory training. Staff were 100% compliant in adult basic life support and adult intermediate life support training. Compliance was lower for care and communication for the deteriorating patient (50%) with the remaining six staff booked on the course between July and September 2019, and training in fire safety within a hospital environment (77%).

Safeguarding

- **Staff understood how to protect patients from abuse.** Staff had training on how to recognise and report abuse, and they knew how to apply it**.**
- The director of clinical services was the safeguarding lead for the hospital. They were a member of the multi-borough safeguarding committee and had good links with the safeguarding team.
- Adult and children safeguarding policies were in place which outlined staff responsibilities should they have any safeguarding concerns. The adult safeguarding policy was currently under review as it was out of date (November 2018).
- Data provided by the hospital showed that from March 2018 to February 2019 two young people aged 16 to 17 years were seen within the outpatient department. Hospital policy was that only adults from 18 years upwards would be seen. The patient appointments had been booked after the consultants had initially seen the patients at a different hospital. Managers told us that the patients were risk assessed and seen only for consultation. An incident was raised, and staff reminded not to book appointments for patients younger than 18 years.
- Staff were aware of and received training on procedures to follow should they suspect any cases of female genital mutilation (FGM). A flow chart was seen on the staff noticeboard for the pathway to follow when reporting any cases of FGM. We were told that to date there had been no such incidents within the department.
- The hospital had an up to date chaperone policy. In certain clinics including gynaecology a nursing

member of staff was present with the consultant throughout the clinic. For other clinics the consultant was able to contact reception when a chaperone was required. We saw posters advising patients that chaperones could be requested.

- Staff were trained in Safeguarding Adult Level 1 (92%) and Safeguarding Adult Level 2 (83%). Compliance with Safeguarding Children's Level 2 was 83% with one member of staff to complete the training. The outpatient manager had been booked on to Safeguarding Adult Level 3, a new face to face training module that was being arranged for all managers.

Cleanliness, infection control and hygiene

- **The service-controlled infection risk well.** Staff used equipment and control measures to protect patients, themselves and others from infection. They kept equipment and the premises visibly clean. However, compliance levels with hand hygiene and 'bare below the elbow' standards were low.
- There were local processes to ensure the safe decontamination of reusable medical devices. There was a decontamination standard operating procedure that referenced the Department of Health's Health Technical Memorandum on decontamination. There was an ENT decontamination process that also followed DH guidelines. CJD labels and sign off sheets for consultants and staff were in line with naso-endoscope risk assessment. We saw naso-endoscopes which were compliant with this process.
- All areas of the outpatient department that we visited during our inspection were visibly clean and tidy. Patients we spoke with said they found the hospital to be clean.
- The hospital reported there had been no incidents of hospital acquired Methicillin-resistant Staphylococcus aureus (MRSA), Methicillin-sensitive Staphylococcus aureus (MSSA), Clostridium Difficile (C. Difficile) or Escherichia coli (E. Coli) from January to December 2018.
- There is an infection, prevention and control (IPC) lead for the hospital and also a link nurse for each department. The IPC lead reported to the director of clinical services. The link nurse attended the IPC committee held quarterly at the hospital.
- Managers within outpatients told us that hand hygiene had been a challenge within the department, particularly consultants not adhering to "bare below the elbow" guidelines. We saw the hand hygiene audits for January and February 2019 and found that compliance rate was 32% and 29% respectively. An action plan had been implemented whereby consultants who were compliant were recognised by having stars on their doors. Managers said that where compliance continued to be a problem this was escalated to the senior management team, who in turn told us they would challenge individuals who remained non-compliant.
- Posters advocating "bare below the elbows" were seen in consulting rooms and displayed on doors to remind staff of the importance of complying with the infection control standard. Staff said that one of the consultants within the hospital had agreed to be part of the poster campaign so that other consultants could relate to it.
- Hand sanitisers were found throughout the department. We saw posters displayed with the five moments of hand hygiene and seven steps to hand washing. There were non-touch taps for the sink within the treatment room.
- There was enough personal protective equipment available for staff to wear.
- We observed a minor procedure where we saw the trolley was cleaned before use and aseptic non-touch technique was used to open all consumables therefore reducing the risk of cross contamination. The consultant washed their hands prior to and following the procedure and appropriate PPE (personal protective equipment) was worn.
- We saw that sharps bins were appropriately labelled, signed and dated and were not overfilled.

Environment and equipment

- **The design, maintenance and use of facilities, premises and equipment kept people safe. Staff**

were trained to use them. Staff managed clinical waste well. However, the treatment room did not meet all the environmental requirements set out in the BMI policy 'Surgical Procedures in Outpatients'.

- The environment within the outpatient department was spacious, bright and uncluttered.
- During the last inspection we found that the dirty utility room was not fit for purpose as the temperature was too hot and nothing that required storage below 25 degrees Celsius could be stored in there. At this inspection we found that an air conditioning unit had been installed which enabled the room temperature to be modified, and that items requiring a cooler temperature could be stored within the room.
- Further refurbishment was required within the dirty utility. We were told storage cupboards were due to be replaced later that year. We saw there was disrepair to some of the ceiling tiles, and replacement of these was undertaken during our inspection.
- During the last inspection we found that the fabric of the building needed updating as there were areas within outpatients that were carpeted which is unsuitable within clinical areas. During this inspection we found that suitable flooring was now in place providing non-slip and easily washable surfaces which were in line with infection control protocols.
- At the time of the last inspection it was found that many of the doors were not labelled appropriately as fire door and the hospital had an ongoing programme to replace the doors. During this inspection we viewed the health and safety audit for June 2019 which confirmed that all fire doors within outpatients were labelled appropriately. A fault with one set of fire doors had been identified when they had not closed during a fire test. This had been reported to engineers and staff had been made aware of the issue.
- We were provided with information by the hospital that a fire inspection had taken place in January and February 2019. In response to the findings of this, immediate action had been taken to have fire doors repaired and fire stopping carried out to protect high risk areas, and a contract had been raised with the fire company for maintenance of fire dampers. It also found there was a lack of suitable compartmentation in the event of an evacuation, and we saw that capital funding had been sought and approved for fire compartmentation works to be undertaken. This remained on the risk register for monitoring.
- The hospital had increased security staff presence at the entrance of the hospital. At the time of our inspection patients and visitors to the hospital could access all areas through use of the lift and stairwell. Senior managers told us that funding for improvements had been agreed that included card swipe access to the lifts and all departments of the hospital. Outpatient managers were contacted by the main hospital reception should there be any concerns about a patient or visitor attending the department and they were met at the lifts. In the event of a patient becoming aggressive staff contacted security, however staff did not raise any issues of this nature with us during the inspection. Security for out of hours (7pm to 6am) and at the weekend was provided by the BMI preferred security provider. In hours, the portering team provided support and presence at the main reception desk and throughout the hospital as required.
- We checked six items of equipment all of which had been serviced. Electrical testing for equipment was up to date. Equipment was dust free and had 'I am clean' labels with date and signature attached to them.
- During the last inspection the health and safety audit recorded that 'power tools and electrical tools in good working order, free from splits, cracks and deformities' was rated as poor. Equipment we checked during this inspection was in good repair and the health and safety audit of June 2019 rated this item as good.
- Nursing staff were responsible for ensuring consulting rooms were clean prior to clinics taking place. We saw a daily clinical cleaning schedule that was up to date. A daily checklist was in use which included checking of the resuscitation trolley and medicine fridge temperature, and preparation of the treatment room.
- Rooms and storage cupboards containing controlled substances hazardous to health (COSHH) were kept locked and secure. Staff were required to sign the

health and safety and COSHH folders kept within outpatients confirming that they had read the contents and were aware of the relevant policies on the intranet.

- A range of medical consumables were kept within the treatment room. We checked a sample, all of which were within their expiry date. Disposable curtains were used in the treatment room which were in date.
- In the Ears, Nose and Throat (ENT) consulting room a green and red tray system was used to denote clean and dirty endoscopes. A three step system was used to decontaminate the naso-endoscopes. A log book was used to detail cleaning of the scopes. This helped to reduce the spread of infection. The naso-endoscope audit for June 2019 showed their was 100% compliance for decontamination process signed for.
- Audits on equipment were undertaken bi-monthly within the outpatient department. We saw that the patient equipment audit for outpatients in January/February 2019 and March/April 2019 both scored 100%.
- The treatment room had a suspended ceiling and there was no ventilation or air change within the room. This meant it was not compliant with all the environmental requirements contained within the BMI policy Surgical Procedures in Outpatients.. A risk assessment of the environment had been undertaken which indicated no infections had been identified over three years and controls were in place including monthly deep cleaning. The hospital had introduced a local standard procedure for Surgical Procedures within the London Independent Hospital Outpatients Treatment Room setting out that only level one procedures taking no more than 20 minutes would be undertaken, with monthly health and safety audits in place. This was on the outpatient risk register for corporate review.
- We found that the trolley within the treatment room contained COSHH substances including cellstor pot, thin prep and acetic acid stored together with medicines including silver nitrate cutaneous stick, instillagel sterile gel, local anaesthetic injection as well as zoladex implant and mirena coil. Storage of these together is not best practise. Staff informed us that the substances and medicines had been taken out of the storage cupboard in preparation for the day's clinic and that further preparation would be made for each patient. The door to the treatment room was kept locked at all times.
- Clinical and domestic waste were segregated appropriately. The department had a service level agreement with another company to dispose of the waste.

Assessing and responding to patient risk

- **Staff completed and updated risk assessments for each patient and removed or minimised risks.** Staff identified and quickly acted upon patients at risk of deterioration.
- Each patient referred to the hospital underwent triage before being accepted for their first appointment to ensure the hospital was able to meet the patient's needs throughout all stages.
- If a patient had a body mass index of 40 or more or had a number of comorbidities it may be considered unsafe for them to be seen at the hospital. At this stage patients would be triaged and referred to the anaesthetist. If a patient had a body mass index of over 40 but it had been assessed as safe and appropriate to proceed, the procedure would be carried out. If it was deemed unsafe the patient would then be referred back to the GP.
- Training was provided in using National Early Warning Scores (NEWS) to assess a patient's condition and whether they were deteriorating. Staff knew how to assess for sepsis. We saw posters on the noticeboard reminding staff of the sepsis six bundle. Where staff became concerned they would contact the patient's consultant and the onsite resident medical officer (RMO). Patients could be admitted on to the medical ward or critical care unit within the hospital.
- When a patient became very unwell staff would call the emergency service. The hospital had a service level agreement to transfer deteriorating patients to a nearby NHS hospital.
- Nursing staff were trained in intermediate life support (ILS) whilst other staff in outpatients were trained in basic life support (BLS). The RMO was required to be experienced in Advanced Life Support (ALS).

- The resuscitation trolley was located within the main corridor of the outpatient department and was clean and dust free. A tamper proof tag was in place to ensure the trolley and its contents were secure. We saw that checks were completed on the trolley daily during the month of our inspection. All equipment contained within the trolley was intact and in date. Two defibrillators were in place both of which were in service. An emergency drug box and anaphylaxis kit were both within their expiry date.
- We saw the WHO Observation audit for outpatients in December 2018 which scored 100% compliance.
- A Short Duration Procedures/Surgeries checklist was used in the outpatient department. This included the World Health Organisation (WHO) checklist, checks for allergies, medication, cardiovascular history, that consent had been obtained and identification confirmed. We observed the undertaking of a right knee steroid injection procedure where we saw that all appropriate checks took place.
- When patients attended displaying acute psychiatric behaviour the emergency services were contacted and the patient taken to the nearest accident and emergency department. Information was sent to the patient's GP.
- A biohazard spillage kit and eye wash were located within the dirty utility. Staff knew how to access the kit when required.

Nurse staffing

- **The service had enough staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment**. Managers regularly reviewed and adjusted staffing levels and skill mix.
- The outpatient department used the Power BI tool to plan staffing and ensure that the right number of staff with the appropriate skills were on duty at the right time. Managers planned staff rotas a month in advance based on planned clinics. Rotas were then revisited five days in advance to check for any changes and ensure all staffing requirements were being met.
- During our inspection we were told in outpatients there was a staffing establishment of five whole time equivalent (WTE) nurses and three WTE health care assistants (HCAs). Actual staffing at the time was three WTE nurses and three WTE HCAs with one HCA being on maternity leave. The senior nurse had been taking on the role of clinical manager, alongside an operational manager, and was not included within the staffing establishment although they were involved in clinical practise. The week following our inspection the senior nurse was due to be taking on full clinical and operation management responsibility for the department. We were told funding for a further senior nurse post had been agreed.
- Staffing risks were highlighted at the 9am "Com Cell" meeting and reviewed at the 3pm safety huddle. Where shortfalls were identified staff worked across departments to help fill gaps.
- Between April 2018 and March 2019 the turnover rate for nursing staff within outpatients was 26%.
- Between April 2018 and March 2019, the percentage of bank staff used within outpatients varied. Bank use for nursing staff varied with a peak of 17% in September 2018 and a reduction in bank use thereafter with only 1% used in March 2019. Bank use for health care assistants varied between 6% in April 2018 with a peak of 50% in October 2018. The department had a list of regular bank staff that were used for cover. We were told that agency staff were not used.
- Between April 2018 and March 2019, the average sickness rate for nursing staff was 7.3%. Within the same period the average sickness rate for healthcare assistants was 1.7%.

Medical staffing

- **The service had enough medical staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment.**
- There were 299 consultants working at the hospital and approximately 150 consultants worked within the outpatient department throughout several specialities. All consultants working at the hospital did so under practising privileges and were available for their own patients. Contact was made through the

various departments should the need arise.All consultants were required to confirm suitable cover arrangements if they were unavailable or on annual leave.

- All new applicants for practising privileges were sent an application pack and asked to provide evidence of all relevant clinical experience relating to the practice they wished to bring into the hospital. Consultants had to provide several supporting documents including; curriculum vitae, certificates of qualification, annual appraisal, General Medical Council (GMC) specialist register registration, Medical Indemnity certificate, and Information Commissioners Office (ICO) certificate. A short business case was also completed by the consultant as part of the pre-application process. The executive director interviewed the applicants with those successful being progressed to the Medical Advisory Committee for full ratification. Consultants were required to provide updated documentation annually and failure to do so prior to expiry could lead to temporary suspension or withdrawal of practising privileges.
- There was 24-hour, seven day a week RMO (resident medical officer) cover at the hospital. RMOs were arranged through an agency rather than employed by the hospital. All RMOs were required to have experience in Advanced Life Support (ALS).

Records

- **Staff kept detailed records of patients' care and treatment. Records were clear, stored securely and easily available to all staff providing care.**
- We checked eight medical records all of which were signed and dated with staff grade clearly recorded. All notes had follow up appointments, diagnosis and treatment plan included.
- The hospital had a medical records department where all patient's medical notes were filed, stored and maintained. Staff ensured that records were readily available when patients attended the hospital. Medical records were prepared in advance using the outpatient lists generated from the patient administration system. Records were transported to the relevant clinic prior to the patient's appointment time and locked within the relevant consultant room.
- The availability of medical records had improved over the past eighteen months with more staff recruited in medical records and an expansion of the storage space. Data provided from the hospital indicated that from January to March 2019 4% patients had been seen without all relevant medical records being available. No patients had been cancelled in the six months prior to inspection due to notes not being available. The number of outstanding medical records was discussed at the hospital operational meeting every morning. Where medical notes were not available clinical staff searched the hospital system for any relevant information such as last clinic letter, operation notes or GP referral. Clinical staff also had access to test results such as histology and pathology reports.
- We were told that medical records remained at the hospital, and removal of records from the hospital site was discouraged. Consultants who had practising privileges at the hospital were required to register with the Information Commissioners Office (ICO) as independent data controllers and required to work to the standard set by the Information Commissioner.
- Managers told us there had been challenges with keeping records contemporaneous. Consultants were reminded to attach a copy of any letters following consultation to the patient's medical record. This was still a work in progress and the hospital had just started to audit the process, although we were told that most consultants were now compliant. All eight of the medical records we checked contained contemporaneous notes.
- We viewed the patient records audit for 2019 where 40 medical records were sampled. Items for 'Are there relevant consultant clinic notes available'' and 'Has the consultant written daily progress notes?' recorded 100% compliance.
- An electronic tracking system was being trialled to track notes across departments, although this was yet to be introduced within outpatients.
- Medical records were regularly scanned on to a secure electronic medical records database. Staff could access records from the database as required.
- The electronic discharge system (e-discharge) enabled discharge summaries to go to the GP information

system; in to a hub where it went on to the GP patient record. We spoke with one patient coming in for pre assessment. We were told that their GP received all copies of letters, including the discharge summary.

Medicines

- **The service used systems and processes to safely prescribe, administer, record and store medicines.**
- There had been no medication errors recorded within outpatients in the twelve months prior to the inspection.
- No controlled drugs were used within the outpatient department. We found that medicines were stored securely in a locked cupboard and room. Keys were kept by the senior nurse within the department. Medicines we checked were within date.
- The medicines fridge within the treatment room was kept locked. The fridge was clean and medicines were kept in an organised manner. We checked a sample of medicines stored within the fridge, all of which were within their expiry date.
- A log was kept of fridge temperatures, and we saw that this had been undertaken daily during the month prior to our inspection. Staff were aware of what action to take if the fridge temperature deviated from its normal range.
- We saw that temperature for the treatment room was appropriate and that this was checked daily.
- Patient allergies were checked and recorded before any procedures were carried out.
- All medicines were prescribed by the consultants during their clinics. Only private prescriptions were used in the department, no FP10 prescriptions were issued. Prescriptions were kept within a locked cupboard. Consultants made individual requests when a prescription was required. A log book was kept with the patient name and issuing doctor. A count of prescriptions was undertaken daily and checked by two nurses.
- We checked ten prescription charts all of which were clear and legible, signed and dated. Two nurses checked and signed when medicines were administered.

Incidents

- **The service managed patient safety incidents well. Staff recognised and reported incidents and near misses. Managers investigated incidents and shared lessons learned with the whole team and the wider service.**
- There had been no 'never events' reported at the hospital from April 2018 to March 2019. A never event is a serious incident that is wholly preventable, as guidance and safety recommendations providing strong systemic protective barriers are available at a national level and should have been implemented by all healthcare providers.
- From January to December 2018, there were 144 clinical incidents within outpatients. No incidents were categorised as severe harm.
- Staff were aware of their responsibilities for reporting incidents and we were told this was actively encouraged within the service. Incidents were recorded on the electronic reporting system within the hospital and allocated to the relevant department manager for investigation. Incidents were discussed monthly at the hospital and clinical governance meeting. Lessons learnt from incidents were shared during staff meetings to promote continuous learning.
- A 'comm cell' was held every day, a meeting which included service managers from all departments which enabled information to be shared across the hospital in relation to incidents, deteriorating patients, equipment problems, staff changes and complaints.
- Staff within the service demonstrated an understanding of the duty of candour. The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support to those persons.

Safety Thermometer

- **The service used monitoring results well to improve safety. Staff collected safety information and shared it with staff, patients and visitors.**
- The safety thermometer is a collection of data submitted by all hospitals which shows a snapshot of

inpatients suffering avoidable harm, usually on one day each month. The safety thermometer allows teams to measure harm and the proportion of patients that are 'harm free' from pressure ulcers, falls, urine infections (in patients with a catheter) and venous thromboembolism (VTE - a blood clot which starts in a vein.)

- We saw a hospital wide quality and safety scorecard on the noticeboards in the outpatient department. This displayed safety information for each month between May 2018 and April 2019. Within the timeframe the hospital reported six falls, no hospital acquired pressure ulcers and two serious incidents.
- Other safety information was displayed within the staff area including posters for sepsis six and management of needle stick injuries.

Are outpatients services effective?

We do not rate the effective domain in outpatient services.

Evidence-based care and treatment

- **The service provided care and treatment based on national guidance and evidence-based practice.**
- Policies and guidelines could be accessed quickly via the staff intranet and we saw this in practise during our inspection. For example, we saw that policies were in place for Standard Infection Prevention and Control Precautions, Hand Hygiene and Methicillin Resistant Staphylococcus aureus (MRSA) Screening and Management. We observed that each policy had a purpose description, version number, approval and reviewed date.
- Implementation of NICE guidelines was monitored through the hospital clinical governance committee and shared in the BMI clinical governance bulletin. Where urgent updates to guidelines were received the quality and risk manager would send the information to staff via email. The operational manager for outpatients attended the BMI corporate outpatient forum where policy, guidelines and best practise were discussed, and gave feedback to staff at team meetings.
- Nurses in the outpatient department told us they followed national and local guidelines to ensure safe and effective patient care. There were several assessments that followed published best practise. They included falls assessments, VTE (venous thromboembolism) and malnutrition universal screening tool (MUST).
- Clinical audits were undertaken on a regular basis within outpatients including infection control, WHO checklist and medicines management. Results and action trackers were discussed at the hospital and clinical governance meeting and subcommittees where relevant.

Nutrition and hydration

- **Staff assessed patients' nutritional states and food and drink was provided to meet their needs.**
- We were told that nutritional states were assessed for each patient on admission using the Malnutrition Screening Tool (MUST) and that food and fluid intake was monitored using food charts and fluid balance charts as necessary.
- Water dispensers were placed throughout the outpatients waiting area for patients to use when they attended clinic appointments. A restaurant was located on the fourth floor where additional hot and cold refreshments could be purchased.

Pain relief

- **Staff assessed and monitored patients regularly to see if they were in pain.**
- Pain scores were documented within the patient health record. We checked eight medical records and found that pain was assessed and recorded in all cases.
- Pain was managed by each patient's individual consultant. Where pain persisted or became problematic patients were managed by the Resident Medical Officer (RMO) or the patient's own consultant was called to reassess their patient and amend the medication prescription accordingly.
- Specific clinics for pain management were run by the service to which a patient could be referred.

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- Following a procedure, patients were given an advice booklet on how to manage their pain, and any concerns were discussed and documented.
- Patients were asked to provide feedback in relation to their pain management when completing the patient satisfactory questionnaire. Questions included “Likelihood of post-operative pain explained,”, “Level of pain assessed,” and “Did everything to control pain,”.

Patient outcomes

- **Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for patients.**
- The hospital monitored outcomes following discharge through follow up appointments and physiotherapy sessions. They offered all inpatients a follow up call soon after surgery to review their progress.
- The hospital participated in National Joint Registry (NJR) collecting information on orthopaedic joint replacement surgery, and submitted data for patient reported outcome measures (PROMs) for hip, knee and cataract surgery. We were told the hospital were working towards collecting data for Euro Qol (EQ-5D) which measures patient outcomes for five dimensions of health-related quality of life: mobility, self-care, usual activities, pain/discomfort, and anxiety/ depression.
- The hospital benchmarked their outcomes against other comparable services both internally and through national audit. Where poor outcomes were identified these were discussed at the hospital and clinical governance committee.

Competent staff

- **The service made sure staff were competent for their roles. Managers appraised staff’s work performance.**
- BMI recruitment policies were in place to ensure staff with the right skills and competencies were recruited and Disclosure and Barring (DSB) clearance processes were undertaken.
- There was a BMI policy for practising privileges. This set out that practising privileges were only granted to doctors who were licenced and registered with the General Medical Council (GMC), held a substantive post within the NHS in the past five years or could demonstrate independent practise over a sustained period, and had relevant clinical experience to practise. Each application for practising privileges was assessed by the Medical Advisory Committee (MAC) and we saw evidence of this in the MAC minutes from March 2019 we reviewed. Where a concern was raised in relation to a consultant, advice was sought from the BMI Group Medical Director and the National Director of Clinical Services and appropriate action taken where required.
- The outpatient department had a comprehensive induction programme for all new staff recruited. Initially staff were provided with an orientation, shown safety equipment and introduced to the mandatory training system for completion. Within the first month new starters would have the opportunity to read policies and be introduced to protocols around infection control, cleaning, equipment, patient information and clinical practise.
- Nursing and health care assistants completed competencies which were signed off by the outpatient manager demonstrating that they were able to complete specific tasks. Nursing competencies included defibrillator daily testing, pain management and automatic blood pressure monitoring were regularly reviewed.
- In the last appraisal year 100% of nursing staff and 91% of health care assistants had received their appraisal. Appraisals enabled staff to consider their clinical practise and any learning opportunities they considered would be of benefit.
- Staff development opportunities were provided through the ‘BMI Learn’ Training Academy. External training was available where related to the post and nursing staff told us that face to face wound management training had been arranged. This included training in different types of dressing, stitch removal, clip removal, packing of wounds, negative pressure wound therapy and skin biopsy dressings.

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- Staff said that there was ample scope for learning and development. We spoke with one member of staff who had recently been recruited to a senior nurse post. A management course was available for continued development.
- We saw that staff received annual training in the cleaning of naso-endoscopes and transvaginal probes and these were in date.
- We were told that six nursing staff were trained in phlebotomy (the taking of blood for testing purposes). One member of staff explained that they had received face to face training in phlebotomy following appointment. This had been followed by 10 supervised sessions and completion of phlebotomy competencies which were updated every year.

Multidisciplinary working

- **Doctors, nurses and other healthcare professionals worked together as a team to benefit patients. They supported each other to provide good care.**
- Across the outpatient department we observed that staff at all levels worked together to meet the health care needs of patients. Nurses spoke of professional working relationships with consultants, and it was evident that consultants had good regard for nursing input.
- Where staff shortages were identified at the morning “Comm Cell” meeting, appropriate staff from other departments would be required to help cover and address the shortfall. This meant that staff in outpatients became more aware of how other departments were run, and staff felt more integrated in to the hospital as a whole.
- Physiotherapy was located alongside outpatient clinics and patients could access this service prior to or following their surgical procedure as required. We observed good supportive working relationships between the departments.
- A breast care nurse worked alongside consultants within the outpatient department to provide information, education and advice to patients attending clinics, and to give support to those patients with a diagnosis of breast cancer.

Seven-day services

- Outpatient clinics were delivered between 8am and 8pm Monday to Fridays. Clinics were held on a Saturday between 8am and 2pm for new and follow up appointments. Patients we spoke with reported good access to appointments at times that suited their needs.
- The pharmacy was open Monday to Friday 9am to 6pm and Saturdays 9.30am to 12.30pm. An on-call service was provided by the pharmacy team out of hours.

Health promotion

- **Staff gave patients practical support and advice to lead healthier lives.**
- Health advice including exercise, diet and nutrition, healthy lifestyle, hydration, smoking cessation and deep vein thrombosis were provided in clinics depending on individual patient needs.
- Leaflets advocating healthy lifestyle and advice on a range of health conditions were available from the main reception as required. We were told that telephone advice would also be provided to patients on request.

Consent and Mental Capacity Act

- **Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients’ consent. They knew how to support patients who lacked capacity to make their own decisions.**
- Verbal consent was taken for checking vital signs and phlebotomy. Written consent was taken for any minor procedures on the day it was carried out. We observed a minor procedure in which we saw that patient consent was obtained and signed by the consultant. We checked eight medical records and saw that consent had been obtained in all cases.
- We were told that staff received training in the Mental Capacity Act (2005) within the mandatory safeguarding training module. A BMI policy in Mental capacity and Deprivation of Liberty was in place and staff we spoke with were aware of their responsibilities. Where there were concerns that a

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patient lacked capacity they were assessed by a consultant. When it was considered that it was unsafe to proceed then the patient was transferred to another hospital or referred back to their GP so that their individual needs could be catered for.

Are outpatients services caring?

Good

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

Compassionate care

- **Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.**
- Patients we spoke with positive good feedback about the care received within the outpatient department. For example, one patient told us "I absolutely love the place.", choosing it over closer hospitals because, "I come here for the level of care I receive.".
- Patients said that staff were polite and courteous, kind and compassionate. We observed interactions where staff demonstrated an interest in the patient's wellbeing.
- We observed medical and nursing staff talking kindly to patients and reassuring them about the procedures they were about to undergo.
- Patients were treated with dignity and privacy. Doors were kept closed during consultations so that conversations could not be overheard, and curtains were drawn.
- Patients could request a chaperone if necessary giving them access to emotional support prior to, during and immediately after an examination. Women's health clinics had a nursing member of staff available at all times.
- The hospital collected patient feedback through satisfaction surveys. Staff encouraged patients to complete the paper and electronic questionnaires once they had finished their clinic appointment. This helped inform the hospital and department of how to improve the patient experience. A monthly report was completed for the hospital which showed response ratings and rankings against other BMI hospitals and included specific patient comments.
- Data submitted by the hospital for the Friends or Family Test showed that between October 2018 and March 2019 those that would recommend the hospital to a family member or friend ranged between 93.5% and 98%. Response rates to the survey ranged from 3.1% to 20.8%. We saw results of the Family and Friends test for the outpatient department for April 2019 which showed that 97.2% would recommend the service to a friend or family member.

Emotional support

- **Staff provided emotional support to patients, families and carers to minimise their distress. They understood patients' personal, cultural and religious needs.**
- We observed nursing and medical staff providing emotional support to patients attending the clinic. Patients told us that staff were quick to respond to questions about pain relief and other medical concerns.
- A specialist breast care nurse was available to provide counselling to patients attending clinics and signpost to other sources of help where necessary.
- Psychiatric clinics were held at the hospital for patients with depression with the option for patients to be referred for psychotherapy.

Understanding and involvement of patients and those close to them

- **Staff supported and involved patients, families and carers to understand their condition and make decisions about their care and treatment.**
- Patients we spoke with said they felt fully involved in the decisions made about the care and treatment provided to them at the hospital. On one of the outpatient feedback surveys a patient had commented "she (nurse) was so professional, she explained all that she was doing. Spoke to me nicely all the time, gave me some advice.".

Good

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- We saw that consultants explained procedures to patients in a way that was understood, so that patients were aware of the risks and benefits of the procedure and allowed them to answer any questions they may have.

Are outpatients services responsive?

Good

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

Service delivery to meet the needs of local people

- **The service planned and provided care in a way that met the needs of local people and the communities served.**
- The services at the hospital aimed to offer patients full "end to end" care so that patients would benefit from having their healthcare fully provided in one location. These main services offered by the hospital were orthopaedics, cardiology and sports medicine.
- The hospital was located within close proximity to a London underground station and public transport. There was a small car park at the hospital that patients could use free of charge. However, patients told us that securing a space was “hit and miss.”.
- Seating was arranged far away enough from the outpatient reception desk for patients to have private conversations with staff. During our inspection there was enough seating within the outpatient waiting area, additional chairs had been added as the area became busier in the evening. Seating was arranged throughout the department so that patients were seated close to the clinics in which they were booked.
- We observed that reception staff were mostly polite and responded quickly to patient’s needs. This meant that queues within the reception area were kept to a minimum.
- There was clear signage to the outpatient department once inside the main hospital building.
- Accessible toilets and baby changing facilities were located within the outpatient department, we were told the latter had been added as a response to patient feedback.

Meeting people’s individual needs

- **The service was inclusive and took account of patients’ individual needs and preferences. Staff made reasonable adjustments to help patients access services.**
- Individual needs were flagged in referral letters from GPs and picked up during the triage process. This enabled hospital staff to prepare and put in place any specific support or adjustments required for a patient.
- Patients with a learning disability were identified at triage. All patients with a learning disability were advised to bring a carer with them to support them during their appointment at the hospital. Where staff had any concerns they would contact the director of clinical services.
- Staff made adjustments as far as possible for patients with dementia. A dementia awareness nurse was available for advice if needed. We were told that all staff in outpatients completed an annual online training module in dementia awareness.
- The outpatient department was located on the second floor and could be accessed by lift or stairwell. The area had step free access and was accessible to individuals using a wheelchair. During our last inspection it was found that the reception desk within outpatients was not lowered to take in to account the needs of wheelchair users. This remained the same during this inspection. However, there was an equalities impact assessment in place to manage this and the reception desks were listed for redesign in the five year refurbishment plan.
- Interpreters were used where patients were seen whose first language was not English. These could be booked in advance when highlighted on the referral form, and telephone interpreters could be used without any notice.
- Information leaflets were provided by the consultant or could be requested at the reception desk. During out last inspection we found that information was

provided in English only. During this inspection we saw that a variety of leaflets were available explaining many health conditions and could be printed off in several different languages.

- A hearing loop was available on reception for patients who were deaf or hearing impaired. Staff told us they would use various methods to communicate with patients dependent upon their needs. For example, a British Sign Language (BSL) interpreter had recently been used to support a deaf patient attending a consultation at the hospital.
- Cultural and religious needs were taken account of. Staff told us that a prayer room was available for patients and visitors to use if required.

Access and flow

- **People could access the service when they needed it and received the right care promptly.**
- The hospital published their services online and NHS patients booked their appointments on the NHS e-Referral service where a choice of dates and times were given. Private patients could book through the centralised team or through the website where a “live chat” support system was in place. They could contact the consultant’s secretary where appointment changes were required. Patients that we spoke with told us that appointment choice was flexible enough to meet their needs.
- Where follow up appointments were needed these were provided by the reception staff at the end of the patient’s appointment. We saw this in practise following the observation of a right knee steroid injection procedure. The patient was offered a three month follow up appointment with the consultant and an appointment with physiotherapy. A letter to the GP explaining the outcomes was placed on the patient’s medical record.
- The referral to treatment (RTT) pathway was the key access target for NHS-funded patients, stating that no patient should wait longer than 18 weeks from referral to the start of their treatment. Patient outcome slips from clinics went back to the reception to enter the patient outcome of the clinic appointment. Reception staff entered the outcome live into the patient administration system. The Hospital NHS team monitored patient wait times and helped facilitate admissions to ensure breaches did not occur.
- The RTT key performance indicator target was 92%. This was tracked within an RTT dashboard which was shared with the CCG. We saw the data provided by the hospital for April 2018 to March 2019. This showed that 10 of the 18 specialities were always meeting the target. Neurosurgery fell below the target regularly throughout the year. Gastroenterology and ophthalmology fell just below the target for four of the twelve months, and gynaecology and ENT fell just below the target for three months. However, the service was meeting the 92% target in most cases including 100% in 8 of 18 disciplines, and all were better than the national average of 72% of patients meeting the 18-week RTT.
- Managers told us that a recurring theme in patient feedback was the wait for consultants once at the hospital or clinic cancellation. Data provided by the hospital showed that this was an ongoing challenge. For example, in June 2019 we saw that there were 32 late running clinics and 17 cancelled clinics. In addition, clinics were often cancelled with very short notice.
- A process was in place for managing late and cancelled clinics. Administration staff kept a spreadsheet of all clinics cancelled by consultants and how long patients were waiting before being called in to see the consultant. Where it was evident that a pattern in lateness/cancellation was occurring without good reason this was taken up with the individual consultant and escalated to the senior management team where necessary, and we saw evidence where this had taken place. Reception staff said they kept patients informed of waiting times and some patients we spoke with confirmed this had been the case.
- Where patients did not attend (DNA) they were offered up to three appointments. Reception staff would contact patients to arrange further appointments, and this was made a priority where histology test results needed to be discussed. A letter was sent to the GP to inform them of the situation. Data provided by the hospital showed the did not attend rates within outpatients for April, May and June 2019 were 3.58%,

3.74% and 2.30% respectively. The four specialities identified for having the highest DNA rates were ENT, gynaecology, orthopaedics and urology. The service had an action plan to address DNAs including the introduction of a courtesy call to remind patients of their appointments which patients we spoke with said they found helpful.

Learning from complaints and concerns

- **The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff.**
- From April 2018 to March 2019, the hospital received 208 complaints. The data was not broken down and therefore did not show how many of the complaints were received in the outpatient department. None of the complaints were referred on to the Independent Sector Complaints Adjudication Service (ISCAS).
- Complaints were received by the hospital by letter, telephone or a dedicated email mailbox. The executive director had overall responsibility for complaints made to the hospital. Complaints for outpatients were managed and investigated by the department manager along with the director of operations, director of clinical services and quality and risk manager. Most patients we spoke with in outpatients said that they had not seen any information about how to make a complaint, though most said they would initially ask reception staff.
- All complaints were recorded on the incident reporting system at the hospital and were discussed in a variety of forums including the daily "Comm Cell" senior leadership committee, monthly at the patient experience committee and at the hospital and clinical governance committee.
- Managers told us that the main complaint received in outpatients related to patient wait times for consultation once at the hospital. As a result the department had started to record late running and cancelled clinics and where there were recurring problems these were escalated to the senior management team. We were also told that additional seating had been arranged in the waiting area after receiving complaints that there had not been enough during busy evening clinics.

Are outpatients services well-led?

Good

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

Leadership

- **Leaders had the integrity, skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff.**
- The outpatient and physiotherapy departments were led by a clinical services manager. A restructuring was taking place the week following the inspection, whereby the existing clinical services manager would oversee physiotherapy only and another clinical services manager was taking over the outpatients service. Managers had been preparing for the change and felt it was an appropriate step. Both clinical services managers reported in to the director of clinical services, who in turn reported in to the executive director.
- Staff spoke highly of the local leadership within the outpatient department saying that managers were approachable and welcomed feedback about the service.
- We were told that senior managers were visible in the department and around the hospital. Outpatient managers reported to the director of clinical services. They spoke of positive professional relationships with the senior leadership team and felt there had been an improvement in oversight alongside the freedom and support to develop staff and the department. Staff at all levels felt they could escalate concerns to senior managers where necessary.
- It was evident during our inspection that managers would challenge both nursing and medical staff where protocols and procedures were not being adhered to, ensuring that patients received safe care and treatment.

Good

Outpatients

Vision and strategy

- **The service had a vision for what it wanted to achieve.**
- There was a clear vision for the hospital which was aligned to the BMI corporate vision and underpinned by the BMI behaviours. The vision of the hospital was to be the "healthcare provider and employer of choice serving our communities in East London and Essex with the highest possible standard of care". Staff in outpatients were aware of the vision for the hospital and had been involved in its development. The values of kindness, trust, passion and dedication were embedded in to staff practise.
- The strategy was driven through four key objectives: the five domains of safe, effective, caring, responsive and well-led (in line with those set out by CQC); Many skills, One Team; No debate on safety; and Ward to Board. In outpatients' managers told us about their plans for improvement including further development of the orthopaedic and sports medicine services with a focus on safety and quality.

Culture

- **Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service had an open culture where patients, their families and staff could raise concerns without fear.**
- Staff within outpatients were passionate about their work with a focus on safety and patient centred care.
- Staff spoke of and we observed positive working relationships between staff within the outpatient department. Staff told us that peers would readily give advice and support as and when needed.
- The hospital encouraged transparency and incident reporting, this was a matter specifically covered within the new induction. Staff within outpatients felt there was an open and inclusive culture and said they were encouraged to report any concerns.
- The hospital had recently launched their Freedom to Speak up Guardian to provide a safe and confidential route for staff to raise concerns about their service.

Governance

- **Leaders operated effective governance processes throughout the services. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.**
- There was a clear governance and reporting structure in line with the corporate governance framework. The senior leadership reviewed the performance of the outpatient department through a number of different meetings.
- A meeting known as a 'Comm Cell' was held daily, that a representative from each department including outpatients attended. This enabled issues to be escalated and was an effective tool for sharing communication throughout the hospital. "Hot boards" were located throughout departments so that staff could see at a glance pertinent issues raised at the "Comm Cell".
- The hospital and clinical governance committee reviewed incidents, risks, alerts and safety notices, complaints, patient experience and clinical audits with actions reviewed at each meeting. The committee received reports from various subcommittees including medicine management, infection prevention and control (IPC) and resuscitation which met quarterly. The hospital and clinical governance committee fed in to the leadership committee. We saw that the outpatient manager attended both the hospital and clinical governance and leadership committees.
- Clinical quality and governance matters were reviewed by the Medical Advisory Committee (MAC) which met bi-monthly and was attended by representatives from all specialities. Areas of discussion included a review of applications for practising privileges and where these had been withdrawn, updates from the executive director, director of operations and director of clinical services and clinical governance report.
- Information was cascaded from the executive team through to the operational committees, to departmental team meetings and to individuals within the hospital. Governance information was available for staff on information noticeboards in departments.

Good

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Managing risks, issues and performance

- **Leaders and teams identified and escalated relevant risks and issues and identified actions to reduce their impact.**
- The hospital held a risk register which was regularly reviewed to ensure risks were monitored and appropriately managed. Heads of department managed departmental risk registers that fed in to the hospital risk register. Risk issues were discussed at the hospital and clinical governance and health and safety committee.
- We reviewed the risks added to the register for the outpatient department. Staff were aware of the risks which included the lack of airflow in the treatment room and potential for information security breach at the nurse's station. The risk register included a control for each risk added and when it was next to be reviewed.
- A safety huddle was held each afternoon to discuss any risks or concerns pertinent to the running of services at the hospital that day. This enabled managers across departments to be aware of risks and respond to them in a timely manner.
- The hospital's key risks and actions were circulated to staff monthly via the executive director's newsletter.

Managing information

- **The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements.**
- The director of clinical services was the Caldicott Guardian for the hospital. This is a person responsible for protecting the confidentiality of people's health and care information and ensuring that it is used appropriately.
- A computer terminal was based at the nurse's station within the outpatient department where staff could gain access to medical records and respond swiftly to patient queries. Due to the number of staff using the computer terminal, and entering and leaving the nursing station, there was a risk that it could be left unlocked and unattended with the potential of leading to a data breach. This had previously been on the outpatient risk register. Managers tried to ensure that the nursing station always had a member of staff present, although during busy periods this was not always possible. Managers told us that staff had been made aware and the issue had been raised with the senior management team and a request made for a member of administration staff to cover the station at all times.
- The hospital had in place BMI policies for information management and information governance to help safeguard patient data information. All information governance breaches were reported as incidents on the electronic reporting system. Staff were required to complete a four-part mandatory training module which included the General Data Protection Regulation (GDPR) requirement. Compliance rate for completion of information governance training in outpatients was 100%.

Engagement

- **Leaders and staff actively and openly engaged with patients and staff to plan and manage services.**
- Staff meetings were held monthly within the outpatient department at which any important updates were shared including incidents, complaints and patient feedback.
- The executive director sent a weekly newsletter to keep staff aware of hospital developments. Staff forums were held which provided updates on corporate developments, hospital performance and staff opportunities.
- BMI undertook an annual staff survey. However, the results were not site specific and therefore staff did not receive feedback specific to the outpatient department at BMI The London Independent. Managers told us that one finding from the survey had been that allied health professional staff had indicated that they would be less likely to work for BMI in a year's time than nursing staff. Senior managers had arranged a meeting with departmental managers and staff to discuss the result.
- Staff spoke enthusiastically about non-work events organised by managers, for example, a staff party had been arranged a week prior to our inspection.

- The hospital measured patient satisfaction results using friends and family recommendation. These were reported monthly at the leadership and clinical governance committees. A patient experience group had been formed that focused attention on patient centred care and a drive to improve response rates to the Friends and Family Test. Patient representatives were yet to be included.
- Patient feedback was reported back to individual staff members and where a staff member was praised several times for the care they provided, this was recognised at the staff meeting and the feedback shared with the executive director. As well as providing recognition of individual staff practise it also acted as a reminder for staff to encourage patients to complete the satisfaction questionnaires.

Learning, continuous improvement and innovation

- **All staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them.**
- The hospital's Time Outstanding Quality (TOQ) projects involved members of the hospital staff in key areas of identified improvement to ensure ward to board feedback was received and the best improvement decisions were made for patients. We found that medical records and consultant outcomes were included in the hospital TOQ projects.
- The outpatient manager attended the corporate BMI London Outpatients Forum. This was a meeting where good practice, new initiatives and solutions to challenges were shared. There was also a group email for advice and shared learning.

Outstanding practice and areas for improvement

Outstanding practice

- There was an improved reporting and listening culture. Staff were encouraged to raise incidents for learning and improving outcomes for patients.
- There was a culture that supported and valued staff, creating a sense of common purpose based on shared values.
- There was a clear vision and strategy, underpinned by a clinical and non-clinical five year plan with key objectives.
- Throughout our inspection we saw evidence of systems in place for continuously identifying, monitoring and improving services. Improvement and action plans were meaningful.

Areas for improvement

Action the provider SHOULD take to improve

Surgery

- The provider should ensure that all staff comply with hand hygiene and bare below the elbow standards in line with infection, prevention and control guidelines.
- The provider should ensure that information relating to the monitoring of harm free care is on display to patients.

Critical Care

- The provider should provide a follow up clinic where discharged patients could reflect upon their critical care experience and be assessed for progress, in line with Guidelines for the Provision of Intensive Care Services. Any follow up clinic should examine how international patients could be included in and provided with an opportunity for follow up.
- The provider should formalise access to counselling and bereavement services for patients and their family members and ensure that information on these services is made available.

Outpatients

- The provider should ensure that all staff comply with hand hygiene and bare below the elbow standards in line with infection, prevention and control guidelines.
- The provider should ensure staff separate COSHH substances and medicines when preparing clinics in the treatment room.
- The provider should ensure information is available so that patients know how to make a complaint.
- The provider should make the reception area and nursing station in outpatients accessible to those who use wheelchairs.

Outstanding practice and areas for improvement

- The provider should continue to monitor lateness and cancellation of clinics and take action where appropriate.