BMI The Kings Oak Hospital

Quality Report

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

Ratings

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

Mental Health Act responsibilities and Mental Capacity Act and Deprivation of Liberty Safeguards

We include our assessment of the provider's compliance with the Mental Capacity Act and, where relevant, Mental Health Act in our overall inspection of the service.

We do not give a rating for Mental Capacity Act or Mental Health Act, however we do use our findings to determine the overall rating for the service.

Further information about findings in relation to the Mental Capacity Act and Mental Health Act can be found later in this report.

Summary of findings

Letter from the Chief Inspector of Hospitals

BMI The Kings Oak Hospital is operated by BMI Healthcare Limited. The hospital provided inpatient and day care services and had a total of 47 beds, including four children and young people beds. The hospital has two theatres, endoscopy, phlebotomy and minor operations room, outpatients and diagnostic imaging department.

The hospital provides surgery, medical care, services for children and young people, outpatients and diagnostic imaging. We inspected surgery, medical care, services for children and young people and outpatients.

We inspected this service using our comprehensive inspection methodology. We carried out the unannounced inspection on 8 to 9 April 2019.

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.

Throughout the inspection, we took account of what people told us and how the provider understood and complied with the Mental Capacity Act 2005.

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

Services we rate

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

Although we found good practice in all of the four services we inspected with marked improvement in medical care and key physical refurbishments in the medical care and surgical ward, we found areas of improvement in surgery and services for children and young people.

We found areas of practice that require improvement:

Medical care

- Mandatory training was below the hospital target for the inpatient ward staff (79%) and lowest among the medical service.
- Not all staff had received an annual appraisal. Current appraisal rates for nursing staff were 75% which was below the hospital standard of 90%.

Surgery

- Although staff completed and updated risk assessments for patients on the ward, not all staff were fully engaged with best practice processes for safer surgeries. Some staff did not always follow procedures for safer surgery in theatres and other staff did not challenge poor behaviours.
- The service did not always control infection risk well. Although staff mostly kept equipment and the premises clean, they did not always maintain best practice in infection prevention control. We observed that staff were not always bare below the elbow in clinical areas and that clinical waste was not always disposed of properly.
- Although the service had recently refurbished some areas, other areas of the environment continued to require improvement. There continued to be challenges around space in the theatre environment.

Summary of findings

- Although the service followed best practice when prescribing, giving and recording medicines they did not always follow best practice when storing medicines. There was no clear accountability for responsibility of fluids being in date and at the right temperatures in the fluid warming cabinet.
- While we found the service provided enough nursing staff, with the right mix of qualification and skills, to keep patients safe and provide the right care and treatment, there was a high-dependency on bank and agency staff use.
- Although most managers across the service promoted a positive culture that supported and valued staff, we found there were areas requiring improvement in theatres for creating a culture of safety and supporting staff to challenge poor practice.
- Although the service had systems to identify risks, plans to eliminate or reduce them, and cope with both the expected and unexpected, we found in theatres these were not always put into practice, especially in attentiveness of staff with the WHO checklist.
- Although the service had systems in place to improve service quality, in practice we found that these systems were not always effective.

Services for children and young people

- Mandatory training compliance was low for paediatric basic life support (PBLS) and paediatric intermediate life support (PILS) hospital wide. However, children's nurses within the CYP service were trained in PILS and were available when children and young people accessed the hospital..
- Equipment storage in the paediatric resuscitation trolleys was not in standard order. Information folders held on the trolleys was disorganised and contained varying contents in different areas of the hospital.
- Where paediatric warning scores were escalated, there was no evidence of actions taken documented within patient records.
- The hospital wide audit schedule included documentation and pain management audits, however these were not specific to the children and young people's department.
- There was a lack of health promotion material specific to children and young people on Acorn ward and within other areas within the hospital where children and young people were seen.
- There was no designated waiting area for children in the outpatient's department. Children, young people and their parents and carers were seated within the main area along with other adults.
- Areas within the hospital where children and young people were seen lacked a child friendly environment and atmosphere.
- The en-suite bathrooms were not accessible for patients who used a wheelchair as there was no specialist equipment available to use the bath or toilet.
- There was a lack of child friendly or easy read information available within the hospital.
- There was no formal monitoring of the objectives and priorities set out in the five-year plan for the children and young people's service by the senior management team.
- Staff spoke about making improvements within the children and young people's service, however there were no action plans in place to demonstrate how these would be achieved.
- There was no medical representative on the corporate children and young people's committee or the resuscitation committee held within the hospital.

- Departmental risks were recorded on the risk register including those identified for children and young people (CYP). At the time of our inspection we did not find any risks recorded on the register relating to CYP despite staff identifying risks at that time.
- Patient satisfactory forms were available for children and young people, their parents and carers to provide feedback about their care and treatment. However, there was no audit of the feedback provided for children and young people up to the age of 16 years.

Outpatients

- Some aspects of equipment and premises did not meet hygiene standards. This included the resuscitation trolley, the treatment room, the clean utility room fridge, the phlebotomy room, the minor operations treatment room and the urology waiting area.
- Although the service had suitable premises and equipment there were maintenance issues on wall fixings, treatment room trolleys and some PAT testing. There were no aprons available in the phlebotomy room.
- Although the service followed best practice most of the time, we found some issues with the storage of medicines. Resuscitation trolleys were not in a temperature controlled area as advised by the pharmacist due to the storage of medicines on them. Both were kept in the corridor beside a radiator.
- The store cupboard contained a small amount of stock that required temperature monitoring at below 25 degrees. The room was warm and no temperature checking was taking place.
- Waiting beyond appointment times continued to be a problem and was common, often for long periods of up to an hour. Patients felt they received a good service from the doctors and did not mind if the doctor was delayed or overrunning but just wanted to be informed of this. Waiting times for clinics were not displayed in waiting areas. There was a notice on display at the reception desk that advised patients to report to reception if they had been waiting more than 20 minutes. This was an action taken from a complaint regarding waiting times.
- There was an access policy that required six weeks' notice of any clinic cancellation. We were told this was difficult to implement, as clinics were cancelled at late notice.
- All referrals were triaged before being accepted for a first appointment which was described as a time consuming undertaking for the senior nurses involved that meant working weekends when not on duty in order to clear backlogs.
- At the last inspection we found that staff felt the changes in leadership of the hospital were unclear. At this inspection the clinical director and associate clinical director posts had both been vacant for three months. There were new starters for both on the first day of our unannounced inspection.
- Recent staff survey results showed that bullying and harassment continued to be an issue. The results were not broken down by staff site or speciality, so they were unable to identify where the issue was located. The leadership team said they planned to work with staff to address the issue, and that it had improved slightly since the last survey.
- Reception staff were not aware of General Data Protection Regulation 2016 (GDPR).

However we also found the following areas of good practice across all services:

- 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.

Summary of findings

- The service used safety monitoring results well. The service collected safety information and shared it with staff. Managers used this to improve the service.
- Staff cared for patients with compassion. Feedback from patients confirmed that staff treated them well and with kindness.
- Staff provided emotional support to patients to minimise their distress.
- Staff involved patients and those close to them in decisions about their care and treatment.
- The service assessed nutritional states and provided food and drink to meet patient need.
- Staff assessed and monitored patients to see if they were in pain. Patients were asked to complete patient questionnaires upon discharge and through this pain relief was monitored post discharge.
- Staff followed policy and procedures on consent and on when a patient could not give consent.
- Staff of different kinds worked together as a team to benefit patients.
- The services took account of patients' individual needs.
- The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with all staff.
- The service collected, analysed, managed and used information well to support all its activities, using secure electronic systems with security safeguards.

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
Medical care (including older people's care)	Good	Medical care services were a small proportion of hospital activity. The main service was surgery service. Where arrangements were the same, we have reported findings in the surgery section. We rated this service as good overall because it was safe, effective, caring, and responsive and well-led.
Surgery	Requires improvement	Surgery was the main activity of the hospital. Where our findings on surgery also apply to other services, we do not repeat the information but cross-refer to the surgery section. Staffing of wards was managed jointly with medical care. We rated this service as requires improvement overall and inadequate in safe, requires improvement in well-led and good in each domain of effective, caring and responsive.
Services for children & young people	Requires improvement	Children and young people's services were a small proportion of hospital activity. The main service was surgery. Where arrangements were the same, we have reported findings in the surgery section. We rated this service as requires improvement because, responsive and well-led required improvement, although safe, effective and caring were good.
Outpatients	Good	We rated this service as good overall because it was safe, caring, and responsive and well-led. We do not rate the effective domain in outpatients.

Summary of findings

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Requires improvement

BMI The Kings Oak Hospital

Services we looked at
Medical care (including older people's care); Surgery; Services for children & young people; Outpatients

Summary of this inspection

Background to BMI The Kings Oak Hospital

BMI The Kings Oak Hospital in Enfield, London is operated by BMI Healthcare Limited and opened in 2011. The hospital has 47 beds and is located in the grounds of Chase Farm Hospital in Enfield.

The hospital provides a range of services including surgical procedures, surgical and medical inpatient care, outpatient consultations and diagnostic imaging. There are two operating theatres, 12 outpatient consulting rooms, and a minor procedures room, minor treatment room and phlebotomy room.

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

Our inspection team

The team that inspected the service comprised a CQC lead inspector, five CQC inspectors, and a range of specialist advisors with expertise in the areas we were inspecting. The inspection team was overseen by Terri Salt, Head of Hospital Inspections.

Why we carried out this inspection

We carried out this inspection as part of our independent hospital inspection programme. We 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 Kings Oak Hospital

BMI The Kings Oak Hospital provides a wide range of services. Surgical services are a significant proportion of hospital activity. The shared medical and surgical ward is comprised of 42 beds and these services were provided by medical consultants with practising privileges, a resident medical officer (RMO), nurses, health care assistants, a pharmacist, allied health professionals and administrative assistants.

BMI The Kings Oak Hospital offers both day case and outpatient paediatric services for private patients. Children aged three years upwards are seen in the outpatient's department and can be admitted for day case procedures. Acorn ward is a four bedded unit designated to children and young people aged between three and 15 years old who are admitted for day case procedures. Young people aged 16 to 17 years could be treated on the adult pathway overseen by the lead paediatric nurse.

Summary of this inspection

The outpatient department is comprised of 12 consulting rooms with a dedicated treatment and minor procedure room. Consultants see patients across a broad range of specialities supported by a team of nursing and healthcare assistant staff. There is multidisciplinary team support that includes pharmacy, physiotherapy, phlebotomy and infection control. A sister BMI hospital is located a mile away and the same hospital leadership team manage both hospitals. Both outpatient teams reported to one outpatient manager who works across both sites.

The hospital is registered to provide the following regulated activities:

- Surgical Procedures
- Treatment of disease, disorder or injury
- Diagnostic and Screening procedures

During our inspection, we visited themedical and surgical ward,the outpatient department, theatres and recovery and we visited areas of the hospital where children and young people are seen and treated. This included Acorn ward, the outpatients and imaging department, minor operations room and phlebotomy room.We spoke with approximately 40 members of staff, including: senior managers, reception staff,nursing staff, allied health professionals, consultant physicians, resident medical officer, a pharmacist, health care assistants (HCAs), operating department practitioners and ward clerk administrators. We also spoke withfour patients and relatives on Hadley and Ridgeway ward. We spoke with two parents of children and young people being treated at the hospital. We observed interactions between patients and staff. In addition, we considered the environment and looked at records, including 20 patient records. Before and during our inspection we also reviewed performance information about the service.

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

Activity (March 2018 to February 2019)

- The top three surgical procedures performed during the reporting period were injections or aspirations of joints, cysts or bursas under guided imaging (1435 procedures), dorsal root ganglion block (245 procedures), and ultrasound guided biopsies (210 procedures).The inpatient case mix on the wards were approximately 40% orthopaedic, 20% gynaecology, 5% urology, medical patients (2%) and the rest were miscellaneous.
- There were 68 patients between the age of three and 17 years treated for day case surgery at the hospital. There had been one patient aged 16 to 17 years old who had been treated as an inpatient. Within the same period there were 1,622 outpatient attendances for children aged between three and 17 years.
- Between January and December 2018, outpatient attendances (first attendances and follow up attendances in the time period) totalled 35,998. The proportion of outpatient activity broken down by speciality is as follows: orthopaedics 25%, oncology 11%, pain management 10%, general surgery 8%, oral maxillofacial 3%, general medicine 5%, rheumatology 4%, urology 10%, ear nose and throat 6%, ophthalmology 3%, dermatology 5%, gynaecology 8% and plastic surgery 2%.

The hospital provided practicing privileges for 320 doctors and dentists. The hospital employed 23 registered nurses,17 healthcare assistants and operation department practitioners and 54 other hospital staff.

Track record on safety:

- No Never events
- Clinical incidents (January 2018 to December 2018): there were 225 clinical incidents reported;175 were categorised as no harm, 48 were categorised as low harm, two were categorised as moderate harm and none were categorised as severe harm or death.
- There were no serious injuries reported from January 2018 to December 2018.
- There was one incident of hospital acquired E. coli. There were no incidents of hospital acquired Meticillin-resistant Staphylococcus aureus (MRSA), Meticillin-sensitive Staphylococcus aureus (MSSA) or Clostridium difficile (C. diff).

Summary of this inspection

- From March 2018 to February 2019, the provider received 60 complaints.

Services provided at the hospital under service level agreement:

- Pathology
- Histology

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?

Requires improvement

We rated safe as requires improvement because:

- Although staff completed and updated risk assessments for patients on the ward, not all staff were fully engaged with best practice processes for safer surgeries. Some staff did not always follow procedures for safer surgery in theatres and other staff did not challenge poor behaviours.
- We observed that staff were not always bare below the elbow in clinical areas and that clinical waste was not always disposed of properly.
- Although the service had recently refurbished some areas, other areas of the environment continued to require improvement. There continued to be challenges around space in the theatre environment.
- There was no clear accountability for responsibility of fluids being in date and at the right temperatures in the fluid warming cabinet in theatres.
- Mandatory training compliance was low for paediatric basic life support (PBLS) and paediatric intermediate life support (PILS) hospital wide. However, children's nurses within the CYP service were trained in PILS and were available when children and young people accessed the hospital
- Equipment storage in the paediatric resuscitation trolleys was not in standard order. Information folders held on the trolleys was disorganised and contained varying contents in different areas of the hospital.
- Where paediatric warning scores were escalated, there was no evidence of actions taken documented within patient records.
- Some aspects of equipment and premises did not meet hygiene standards. This included the resuscitation trolley, the treatment room, the clean utility room fridge, the phlebotomy room, the minor operations treatment room and the urology waiting area.
- Although the service had suitable premises and equipment there were maintenance issues on wall fixings, treatment room trolleys and some PAT testing. There were no aprons available in the phlebotomy room.
- Although the service followed best practice most of the time, we found some issues with the storage of medicines. Resuscitation trolleys were not in a temperature controlled area as advised by the pharmacist due to the storage of medicines on them. Both were kept in the corridor beside a radiator.

- The store cupboard contained a small amount of stock that required temperature monitoring at below 25 degrees. The room was warm and no temperature checking was taking place.
- Mandatory training was below the hospital target for the inpatient ward staff (79%) and lowest among the medical service.

However, we found the following areas of good practice:

- 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.
- Safeguarding procedures were in place to protect children and young people from harm.
- Pre-assessments were completed for each child and young person being admitted to the hospital so that any risks were identified.
- Admissions were planned so that registered children's nurses were available when children and young people (CYP) were seen at the hospital.
- Staff were aware of their responsibilities to report incidents and lessons learnt were shared.
- Records in the outpatient department were clear, up-to-date and easily available to all staff providing care.
- On the wards, the service had effective governance arrangements to ensure safe storage of medicines, fridge temperatures were checked daily and out-of-date medicines were replaced, when required. The arrangement of disposal of controlled drugs had improved and now carried out in a timely way.
- The hospital had undertaken regular reviews of the operating theatres which showed compliance with good practice.

Are services effective?

Good

We rated effective as good because:

- The services provided care and treatment based on national guidance.
- Staff assessed and monitored patients regularly to see if they were in pain.
- Managers monitored the effectiveness of care and treatment and used the findings to improve them.
- Staff of different kinds worked together as a team to benefit patients.

- There was an adequate amount of multidisciplinary team support that included pharmacy, physiotherapy, phlebotomy and infection control. We observed positive working relationships between nursing, medical and allied health professional staff.
- Some support services also ran on a Saturday when other outpatient clinics were running.
- Staff understood how and when to assess whether a patient had the capacity to make decisions about their care.
- BMI Children and Young People's (CYP) policy was written in line with best practice and care was provided based on the Royal College of Nursing (RCN) guidelines
- The nutrition and hydration needs of all patients were managed well.
- Pain was assessed regularly and appropriately. A new child friendly pain scoring tool was being developed by the service.
- Consent was documented consistently within patient records, and staff understood their responsibilities in relation to Gillick competence.
- The hospital had taken note of concerns raised about the medical service at the previous inspection and made improvements in the areas of staff competencies and governance around the clinical supervision of the resident medical officers.
- The service made sure staff were competent for their roles and supported by their managers to maintain their professional skills and experience. Staff told us they had good access to study days and external training to ensure they were competent for their role. The resident medical officers (RMO) now had regular supervision and annual appraisals through their agency.

However:

- The hospital wide audit schedule included documentation and pain management audits, however these were not specific to the children and young people's department.
- There was a lack of health promotion material specific to children and young people on Acorn ward and within other areas within the hospital where children and young people were seen.
- Not all staff had received an annual appraisal. Current appraisal rates for nursing staff were 75% which was below the hospital standard of 90%.

Are services caring?

We rated caring as good because:

Good

Summary of this inspection

- Staff cared for patients with compassion. Feedback from patients confirmed that staff treated them well and with kindness.
- Staff provided emotional support to patients to minimise their distress.
- Staff involved patients and those close to them in decisions about their care and treatment.

Are services responsive?

Good

We rated responsive as good because:

- The service planned and provided services in a way that met the needs of local people.
- At the last inspection we found there was access to an interpreter service for patients whose first language might not be English, but we observed and were told that relatives were used instead. At this inspection we found that relatives were not accepted to be used as interpreters.
- The service took account of patients' individual needs. Identifying individual need was part of the assessment process. The triage process identified individual needs such as dementia, learning disability or the need for an interpreter. A loop recorder was available at reception to support patients with hearing impairment.
- People could access the service when they needed it.
- In the outpatient department, waiting times from referral to treatment were in line with good practice. The NHS 18 week referral to treatment key performance indicator target was 92% and the service currently stood at 95%.
- There was a team of staff who ensured files were available for appointments.
- The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with all staff. We were given examples where the service had learned from complaints. Patients told us that when something was not to their satisfaction and they raised it with staff, the response was constructive and helpful.
- Nursing staff discussed individual needs during the pre-assessment and made adjustments where possible.
- Staff catered for religious and dietary needs of adults and children and young people, and their families using the service.

However:

- There was no designated waiting area for children in the outpatient's department. Children, young people and their parents and carers were seated within the main area along with other adults.

Summary of this inspection

- Areas within the hospital where children and young people were seen lacked a child friendly environment and atmosphere.
- The en-suite bathrooms were not accessible for patients who used a wheelchair as there was no specialist equipment available to use the bath or toilet.
- There was a lack of child friendly or easy read information available within the hospital.
- Waiting times in the outpatient department continued to be a problem. At this inspection patients told us that waiting beyond appointment times was common, often for long periods of up to an hour.

Are services well-led?

Requires improvement

We rated well-led as requires improvement because:

- Although most managers across the service promoted a positive culture that supported and valued staff, we found there were areas requiring improvement in theatres for creating a culture of safety and supporting staff to challenge poor practice.
- Although the service had systems to identify risks, plans to eliminate or reduce them, and cope with both the expected and unexpected, we found in theatres these were not always put into practice, especially in attentiveness of staff with the WHO checklist.
- Although the service had systems in place to improve service quality, in practice we found that these systems were not always effective.
- There was no formal monitoring of the objectives and priorities set out in the five-year plan for the children and young people's service by the senior management team.
- Staff spoke about making improvements within the children and young people's service, however there were no action plans in place to demonstrate how these would be achieved.
- There was no medical representative on the corporate children and young people's committee or the resus committee held within the hospital.
- No risks were recorded on the risk register for children and young people, despite staff identifying risks at the time of our inspection.
- Patient satisfactory forms were available for children and young people, their parents and carers to provide feedback about their care and treatment. However, there was no audit of the feedback provided for children and young people up to the age of 16 years.

Summary of this inspection

- Reception staff were not aware of General Data Protection Regulation 2016 (GDPR).
- At the last inspection we found that not all staff were positive about their local leadership. At this inspection managers looked to promote a positive culture that supported and valued staff. However, recent staff survey results showed that bullying and harassment was still an issue. The results were not broken down by staff site or speciality, so they were unable to identify where the issue was located. The leadership team said they planned to work with staff to address the issue, and that it had improved slightly since the last survey.

However, we found the following areas of good practice:

- The service collected, analysed, managed and used information well to support all its activities, using secure electronic systems with security safeguards.
- The service worked to good information governance processes. Patient notes were held securely by the hospital and the hospital strongly discouraged the removal of hospital medical records from the site in all circumstances. Secure NHS.net accounts were given to NHS bookings team who received the NHS referrals.
- The service had a vision for what it wanted to achieve and workable plans to turn it into action, which it developed with staff and patients.
- The children and young people's service were managed by the lead paediatric nurse who planned for and cared for children and young people throughout departments within the hospital. They were passionate and committed to their work, and had the appropriate skills and experience for the role.
- Staff within the service were enthusiastic and dedicated to their work with children and young people within the hospital.
- There was a process in place for staff to identify poor practice and raise the issue with the provider who had an improvement process in place.
- The hospital had taken note of concerns raised about the medical service at the previous inspection and made improvements in the areas of leadership, governance and managing the risk register.

Detailed findings from this inspection

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Medical care (including older people's care)	Good	Good	Good	Good	Good	Good
Surgery	Inadequate	Good	Good	Good	Requires improvement	Requires improvement
Services for children & young people	Good	Good	Good	Requires improvement	Requires improvement	Requires improvement
Outpatients	Good	Not rated	Good	Good	Good	Good
Overall	Requires improvement	Good	Good	Good	Requires improvement	Requires improvement

Good

Medical care (including older people's care)

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

Are medical care (including older people's care) safe?

Good

Mandatory training

The medical care service provided mandatory training in key skills such as basic life support, intermediate life support, blood transfusion, moving and handling and safeguarding to all staff on a rolling annual programme via e-learning modules or face-to-face sessions in the hospital. Staff understood their responsibility to complete mandatory training. Staff told us they received BMI certificates for completed training.

- The hospital set a target of 90% for completion of all mandatory training courses. The hospital data showed an overall 90.4% compliance for the medical service which was better than the hospital target and an improvement from the last inspection (74%). The hospital reported an overall 96.1% compliance for the oncology ward, 96.2% for the endoscopy unit and 79% for the wards. Senior managers told us training compliance had improved and it was one of the hospital 2018 key successes from their improvement plan.
- The annual adult basic life support mandatory training showed 100% compliance in oncology and 63% compliance on the wards. The annual immediate life support compliance was 100% on the oncology ward and while the ward staff achieved compliance with three staff in progress of completing their training.
- Staff told us they received a reminder from the human resource (HR) department for their due mandatory training and were given protected time to complete their training. They also said if they asked their managers to attend other training or learning sessions, the senior nurse and managers worked to accommodate their request.
- Temporary and locum staff were required to provide evidence of mandatory training compliance from their employers.
- Consultants and clinicians with practising privileges were not required to complete training via the hospital system but assurance of mandatory training was checked by the medical advisory committee.
- The resident medical officers (RMOs) were managed via an external employment agency which they received mandatory training from. They had access to the hospital on-line training system.

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.

- The hospital had appropriate systems, processes, and practices to safeguard patients from avoidable harm, abuse and neglect that reflected relevant legislation and local requirements.
- Staff told us they had access to the hospital's safeguarding policy through the hospital intranet and knew how to access the safeguarding team for advice and guidance when required. Staff had good

understanding on safeguarding issues including modern day slavery, human trafficking, and female genital mutilation (FGM). They knew how to raise or report safeguarding concerns.

- Service had a safeguarding lead and staff we spoke to knew who they were. They felt supported by the safeguarding team with the safeguarding concerns and queries they had escalated to them.
- For the period of April 2018 to March 2019, the hospital reported one safeguarding incidents across the hospital's department that required a safeguarding referral to the local authority.
- Safeguarding was part of the hospital's annual mandatory training which included safeguarding vulnerable adults 1 and 2, and safeguarding children 1 to 4. The hospital target for safeguarding training was 90%. The overall safeguarding training compliance for all medical care staff in the oncology ward and endoscopy unit was 100%. The ward staff achieved 100% compliance on safeguarding vulnerable adult's level 1 and 2 training, 96.7% on the safeguarding children level 2 training and vulnerable adults level 1 training. Staff achieved 86% on the safeguarding children level 3 training. This was an improvement from the last inspection.
- Staff were also required to complete other additional safeguarding training as part of their mandatory training. Staff achieved 98.9% on the 'protecting people at risk of radicalisation' (PREVENT) training and 94.3% compliance on the FGM training.

Cleanliness, infection control and hygiene

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

- The medical wards and communal areas appeared tidy and visibly clean at the time of inspection. At the last inspection we had concerns on the storage and monitoring of cleaning of equipment and carpets in the clinical areas, hand hygiene, and the lack of storage and segregation of space area in the pharmacy department. During this inspection we saw improvement and all the concerns had been addressed by managers.
- We saw cleaning schedules for the medical ward areas and equipment. 'I am clean' stickers were in use in all the medical areas visited to indicate when equipment was cleaned and if it was ready for use.
- The service had an infection prevention and control (IPC) team that met monthly to discuss any IPC concerns, review IPC risks and address issues identified at the previous inspections. We reviewed the IPC meeting minutes and saw the IPC risk register was reviewed regularly at the meetings. The hospital had an IPC lead nurse who was supported by the director of clinical service and consultants and staff knew how to access them for support.
- During inspection, we observed there were no clinical sinks in some of the patient rooms for staff to use to wash their hands in line with the HBN inpatient guideline. The risk had been identified by staff and mitigated through using hand gel. Staff could also wash their hands in the sinks outside patients' rooms on the corridor. We saw this risk and issue had been escalated and discussed at various governance meetings. The installation of new hand sinks was part of the hospital on-going installation programme due to be completed by June 2019. We noted 29 hand washing sinks had been installed across the hospital during the inspection period. Following the inspection, we noted that the hospital was at the final stage of completing the clinical sinks across the hospital.
- The service provided staff with personal protective equipment (PPE), to prevent and protect people from a healthcare-associated infection. Staff adhered to the hospital's 'arms bare below the elbow' policy to enable effective hand washing and reduce the risk of spreading infections. We observed posters on 'go bare below the elbow', sepsis and six steps to hand hygiene were displayed on the medical wards.
- There was access to hand washing facilities, hand sanitiser and a supply of PPE, which included sterile gloves, gowns, and aprons, in all areas. Staff applied hand sanitising gel when they entered clinical areas. We observed staff disinfected their hands between patient contact, in accordance with national guidance (National Institute for Health and Care Excellence (NICE) Infection prevention and control: QS61).

Good

Medical care (including older people's care)

- The November 2018 IPC hand hygiene audit showed an overall 97% compliance on the standards audited. We saw the service had an IPC work plan with the actions mostly completed or on-going.
- Patient we spoke to told us their room had been regularly cleaned by the housekeepers and they have observed staff washing their hands regularly and using appropriate PPE. Patients comments included; "room was clean and sterile", "well equipped and clean room", "cleanliness was exemplary".
- The hospital took part in the 2018 patient led assessments of the care environment (PLACE) audit. The hospital scored 98.2% for cleanliness which was similar to the national average of 98.5%. The hospital scored 88.2% for environment's condition, appearance and maintenance, which was below the national average of 94.3%. The hospital had an on-going refurbishment plan to improve the hospital environment.
- Cleaning of the medical ward areas was scheduled daily and in between patient's discharge or transfer. Staff also requested the deep cleaning of rooms or bed areas if a patient had Methicillin-resistant Staphylococcus aureus (MRSA) or an infected wound.
- The inpatient rooms were single occupancy and therefore no additional isolation was required. Staff used isolation signs on the wards to advice staff and patients when isolation or precautions were needed.
- The service carried out regular water quality testing for gram-negative bacteria (coliforms), E.coli, pseudomonas and total viable count on the medical wards areas and the clinical hand washing sinks.
- For the period of March 2018 to February 2019 the hospital reported zero cases of MRSA, Methicillin-sensitive Staphylococcus aureus (MSSA), C.difficile and E.coli. However, in the hospital 2018 Quality account we noted there was one reported incidents of hospital acquired E.coli.
- The decontamination of endoscopy instruments in theatre was carried out in accordance with the Department of Health (DoH) guidance HTM 01-06. Staff we spoke with understood their responsibilities in this process. Staff told us the scopes for decontamination were transported to another BMI hospital close to BMI The Kings Oak with appropriate decontamination facilities.

Environment and equipment

The medical care service had suitable premises and equipment for patients who accessed the service and looked after them well.

- The service had processes to ensure equipment was maintained and tested for electrical safety, to ensure it was fit for purpose and safe for patient use.
- Since the last inspection, there had been refurbishment in the hospital and clinical areas. At the last inspection we had concerns around storage in the endoscopy room and pharmacy department environment. During this inspection we noted endoscopy procedures were carried out at the hospital sister site at Cavell and any endoscopy procedures undertaken in the hospital were carried out in theatre as part of a surgical procedure. The pharmacy department had been moved to a new location within the hospital which was compliant with the Department of Health: Health Building Note 14-01. Staff we spoke to were happy and proud of the improvement in the hospital environment particularly around the new floors which was in line with national guidance. We saw the carpet floors had been replaced with new wooden floors, which was highlighted as part of the hospital key success in 2018. The air conditioner and heating were still an on-going issue and managers had received funding to replace this.
- The inpatient and clinical facilities were designed in line with Department of Health (DoH) guidance HBN 04-01. The clinical sinks had been replaced as part of an on-going refurbishment in line with national guidance.
- The cleaning and decontamination of all reusable equipment for endoscopy procedure were all up to date and managed in line with the Department of Health HTM01-06 guidance.
- There was appropriate emergency equipment on the ward including resuscitation equipment, fire cylinder, fire blankets, defibrillator, emergency eye wash, oxygen cylinder and cardiac arrest. The service had systems to ensure emergency equipment was checked daily and records confirmed staff completed these checks as required. We checked a range of consumable items from

the resuscitation trolley, including syringes, airways and naso-gastric tubes and emergency medicines and noted they were all were in-date. All resuscitation trolley drawers seen were secured with a tamper evident tag.

- We saw staff completed checks in the patient's bedroom to ensure they were readily available and safe to use during emergencies. These checks included assessment of the oxygen, suctions, call bells and drip stands.
- There were arrangements to safely manage waste and clinical specimens. Waste was handled appropriately with separate colour-coded arrangements for general waste, clinical waste, and sharps. We observed general, sharps and clinical waste bags were changed frequently by staff. Staff used sharps bin appropriately and these were not overfilled, dated, and signed by staff in a timely manner.
- All Control of Substances Hazardous to Health (COSHH) items in all the medical ward's areas were locked and labelled appropriately to prevent or reduce staff and patient exposure to substances that are hazardous to their health. This was in line with the Health Regulations 2002 regulations and hospital policy.
- The service had a plan for the 2018/19 influenza (flu) vaccination programme for staff to minimise the risk of cross infection. The hospital reported 55% of clinical and non-clinical staff have had their flu jab. There was no target for the completion of flu jab.

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.

- Staff completed regular risk assessments to assess patients during admission and ward rounds using national risk assessment tools in areas such nutrition, falls risk, medical history, mental health history, skin integrity, social needs, high blood pressure, MRSA, venous thromboembolism (VTE), diabetes and high body mass index (BMI). VTE is a condition in which a blood clot forms most often in the deep veins of the leg, groin, or arm. This was confirmed in the patients' records we reviewed.
- We reviewed patient records during inspection, which showed evidence of risk assessments such as blood borne virus, IPC infection risk assessment tool, smoking assessment, urinary catheter, National Early Warning Score (NEWS), falls, MRSA screening, VTE, sepsis assessment and care plans seen in patients' notes. We also saw evidence of combined risk assessment by multidisciplinary team (MDT) staff, fluid balance and anaesthetic records.
- All medical patients were triaged using a pre-admission medical screening tool. Patients were also individually risk assessed during admission and their treatment to ensure that treatment plans were tailored to their needs. We saw staff frequently assessed patients during their procedures such as endoscopy.
- We saw staff gave patients and "alert card' for non-vitamin k anticoagulant which they are always required to carry due to the risk of bleeding and patients on vitamin k should be stopped before endoscopy or invasive procedures.
- There was a process to ensure resident medical officers (RMOs) were involved in the admission of patients, which ensured patients were seen quickly and risks were identified and addressed. Nursing staff informed the RMO immediately of patient admission and the RMO would assess patients within 30 Minutes. Staff told us RMOs were normally part of the admission process. All patients were further reviewed within 12 hours of admission in line with the hospital policy.
- The hospital had a hospital admission policy that outlined the admission criteria and out of hours admission. All patients were admitted to the medical service under the care of a named consultant. There was an out of hours decision support tool that guided staff on the admission criteria, ensuring patient had a detailed medical report for admission and having the appropriate staffing and skill mix to ensure safe admission and reduce patient risk.
- Out of hours patients were able to phone the inpatient ward nurses for advice.
- Staff received training on emergencies such as fire emergencies, blood transfusion and cardiac arrest. The annual adult basic life support mandatory training showed 100% compliance in oncology and 63% compliance on the wards. The annual immediate life support compliance was 100% on the oncology ward and while the ward staff achieved compliance with three staff in progress of completing their training.

Good

Medical care (including older people's care)

- The hospital carried out regular resuscitation scenarios and held a twice-daily resuscitation huddle for staff. Staff we spoke told us they also had regular fire drills.
- We saw there were systems to advise staff of patients that were not for resuscitation. Staff we spoke to were aware of the do not attempt cardio-pulmonary resuscitation (DNACPR) process and its implication to practice
- The service used the National Early Warning Score (NEWS), designed to allow early recognition and deterioration in patient by monitoring physical parameters, such as blood pressure, heart rate and temperature. During inspection we observed nursing staff used the NEWS and knew the threshold for escalation to the RMO. The RMO were available on the wards and ensured prompt identification and managing of deteriorating patients. Staff also carried out further investigations such as blood tests as required. Staff told us there have been improvement in staff competency on NEWS score and managing deteriorating patient.
- The hospital December 2018 NEWS audit showed 100% compliance on the standard audited. During inspection we observed displayed posters which prompted staff to ensure the NEWS score were completed and calculated accurately. This was an improvement from the last inspection.
- Staff we spoke to told us they carried out regular clinical observation to ensure patient safety and recovery.
- Staff received training on sepsis and we saw posters of sepsis six (management of sepsis that usually involves three treatments and three tests) and escalation using the internal emergency service during inspection. There was information on the wards that had contact details for emergencies that staff could call where there concerns including out of hours.
- The hospital 2018 VTE audit showed 100% of patients were assessed on admission which was a 18.2% increase from the 2017 audits. The hospital reported one hospital acquired VTE in the last 12 months. The hospital holds a VTE exemplar centre status by the Department of Health and Social Care.
- The hospital reported four unplanned transfer to another hospital due to deterioration, clinical complication or emergencies and zero unplanned re-admissions to the service for the period of January to December 2018. We noted that one of the patient transferred to a local NHS hospital was a medical patient who had an endoscopy procedure.
- The endoscopy service used the World Health Organisation (WHO) safety checklist for patients throughout the perioperative journey, to prevent or avoid serious patient harm during their procedure. This was in line with national recommendations (NPSA Patient Safety Alert: WHO Surgical Safety Checklist). The hospital WHO surgical safety checklist audits carried out in December 2018 showed 90% overall compliance. From observation and records reviewed we saw WHO checklists were fully completed by staff.
- Staff were required to complete an e-learning training on aggression to manage patient risk and risks to themselves. Staff we spoke to told us they rarely experienced violence and aggression from patients, however when this occurred they knew how to manage the situation and risks.
- During inspection we observed displayed resuscitation flow chart, sepsis screening tool, and shock and bradycardia algorithm guidance on the wards which advised staff on process to take during clinical emergencies.
- We saw the service responded appropriately following risks identified from audits and incidents reported. For example, following three recent patients falls on the wards, posters were now displayed on the wards which encouraged and reminded patient to use their call bell to call for support if they need to mobilise after surgery to prevent falls. Findings from the falls incidents had identified that some patients felt they were strong to mobilise independently post-surgery or did not seek for staff help when needed.

Staffing

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

- The hospital used the BMI Healthcare nursing staffing planner tool to determine staffing levels. The regular staff to patient ratio was 1:6. Senior staff used the tool to allocate staff in advance based on pre-determined

nursing demand and acuity of patients. The day unit staffing requirement was determined by the number of hours each patient would be in the unit. The ward sister prepared the staff roster two weeks in advance and it was reviewed at the daily communication meeting. Staff we spoke with said there was sufficient staff to meet acuity.

- During inspection we saw the required and actual staffing were displayed on the wards which reflected the acuity on the wards. Temporary staff were also used to achieve safe staffing levels.
- For the period of December 2018 to February 2019 the hospital reported all shifts were filled and achieved it by use of permanent and temporary staff.
- For the period of December 2018 to February 2019, the average number of shifts covered by temporary staff was 6.8% which was better than the previous inspection average of 10.4%. Data provided by the hospital showed bank staff were regularly used rather than agency staff to ensure they were familiar to the clinical area. The bank to agency staff ratio was 1.8 to 1. This is an improvement from the last inspection.
- The average use of bank and agency staff for nurses for the period of March 2018 to February 2019 was 2.8% for nurses and 1.8% for the health care assistant (HCA). This was an improvement from the last inspection where temporary staff useage accounted for 16.5% for the HCAs and 4.3% for nurses. The staffing ratio of nurses to HCA was 2.3 to 1 within the same period.
- Staff told us the hospital had a process for managing the bank and agency staff to ensure they were able to meet the requirements for patients on the wards and specialist wards.
- The hospital staffing for the inpatient wards as at March 2019 was 16 fulltime equivalents (FTE) for the nurses and 7FTE for the HCAs. The hospital reported 54.4FTE for other clinical and non-clinical staff across the hospital.
- During inspection, there were two trained nurses and three HCA on duty. The nursing staff can be two to three on each shift depending on acuity. Staff told us acuity may change depending on the age and independence of patients admitted on the ward. The nurse sister would request for additional staff when they had more patient admitted as day cases or endoscopy procedure
- For the period of March 2018 to February 2019 the hospital reported there was no staff turnover in the service. Staff told us they had good turnover rate and people had worked in the service for a long time.
- The average sickness rate for period of March 2018 to February 2019 was 0.9% for nurses and 2.4% for the HCAs.
- During inspection, there were two vacancies each for the HCA and nursing staff and this post have been advertised for according to senior staff. Staff we spoke told us they were well staffed, worked flexible hours and had very low staff turnover. There was not a high usage of bank and agency staff.
- A senior nurse was in charge as a contact point for staff, consultants, and patients 24 hours a day, seven days a week and we noted the wards were well staffed.
- There was a dedicated fulltime physiotherapist on the ward who worked Monday to Friday, 9am to 5pm. The hospital also had a part time physiotherapist who covered weekend shifts.
- The hospital had two receptionists who covered the inpatient wards.

Medical staffing

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

- Consultants worked under practising privileges agreements in the service. Under practising privileges, a medical practitioner is granted permission to work within an independent hospital. The medical advisory committee (MAC) was responsible for granting practice privileges and was overseen by the medical director. Consultants with practicing privileges had their appraisal and revalidation undertaken by their respective NHS trusts. Staff we spoke to told us the process for managing practice privileges and consultant’s’ scope of practice was robust.
- The hospital reported no suspension, removed practice privilege, or supervised practice of medical staff in the last 12 months before the inspection.
- The service had anaesthetists who covered the wards and the endoscopy procedures in theatre. There was no

formal rota for on call consultant surgeons or physicians. The relevant staff would be contacted directly by staff when needed. Staff told us this arrangement worked and no concerns identified.

- The RMOs were provided under contract with an external agency that provided training and support. The RMOs provided 24-hour 7 day a week service on a two-week rotational basis. Senior staff told us the RMOs were selected specifically to enable them to manage a varied patient caseload and particular requirements. The hospital had two inpatient RMOs who rotated for at least six months to ensure continuity of care. The resident medical officer (RMO) provided day to day medical service and dealt with any routine and emergency situations in consultation with the relevant consultant. Out of hours, consultants provided either telephone advice or attended in person.

Records

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

- The hospital used paper and electronic system to record patient needs and care plans, medical decision-making, reviews, and risk assessments.
- Staff told us all patient notes were kept securely in the hospital following discharge and doctors could have copies of the patient discharge letters.
- Staff had access to the BMI clinician app through a remote log in that allowed real time information to the clinic list, theatre list, booking request and individual patient view information. Staff we spoke told us they had timely access to patients record on the wards and theatre for the endoscopy procedures.
- The hospital data showed all patients were seen by staff with their records readily available in the last three months before inspection.
- We saw staff stored patient records securely, and when electronic records were not in use staff logged off their computer.
- We looked at seven sets of patient records and their prescription charts during inspection. Staff documentation on patients' records was concise, legible, and written in accordance with the NMC record keeping guidance. There was evidence of discussion and collaboration with patients and their relatives by the MDT staff. Staff carried our risk assessments and reviewed patients' past medical history on the patients notes reviewed. We saw evidence in patients' records staff had completed the safety checks undertaken during an endoscopy procedure using the World Health Organisation (WHO) 'Five Steps to Safer Surgery.
- The hospital undertook monthly audits of patient's health records, which included monitoring of risk assessments such as falls and pressure areas. The health record documentation December audit in 2018 audit showed an overall 81% compliance on the four standards audited. Staff achieved 90% compliance on the WHO checklists, 80% on the general standards, 79% on the clinical risk assessments and 70% on the pharmacy prescription chart on allergies and weight standard.
- Information Governance was part of the mandatory training programme which all staff were required to attend.

Medicines

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

- The service had robust systems for the management and reconciling of medicines in line with national standards and guidelines. The service carried out several audits of medicines to identify and address safety issues, improve patient outcomes and to offer support to staff.
- Staff were provided with several policies and guidance on medicines management such as the post-operative analgesia prescribing and administrative guidance.
- There was effective process for managing controlled drugs (CDs) and emergency medicines. CDs were stored securely and managed appropriately. CDs were checked daily by two nurses and appropriate records were maintained. We saw controlled drugs were stored, destroyed and managed appropriately. CD medicines reconciliation was completed and recorded while identified areas of discrepancy were actioned and processes were audited.

- At the last inspection we had concerns CDs were not disposed of in a timely manner and during this inspection we saw this had been addressed and no delays were identified.
- At the last inspection we also had concerns around the governance arrangement of the CD signatories. At this inspection, the pharmacist had an up to date signature off all staff who had access to CD including the pharmacy, imaging, theatres, and medical ward staff.
- Since the last inspection, the pharmacy department had moved from the outpatient department and relocated into to suitable and appropriate premises with adequate equipment on the lower ground floor. This was an improvement from the last inspection.
- Medicines were also stored in locked fridges and trolleys within locked clinical treatment rooms and only relevant clinical staff could access them. During inspection we observed all medicines stocked on the wards were managed safely. There was system on the wards which alerted staff through a red flashing light signal when the medicines room was opened and unsecured.
- All medicines stored in the fridge and cupboards were all in date. We also saw emergency medicines were available on the wards and regularly checked by staff.
- Medicines were supplied by the onsite pharmacy staff. Staff ordered, dispensed, and disposed of medicines safely and securely. There were effective arrangements to facilitate medicines supplies and advice out of hours. Clinical pharmacy services were available every day from 9am to 5pm and the RMOs had permission to access the pharmacy out of hours to obtain any medicines which wards had run out of. There were also labelled pack of to take away (TTA) medicines on the ward which were dispensed by the nurses and checked by RMO during out of pharmacy hours. Nursing and medical staff were required to complete patient details and name of the medicines dispensed in the TTA book on the wards which would be reviewed by the pharmacist the next day.
- Staff told us the pharmacy team were visible, accessible and a valuable resource in identifying issues with medicines and encouraging improvement. Staff told us the pharmacists always double-checked prescriptions to reduce the chance of error or side effects, and they explained medicines information to patients. In all the areas we inspected there was good clinical input by the pharmacy team, providing advice to staff and patients, and making clinical interventions with medicines to improve patient safety. The pharmacists also counselled patients on how to take their medicines at discharge with leaflets given.
- Arrangements were in place to ensure medicines incidents were reported, recorded, and investigated and staff we spoke with knew how to report incidents involving medicines. Staff knew how to report medication errors. For the period of 1 November 2018 to 28 February 2019 there were three medicines incidents which were all related to controlled drugs error. The themes included legibility of record and the calculation of supply, administration and wasted record. The pharmacist staff also discussed and shared medicines incidents themes to MDT staff across the hospital or in UK at team meetings.
- The service carried out a range of nine medicines audits to assess how they were performing, and to identify areas for improvement. These included audits such as controlled drugs, missed dose, antimicrobial, medicines reconciliation, intervention monitoring, dispensing turnaround, and medicine management audit.
- The March 2019 missed dose audit showed 100% compliance against the three standards audited. The result showed staff recorded the reason for omission using an approved code and none of the omission related to a critical medicine.
- The April 2019 dispensing turnaround time audit for the TTO (to take out) showed an overall 15.8 minutes turnaround time which was better than their target.
- The March 2019 antibiotics audit showed 100% prescription were compliant with the local policy and had allergy status indicated. None of the infections were hospital acquired, the clinical indication was documented, and prescribers were contactable when needed. However, 20% antibiotics were prescribed according to antimicrobial sensitivity and only 30% of prescription stated the duration or review date of the antibiotics prescribed. The recommendation included prescribers to clearly indicate the treatment duration and review date of antibiotics and to undertake antimicrobial sensitivity prescribing rather than empirical treatment to be increased.

- The hospital carried out the medicine management audit in March 2019 to assess the safe and security of medicines. The result showed an overall 97% compliance against all standard audited. The areas of non-compliance related to indicating patient allergies, other items stored in the fridge and medicines preparations.
- The hospital carried out a pharmacy department base line service and process audit for the period of 2018/19 which assessed medicines management, environment, and risk assessments in the pharmacy department: the result showed an overall 90% compliance audit against the 124 standards audited. There were 13 actions in the action plans which were reviewed regularly and had been completed or on-going.
- The March 2019 hospital pharmacy intervention audit showed there had been four cases that required the pharmacist interventions, which had involved the nurses and RMOs. The interventions related to allergy not filled on each page, missing quantity of CD to be taken, risk of drug interaction and drug strength not indicated.
- The National Institute for Health and Care Excellence (NICE) guidance states 100% of patient should have an accurate drug history taken and medicines reconciled within 24 hours of admission. The March 2019 medicines reconciliation audit showed 89% compliance against four standards audited. Staff achieved full compliance on the prescriptions that had the medication history completed and documented at pre-assessment and the number of prescriptions the pharmacy team had completed the medicines history for. During inspection, we saw the pharmacists completed full medicine reconciliation for all patients on the medical wards within 24 hours of admission during weekdays.
- The hospital carried out an antimicrobial audit in February 2019 which showed 86% overall compliance against the 29 standards audited. We saw an action plan was and reviewed regularly to address areas of improvement.
- Fridge temperatures and clinical room ambient temperatures were monitored and recorded daily. During inspection we saw all fridge and room ambient temperatures were within the expected range. For example, the fridge temperatures were expected to be within the range of two to eight degree centigrade and during inspection we noted it was 4.4. Staff were compliant in the monitoring of the ambient and room temperature and the fridge temperature were regularly calibrated.
- We reviewed seven patient drug charts during inspection. Patients' allergies were recorded on prescription chart in line with NICE guidance. Patients regular medicines prescribed included the route, frequency, all signed by prescriber and no missed doses. Medicines that are taken when needed (PRN) all included frequency and maximum dose in 24 hours.
- Safety medicines leaflets were available and given to patients which included safe use of antibiotics contained its useage, allergies and side effects. The leaflets also contained unlicensed medicine, use of non-steroidal anti-inflammatory drugs (NSAIDS).

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.

- Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.
- From April 2018 to March 2019, the hospital reported no incidents which were classified as never events for medical care.
- For the period of April 2018 to March 2019 the hospital reported two incidents for the medical services. These incidents related to the deterioration and re-admission of patients within 28 days of discharge.
- The hospital reported 225 incidents reported for the period of January to December 2018 in all the services of which 78% were no harm, 21% low harm and 0.9% were categorised as moderate harm. No incidents were reported as leading to "severe" harm for the period of January 2018 to March 2019.

- The hospital reported one patient death in last 12 months before inspection and which was an expected death. There was no unexpected death reported in that period and staff told us all unexpected death would be investigated using a root cause analysis and findings would be reported under the clinical governance committee meeting. Findings from the death investigation would be shared with the patients and their family, staff, and the regional and corporate quality team. Unexpected death would also be discussed at the BMI regional quality assurance committee and their national clinical governance committee meetings.
- Since the last inspection, the hospital had introduced a new risk management electronic incident reporting system which was since December 2016. Staff told us this was to ensure all staff had access to reporting incidents and near misses. This was an improvement from the last inspection.
- The hospital had a monthly lesson learned workshop which was chaired by the risk and quality assurance team and where all MDT staff including housekeepers attended. Learning from incidents, risks and complaints were discussed and shared with staff. We reviewed three lesson learnt workshop bulletin which showed several examples of learning from incidents and complaints. This included the pharmacy team devising a chart of 'to take away' medicines and licensing requirement that staff could refer to if they need to dispense medicines out of hours. The hospital had introduced a reminder system for staff to ensure they check all necessary equipment needed for patients procedure or surgery where available a day before admission to prevent last minute cancellations.
- Staff had good understanding of recent incidents that had occurred and had received feedback on reported incidents. Staff told us there was a no blame culture and they received appropriate support from colleagues and managers following an adverse incident.
- Senior managers told us they had a good incident reporting culture and the hospital had an action tracker to monitor all incidents reported and been investigated.
- The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain 'notifiable safety incidents and provide reasonable support to that person, under Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.
- For the period of 2017/18 there were four reported incidents that required duty of candour in the hospital. We noted meetings were held with patients and their relatives to discuss what had occurred along with treatment plans.

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.

- The safety thermometer is used to record the prevalence of patient harm and to provide immediate information and analysis for frontline teams to monitor their performance in delivering harm free care. It measured the proportion of patients that experienced 'harm free' days from pressure ulcers, falls, urinary tract infections in patients with a catheter and venous thromboembolism. Measurement at the frontline is intended to focus attention on patient harms and their elimination.
- Staff we spoke to were aware of their responsibility to reduce and reports incidents such as falls, pressure ulcers, urinary tract infection (UTI) relating to the use of catheters.
- During inspection, staff told us they had a patient fall few weeks before the inspection.
- We observed safety thermometer data were displayed in hospital areas which showed information about incidents and patient satisfaction.
- The hospital data showed the service reported there was no hospital- acquired pressure ulcers, VTE and UTI for the period of April 2018 to March 2019.
- The hospital 2018 VTE audit showed 100% of patients were assessed on admission which was a 18.2% increase from the 2017 audits. The hospital reported one hospital acquired VTE in the last 12 months.
- We saw that staff carried out risk assessments on patient falls, VTE and UTI in the patient records reviewed.

Good

Medical care (including older people's care)

Are medical care (including older people's care) effective?

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.

- The medical service had effective systems to ensure policies, protocols and clinical pathways were reviewed regularly and reflected national guidance and legislations.
- Guidelines were available on the hospital intranet and were updated and guided by the Royal College of PhysiciansRCOP), Royal College of Nursing and National Institute for Health and Care Excellence (NICE) guidance when reviewed. We saw the pharmacist used the NHS England controlled drugs (CDs) guidance to inform their practice. Staff we spoke to were aware of how to access their policies and guidance.
- The pharmacy team worked with a local NHS hospital pharmacy team to review their guidelines for antimicrobial guidance to ensure it is evidence bases, in line with best practice to improve patient safety and outcome.
- At the last inspection we had concerns on the end of life care provision and lack of a palliative consultant in post. During this inspection we saw the service no longer provided end of life care and would refer patients to hospices.
- The service used current evidence-based guidance and quality standards to inform the delivery of care and treatment patients. The hospital had an annual audit calendar which set out the audits to be undertaken across the hospital. The audits included patient health records, hand hygiene, VTE, hand hygiene, controlled drugs, and medicines management.
- Staff were informed of changes to national guidance and local policies and procedures through their newsletter, staff meetings, handovers, and various governance meetings.
- The main endoscopy unit has been moved to their sister hospital. The endoscopy procedure would only take place in the hospital as part of a surgical procedure in the theatre. The endoscopy service was not JAG accredited and had a scheduled visit in May 2019.

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.

- Staff screened and assessed patients' nutrition and hydration on admission, taking their cultural, dietary, and religious need in consideration, to ensure they were not at risk of malnutrition. Staff used the malnutrition universal screening tool (MUST) for assessing patients' nutrition. MUST was a nationally recognised method used to identify the risk level of each patient and this was documented in the set of notes we reviewed. We saw risks were identified staff referred patients to the dietitian service through a service level agreement.
- Staff gave advice and followed up patients where nutrition and hydration concerns were identified through their weight, blood result such as urea or appeared dehydrated. Where severe dehydration was identified the nurses liaised with the medical staff to prescribe intravenous (IV) fluids.
- Fluid and food chart were used to monitor patient input and output particularly following a surgical procedure.
- Patients had timely access to dietitians following referrals by medical or nursing staff.
- Patients' dietary requirement were communicated to staff including catering staff during handover and using signs in patients' rooms and yellow jugs on the ward. this ensured staff were aware of patients on restricted drinks or food or required assistance with feeding.
- Patient told us they were given adequate food and water regularly by staff and the food were of high standard, exemplary and very tasty.

- The hospital food was outsourced to catering company. The 2018 Patient-led assessments of the care environment (PLACE) showed the hospital scored 97.8% for the ward food which was better than the national average of 90.5%.

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.

- Staff used the numeric or smiley face pain score to assess patient pain depending on the needs of patient, which was recorded in the pain chart record.
- The 2018 hospital pain management audit showed an overall 47% compliance against all standard audited. The hospital had five actions on the action plan which were completed or on-going.
- Pain relief was also captured via the patient satisfaction surveys to monitor the way staff assessed and explained pain management to patients and the pain relief that was then offered.
- Patient we spoke to during inspection reported excellent pain control by staff and they had received pain killers as part of their TTO (to take out) medicines.
- During inspection we saw patients were given hospital leaflets on a guide to pain relief and management during their admission. Information on pain included pain and nausea assessment, before surgery or endoscopy procedure, types of pain killers and other pain control techniques such as deep breathing and heat or cold compresses.

Patient outcomes

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

- The hospital measured patient outcomes via a range of measures which included mortality, transfers out, infection rates, readmission rates, referral to treatment times, patient satisfaction scores, incidents, complaints, staff questionnaires, audits, Friends and Family Tests, and mandatory training rates.
  Between January 2018 and December 2018 there were no unplanned re-admission of medical in patient within 28 days.
- Between January 2018 and December 2018 there were one unplanned transfers to acute NHS hospitals for the medical service due to clinical deterioration following an endoscopy procedure. The number of unplanned transfers was lower when compared to other independent acute hospitals.
- The hospital reported one patient death in last 12 months before inspection, none were recorded as unexpected.

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 service had system for the induction and training of clinical and non-clinical staff. The service had a framework for assessing staff competency and governance process for managing staff professional registrations.
- All staff including agency staff underwent a hospital induction and orientation programme, which included mandatory and department specific training.
- The RMOs spent time with the pharmacy team as part of their induction process and covered areas such as TTA (to take away) medicines, out of service medicines arrangement and prescription writing with the aim of improving their skills and knowledge on medicines management. Staff told us student nurses also had the opportunity to shadow the pharmacy team for a day.
- Staff were supported by their managers to maintain their professional skills, competencies and experience through internal and external training, study days and career progression. Nursing staff we spoke to told us they were supported by the senior nurses in attending relevant courses and compiling their CPD evidence for their revalidation. Courses were usually advertised quarterly to encourage and enable staff prepare in advance.
- Medical and nursing staff told us they had received revalidation support from colleagues and senior staff.

Staff were up to date their professional revalidation. This meant we were assured the service had appropriate measures to ensure all staff were up-to-date and fit to practice.

- We saw all medical staff working or practicing under rules or privileges had completed their professional revalidation. The medical advisory committee (MAC) reviewed each application for practicing privileges. The MAC advisory function covered granting, renewal, restriction, suspension, and withdrawal of practicing privileges. Consultants completed their annual appraisal at their individual NHS trust and kept up to date with CPD through regular attendance at national and international meetings.
- There were processes for managing staff appraisals. The appraisal rate was 75% compliance for the nurses and HCAs and 70% for theatre and endoscopy staff compared to the hospital target of 100%.
- The RMOs were supported by an allocated medical staffing manager assigned by their agency that provided mentoring and carried out their annual appraisals.
- Medical staff had attended an orthopaedic conference for GP's and a monthly GP education events run. We noted this was highlighted as one of the hospital 2018 key success.
- The pharmacy team updated their skills and competency through evidence-based practice and best practice. We saw the pharmacy staff kept up to date with latest medicines guidance, trends through the pharmacy journal which were shared with colleagues and other MDT staff. For example, the pharmacy discussed and shared a recent article by the NHS Improvement on medication errors.
- The pharmacy manager was on a Chartered Management Institute (CMI) level 5 course which was funded by the hospital. The manager reported good support with the training from the executive director.
- Two nursing staff were currently enrolled on the mentorship training to help develop their competency in supporting student nurses on placement in the hospital.
- A nurse was currently enrolled on a wound care course to develop their skills and competency in the management of patients wound on the ward.
- The IPC lead nurse held monthly IPC link nurses meeting across the hospital sites to strengthen the link nursing group support and provide a forum for training and guidance. The group shared local best practice and reviewed latest national trends and guidance.

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.

- The medical service multidisciplinary team (MDT) worked together and with external professionals and hospitals to improve patient care and outcomes. Doctors, nurses, pharmacists, CNS, health care assistants, physiotherapist, dietitian, and the occupational therapist (OT) supported each other and were involved in assessing, planning, and delivering patient care and treatment. We saw there was good liaison and collaborative working between the MDT which was evident in the patient notes reviewed. The service also worked closely with social services, insurance company and local NHS hospitals.
- MDT staff we spoke with reported good working relationships with each other and other hospital services. During inspection we saw a medical patient on the ward had been seen and assessed by other MDT professionals such as a cardiologist, dermatologist, and vascular surgeon to plan the delivery of their care before discharge.
- There were various meeting attended by MDT staff to discuss and improve patient care such as the daily morning 'comm cell' meeting, afternoon 'safety call meeting', ward rounds and resus meetings and antibiotics and sepsis meetings. In 2018 the hospital introduced a "Daily Board Round" on the ward as part of the multidisciplinary approach to patient care to ensure care needs are met & the best outcomes for the patient.
- The safety call meeting differed from the morning comm cell meetings as it was safety focused. The RMO and representative from all MDT team and departments such as endoscopy, oncology, theatre, and IPC attended the meeting. The standard items on the safety call meeting agenda included discussion around deteriorating patient, safeguarding concerns, resus meeting, ward admission since the morning comm

meeting, any surgical and endoscopy procedures after 4pm, staffing issue and need for temporary staff, incidents that had occurred or reported, expected day cases and overnight admission, equipment issues, complaints, staff accidents, on call manager and other hospital business.

- The daily ward round meetings were attended by the RMO, nurses, nurse in charge, pharmacist, and physiotherapist to discuss patient care and progress and agree on discharge.
- Staff attended a daily antibiotics and sepsis ward round meeting which was introduced since October 2018. This meeting feeds into the bi-annual Commissioning for Quality and Innovation (CQUIN) antimicrobial data collection audit. The hospital attended regional pharmacy meetings where audit, trends and performance data were discussed.
- There were receptionists on the ward that worked with other MDT staff in improving patient pathway and experience through the booking of patient appointment and porters, arranging ambulance and patient transport, orienting patient on the wards and sending patient discharge information to the GP.
- There was pharmacist support on the ward and they provided information to patients on their medications. The pharmacist attended the ward rounds and MDT meetings such as the oncology MDT and comm cell meetings.
- There was a dedicated fulltime physiotherapist on the ward who worked Monday to Friday, 9am to 5pm. The physiotherapists were mostly involved with the surgical patients that have undergone hips, knees, shoulders, or hand surgery. They were also involved in the pre and post-operative assessment and care.
- There was access to an on call occupational therapist (OT) and dietitian on the ward through referrals. Patients were contacted by the OT before surgery and assessed by the occupational therapist on day two post-surgical procedures with patient ordered equipment delivered before patients discharge home.

Seven-day services

- Patients were admitted to the medical wards under the care of a named consultant who provided consultant level cover. Consultants were supported by RMOs 24-hours a day, seven days a week.
- There was pharmacy cover five days a week from 9am to 5pm and there was on-call provision through another BMI hospital during out of hours and weekends. The on-call provision was an improvement since the last inspection. There was also out-of-hour access to the pharmacy by the resident medical officer and nurse in charge.
- Patients received physiotherapy seven days a week.
- The hospital had a policy which required all consultants to remain available (both by phone and, if required, in person), and formally arrange appropriate named cover if they were unavailable, at all times when they had inpatients in the hospital.
- There was 24-hour access, seven days a week to the diagnostic services such as x-ray, ultrasound, and pathology. All inpatient imaging requests were actioned within 24 hours.

Health promotion

- Staff supported patients who accessed the medical service to live healthier lives and manage their own health, care, and wellbeing. Staff gave health promotion advice with leaflets given in line with national priorities to patients and their relatives on various topics such as smoking cessation, exercise, alcohol reduction and healthy eating.
- The hospital carried out an heart awareness week in February 2019 for the local population to receive an assessment of their heart and advice on loving health life. The hospital reported that following the assessment 37% if patients were diagnosed with hypertension, 37% had elevated cholesterol, 15% had significant valve disease and required echo surveillance and 4% had dilated heart artery that required computerised tomography (CT) scan.
- The hospital tobacco audit for the period of April 2017 to March 2018 showed an average of 98.4% compliance on smoking assessment and advice.

Medical care (including older people's care)

Good

- The alcohol audit for the period of April 2017 to March 2018 showed an average of 99.7% compliance on the standard audited.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

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

- There were systems to obtain consent from patients before carrying out a procedure or providing treatment. Staff understood their responsibilities regarding consent. We saw there was an up to date consent policy for staff.
- Staff obtained verbal and written consent from patients prior to the delivery of care and treatment. Patients we spoke to told us staff gave them enough time to ask questions and they received the verbal information needed to give informed consent. Consent to endoscopy procedures and medical treatment were obtained by staff and documented in the patient notes we reviewed which was in line with best practice and national guidance.
- The hospital included a consent form in the 'carers and comforters folder' for patients and their relatives to give their consent when a loved ones wishes to be with the patient during diagnostic procedures such as x-ray. Patients relatives were advised of the risk involved with exposure to x-ray before they consented.
- Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005. They knew how to support patients experiencing mental ill health and those who lacked the capacity to make decisions about their care.
- Staff were able to give clear explanations of their roles and responsibilities under the Mental Capacity Act 2005 (MCA) regarding mental capacity assessments and DoLS.

Are medical care (including older people's care) caring?

Compassionate care

Staff treated and cared for patients with compassion, respect, and dignity. Feedback from patients and their relatives was positive and confirmed that staff treated them well and with kindness. We observed staff speaking to patients and families in an appropriate and caring way.

- Patients told us all staff introduced themselves by their first name and they remembered the names of staff involved in their care. This was also evident in the thank you and feedback cards reviewed.
- Patient we spoke to were happy and impressed with the care they had received, staff politeness, would recommend the service to other and their dignity had been maintained during their stay.
- Patients' privacy and dignity was respected, especially during physical or intimate care. The ward environment ensured privacy as there were only single occupancy rooms. The HCA acted as chaperone when patient was examined by the doctors and nurses, particularly post-surgery.
- The hospital 2018 PLACE audit showed the hospital scored 89% for privacy, dignity and wellbeing which was better than the national average of 84.2%.
- We were told and observed staff knocked and asked permission before entering a patient's room and would introduce themselves. Patients and their relatives we spoke with told us staff called them by name, knew and remembered them which made them feel valued and respected.
- We saw several thank you cards from patients and their loved ones thanking the ward staff. Specific comments included "thanks for keeping an eye on me during the night and for the lovely chat", "thanks for your patience, time and kindness", "thanks for looking after my husband in a caring manner", "wonderful nursing staff", "thanks for all the love and kindness you gave me during my stay, "you are a wonderful bunch of people". "Thanks

to all staff for everything you have done to fix, treat and care for my relative in such an incredibly professional and thoroughly dedicated, caring and compassionate manner", "you were all just so kind and professional", "the lady who served breakfast and lunch a big thank you".

- We reviewed some of the inpatient feedback forms completed by patients during inspection. Patients comments were highly positive and specific comments included; "exemplary care", "felt comfortable and made to feel valued", "makes a huge difference when the nursing staff are friendly and attentive to my needs", "service provided was outstanding and cant thank you enough", "everything excellent", "all nurses are superb and lovely and consultant very approachable". "Porters were very good", "was looked after extremely well", "nursing care great", "friendly staff", "excellent staff service and out of hours service was excellent".
- We spoke to two patients and their relatives during the inspection. Patients were positive about their experience within the service. Specific comments received included "staff were extremely helpful, polite and professional", "excellent support from everyone", "been very well treated and cared for".
- The 2018 patient satisfaction scores showed 97.6% patient said they were likely, or extremely likely, to recommend the service to others, 96.7% said the quality of care were very good or excellent and 96.8% felt their expectation were met or exceeded.
- Patients were asked to complete a questionnaire on discharge about their experience, and the results showed high satisfaction in many areas. The Friends and Family Test is a measure of patient satisfaction. The 2018 hospital internal FFT result showed 98.1% of patient would recommend the service which was better than national average of 97.1%. Recent figure received during inspection for the period of September 2018 to February 2019, showed the FFT score was 97% with an average response rate (better) of 64.7% which was better than the last inspection (48%).
- The patient satisfaction 2018/2019 dashboard which was displayed on the wards showed improvement in the patient feedback about their experience and care received from the physiotherapists staff.
- The service had introduced an hourly rounding for staff to check on patients following patients feedback received about the lack of adequate contact with nurses as patients were all in a single ensuite rooms. We saw staff checked on patients regularly to ensure they were comfortable and responded to their needs in a calm and compassionate manner.

Emotional support

Staff provided patients and their relatives with emotional support to minimise their distress. Staff treated and involved patients and their relatives as partners in assessing and meeting their emotional and social needs, which was understood as being crucial in the patient care.

- Nursing and medical staff showed an awareness of the impact that a patient's care, treatment, or condition could have on their well-being and those close to them. Patients confirmed all MDT staff had an awareness of their treatment on their well-being and they were very caring and supportive.
- All the patients and their relatives and carers we spoke with told us they felt supported throughout their journey from consultation, pre-assessment through treatment and therapies.
- Patient we spoke told us their emotional health and mood had been discussed and assessed by staff. Specific patient comment received included; "everyone has been very comforting, friendly and reassuring", "very calming atmosphere".
- Specific comments on the patient thank you cards included "thank you for calming down in theatre" and "thanks for comforting me when I got upset".
- Psychological and emotional support was available to patients and their relatives following diagnosis of long term condition. Staff could arrange a funeral and chaplain for bereaved families if needed.
- Patients consistently said they had been offered emotional support and that it was available if they needed it.

Patients could call staff on the wards seven days a week for support. The medical service signposted patients with long term conditions to other agencies and charities such as Macmillan for additional support and counselling.

Understanding and involvement of patients and those close to them

Patients and their relatives were treated as active partners in the planning and delivering of their care and treatment. We saw staff were committed to working with patients and their relatives, gave them appropriate information and encouraged them to make joint decisions about their care.

- At the last inspection we were concerned on the lack of evidence in patients' notes of discussions about the choices of care and treatment available. During this inspection staff involved and discussed with patients and their loved ones their care and treatment choices.
- Patients relative we spoke told us they had been kept informed of their care and recovery of their loved ones.
- Specific comments received from patients included, "explained process, condition and procedure in terms I could grasp", "all staff are highly attentive and extremely friendly", "everything explained well", "staff are attentive", "complications and risk explained well before signing the consent form", "been well informed, leaflets given and family were involved in care"
- Staff spoke passionately about the importance of updating patients and their relatives about the care, recovery, and discharge process and how it impacted on patient care and experience.
- We observed patient clinical procedures and handover and noted the consultant had clear communication with patients and explained their findings and treatment plans in detail in a way they understood. We saw staff took their time to explain information to patients and involved them in their treatment plans.
- Specific comments from the patient thank you and feedback cards included: "my family were contacted and reassured by staff back on the ward", "everything was explained well and carried out exactly", "pleased how the doctor communicated procedure I underwent today", "informative and down to earth", "excellent treatment and information given to me at all times", "highly attentive staff", "thanks for been so informative and caring after my procedure"

Are medical care (including older people's care) responsive?

Good

Meeting people's individual needs

- **The service took account of patients' individual needs.**
- During inspection we noted the needs and preferences of patients were considered when delivering and coordinating services, including those who were in vulnerable circumstances or had complex needs such as learning and physical disabilities. Care and treatment were coordinated with other services and stakeholders, to ensure the needs of patients and their families were met.
- The medical ward environment was spacious with clear signage and patients felt it had a relaxed and homely feel. There was wheelchair access to the wards and the patient rooms were ensuite with accessible toilets which were suitable for people with reduced mobility. All rooms had a shower or a bath tub. The ward also had assisted wet room for those unable to access the bath or shower in their room.
- The service recently purchased a large wheelchair to meet the needs of bariatric patients.
- Staff told us they had few vulnerable patients that accessed the service and mostly see patients with mild cognitive impairment.
- Staff we spoke with had a good understanding of meeting the needs of patients living with dementia and the hospital had policies and strategy to improve quality of care of patients living with dementia and for their relatives and carers. The hospital data showed the dementia training was 98.5% overall in all medical areas.
- The pharmacy team had implemented a 'medication record card' for patients with dementia, learning

disability and confused patient. This was to improve their understanding on their medicines and reduce medicines related incidents. Information on the medication record card include the drug name, usage, indication and remarks.

- Interpreter services were available for patients for whom English was not their first language if required. These were provided face-to-face or via a dedicated telephone interpreter service and staff were always able to access interpreters. Interpreting service request were booked by the receptionist.
- Patient had a choice of meals, which took account of their individual preferences, respecting cultural, medical, nutritional, and personal choice such as halal, diabetic and kosher meals. outside of set meal times. Patients could order from the menu list and were they wanted something different staff would place an order to the catering staff. Specific comments from patient about their meals included “thanks to all the catering staff for meeting my needs”, “the food was always delicious”, “thanks for the endless pots of tea during my stay”.
- Follow up appointments were given to patients in timely manner during clinic consultation and we saw staff accommodated patient preferences and commitments.
- Patients told us staff responded to their call bell promptly and they were given adequate pain medication in a timely manner.
- Consultants visited their patients daily during the ward round with the nurse in charge present, which ensured patients had opportunity to discuss their care and needs.
- The patient led assessments of the care environment (PLACE) 2018 audit result for the hospital was 98% for food which was better than the national average.
- At the last inspection we noted the ward environment was not suitable for the needs of patients living with dementia and physical disabilities. During the inspection we noted improvement in the environment and provision of care. There was on-going refurbishment in the hospital as part of their five-year refurbishment plan. As part of the refurbishment plan, there were plans to design two patients rooms as a designated dementia rooms with the use of appropriate colours, toilet sits and option to cover the mirrors.
- The patient led assessments of the care environment (PLACE) 2018 audit result for the disability provision was 76.9% which was worse than the national average of 84.2% but 1.9% improvement from the last inspection. The hospital scored 69.2% for dementia provision which was worse than national average of 78.9%.
- The 2018 standard of care audits showed the hospital scored 94% in the hospital responsiveness to the personal needs of its patient.

Access and flow

- **Patients could access the service when they needed it. Waiting times from referral to treatment and arrangements to admit, treat and discharge patients were in line with good practice.**
- The hospital had a hospital admissions policythat outlined the admission criteria that ensured suitable patients were admitted to the ward. Patients were admitted under the care of a named consultant following completion of a booking form. The consultants reviewed patients prior to commencement of each treatment and provided a 24 hour on call service as and when required.
- For the period of October 2015 to September 2016 the hospital reported 119 episodes of care carried out by consultant with practice privileges.
- From April 2018 to March 2019, there were 45 medical admissions in the service and which mostly related to chest infection, urinary tract infections and cellulitis.
- For the period of January to December 2018, the hospital reported 890 inpatient attendance, four (0.4%) unplanned transfer and four unplanned readmissions for the medical and surgical patients.
- The hospital re-admission rate within 28 days of discharge for patients in 2018 was 6.2 which was better than the national average of 10. The hospital reported all readmissions within this period were unpreventable.
- Between April 2018 and March 2019 a total of 182 endoscopies were undertaken as part of a surgical procedure. Most patient underwent flexible cystoscopy

and biopsy (45.1%), endoscopic resection of prostate (TUR) and cystoscopy (16.5%), endoscopic insertion or removal of prosthesis into ureter (5.5%), diagnostic colonoscopy (4.9%), flexible sigmoidoscopy (3.8%).

- For the period of March 2018 to February 2019 one of the most common medical procedure was botulinum toxin injections to muscle (6).
- Patients repeatedly told us they had good access to the hospital and did not experience prolonged delays to be seen.
- Following referrals to the therapists such as physiotherapist and occupational therapists, patients were seen the same day or within 24 hours. The physiotherapist saw patient same day following referral and were informed before the admission of surgical patient which ensured timely access, assessment and discharge post-surgical operation.
- All medical patients admitted on the wards were private patient and while the endoscopy patients were a combination of private and NHS patients. Patients referred by their GP for endoscopy procedure could book a convenient date and time for their appointment through NHS ‘choose and book’ electronic booking system. The private patients were mostly self-pay and insurance patients. During inspection, there were two general medical patients admitted on the inpatient wards for infections. The hospital told us they had 10 patients that accessed the oncology service.
- All NHS referral to treatment times (RTT) met the target rate for the period of April 2018 to February 2019.
- Senior staff told us they had an average of 20-day cases and three inpatient stay on the wards on Mondays to Fridays and a list of 12 cases on Saturdays. There were no surgical procedures on Sundays.
- Bed capacity planning meetings took place weekly and representatives from each clinical area were present. This ensured heads from all clinical areas were aware of the issues around the hospital and could offer further assistance by way of additional staff if necessary.
- For the last 12 months before inspection the average length of stay was 2.6 days. The length of stay for medical patients varied from hours to a week depending on the reason for admission and agreement with the insurance company. Staff told us the discharge process was effective and they had few cases of delayed discharge.
- Staff we spoke to told us they had few cancellations and reasons were related to non-compliance of patient such as nil by mouth before surgery, did not attend (DNA) and use of aspirin before coming for surgery.
- For the period of April 2018 to February 2019 the follow-up ‘did not attend’ rate was 4.5% which was better than their target of 5%.
- We noted during Christmas and major bank holidays like Easter, the hospital ward was closed, and patients were seen and diverted to their sister site at the BMI Cavell hospital. The telephone calls were also diverted to the Cavell site during this period.

Learning from complaints and concerns

- **The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with all staff.**
- There were processes to ensure complaints were dealt with effectively. Information was displayed and provided to patients on how to report concerns and make a complaint. Patients and relatives could make a complaint verbally or written, by face to face contact, telephone calls or through the hospital website.
- From 8 October 2018 to 10 March 2019 there were five complaints related to the medical service. These related to clinical investigation, care treatment and prescription error.
- The top five hospital complaints in the last 12 months before inspection were communication, clinical care and treatment, billing and payment process, complaint management and complaints about consultants.
- We saw there were leaflets on the wards with information on how to make complaints with details on the complaint process and how to contact other agencies if patients were not pleased with the hospital response.
- Patients we spoke with knew they could make a complaint if they wanted and said they were

Medical care (including older people's care)

Good

comfortable bringing up issues to staff. There was a duty ward manager at the hospital daily who patients or visitors could speak too if they had any concerns or compliments.

- Staff understood how to handle complaints, including out of hours. Staff told us the common complaints would be patient that came early before their appointment and required to be 'nil by mouth' but wanted to eat before having their surgery or endoscopy procedure.
- We saw examples of actions being taken in response to complaints received about the blinds were not sufficient to ensure patient privacy and which 80% of the blinds have now been changed.

Are medical care (including older people's care) well-led?

Good

Leadership

- **The medical care service had managers at all levels with the right skills and abilities to run a service and provide high-quality, sustainable care.** There was a clear management structure within the hospital and service with defined lines of responsibility and accountability, and clear lines of communication with the executives. The leaders were passionate about the service provided and knowledgeable about their risks, quality issues and priorities, understood what the challenges were and acted to address them.
- The medical and surgical services were led by a senior management team consisting of an executive director, director of operations, director of clinical services, clinical service managers and a quality and risk manager. There were appointed clinical service managers for the wards and pharmacy that covered both hospital sites. Consultants, resident medical officers, and senior nurses supported the senior management team.
- At the last inspection we had concerns about the senior managers lack insight on the regular endoscopy procedure taken place in the hospital, lack of leadership for end of life care and lack of nursing leadership at the cross-site meeting. During this inspection we saw improvement and all the concerns had been addressed. There was good representation of all executives at various governance meeting and the hospital no longer provide an end of life provision.
- The leaders at every level prioritised safe, high quality, compassionate care and promoted equality and diversity. The leadership model of the service encourages cooperative and supportive relationship among staff and patients so they felt respected, valued, and supported.
- Since the last inspection, the hospital had recruited new executives such as the director of clinical service to strengthen the governance framework and leadership. The hospital introduced a new on-call rota process in April 2019 which required the presence of an on-call mangers to support staff and be present in clinical areas on Saturdays. This was an improvement since the last inspection.
- The executive director was responsible for both Cavell and Kings Oak hospital and reported to the corporate regional director and had a bi-monthly one to one meeting and a bimonthly meeting of all regional executive directors.
- The executive director told us medical staff supervision had improved since the appointment of a new MAC) chair person in 2018 . They said there was an issue with getting enough doctors to be part of the MAC and were trying to encourage new members. The ED said they aimed to ensure the MAC was representative of the consultant body and that they had a good range of consultants including anaesthetists and surgeons of different specialties. However, the MAC was currently all-male staff and the ED was working to change this and two female consultants were about to join the committee.
- Staff including the senior nurses and ward managers told us the executives were visible, accessible, and supportive, and encouraged their career progression. Staff felt the management team were interested in the medical and surgical service.

Vision and strategy

Good

Medical care (including older people's care)

- **The service had a vision for what it wanted to achieve and workable plans to turn it into action, which it developed with staff, patients, and local community groups.**
- The hospital had a five year vision for 2015 to 2020 which was achieved through their eight strategic objectives and priorities. The objectives and priorities included patients, people, communications, growth, governance, efficiency, facilities, and information. This was achieved through their strategies which included delivering the best clinical outcomes through best practice pathways. The strategies were also achieved by developing staff to be skilled and competent in their roles, listening and adapting staff feedback, enhance communication through better use of digital technology and apps and extend the range of services provided to meet the health care demand. The hospital also aimed at improving patient experience, investment in new medical technology and equipment and improving the look of the hospital through refurbishment. The strategy also included improving patient management by moving to electronic records, to provide ease of key information through a new staff intranet and enhancing staff and patient connectivity with digital technology.
- The hospital vision was to deliver the best patient experience, in the most effective was from their comprehensive UK network of acute care hospitals. They aimed at delivering the best possible patient outcomes and experience across all groups by consistently delivering quality care and services in a cost effective way.
- The hospital priorities for the medical services included recruitment of nursing staff into pre-assessment and endoscopy and creating a clinical service manager post for the endoscopy services. The hospital also aimed at expanding the oncology services and to develop an end of life services in oncology at the BMI Cavell site.
- The six Cs initiatives which encouraged staff to embrace the values of compassion, competence, care, communication, courage, and commitment were displayed throughout the hospital.

Culture

- **Managers across the service promoted a positive culture that supported and valued staff, creating a sense of common purpose based on shared values.**
- Staff we spoke with had a strong commitment to their job and were proud of the team working, continuity of care, positive impact to patient care and experience, and improvements they had made to the service since the last inspection.
- There was good staff turnover and some staff had been working at the hospital for several years and reported good job satisfaction and progression. For example, a junior nurse we spoke to told us they were encourage and supported to progress in their role by their manager.
- All staff we spoke with described good teamwork and respect within the medical service and across disciplines and gave examples of good team working on the wards between staff of different disciplines and grades. Staff felt respected and they could approach any member of staff and challenge practice or behaviour if necessary.
- Staff told us they felt supported and valued by colleagues and senior managers and there was drive for learning and progression. Examples of specific comments received from staff included, "King's Oak is a friendly place and patients like it, "all staff are welcoming, friendly and well supportive", "I love to work here", "as a bank staff I feel much like part of the team", "team fantastic", "happy how we look after patient", "well supported and happy environment". Junior nurses we spoke to told us they were encouraged and supported to progress in their role.
- The 2018 staff survey results showed bullying and harassment was still an issue across the two hospitals. The results were not broken down by staff site or speciality, so they were unable to identify if the issue was localised. The ED said they planned to work with staff to address the issue, and that the survey result had improved since the last survey.
- The number of staff who responded to say they would recommend the hospitals to family and friends as both a place to work and for treatment had increased. The hospital introduced a 'wow day' which was a weekly work out initiative that required head of department spending time working in another department. The

hospital also launched a staff newsletter in 2017 and staff were encouraged to contribute to its content. The hospital also had regular staff forums which was led by the executive director for staff to share their views and escalate any concerns.

- The hospital celebrated staff and team success through various star awards and displaying of team success. During inspection we saw displayed posters of certificate of recognition for staff behaviour of the week for demonstrating the hospital values of communication. We also noted the ward and the night staff had received these awards in April and July 2018.

Governance

- **The service systematically improved service quality and safeguarded high standards of care by creating an environment for excellent clinical care to flourish.**
- The service gained assurance through various governance meetings such as the clinical governance committee, health and safety committee, MAC meeting, senior management meeting, infection prevention control (IPC) meeting and the cross site departmental meeting.
- The hospital governance meeting was held regularly to review all incidents, significant events, audits, complaints, compliments, patient satisfaction and practice privilege.
- The clinical governance committee meeting: was a cross site meetings and held monthly. This meeting was attended by all hospital departmental leads and executive director, director of clinical services and pharmacists. Agenda included CQC action plan, update from the local hospital clinical governance reports, update from the hospital quality and risk management report, incidents case reviews and learning, pre-assessment, medicines management, staffing, policies, health promotion, clinical bulletin, national safety alerts, dashboards, complaints, risk register, patient satisfaction and unplanned transfers. In the February 2019 meeting minutes, we saw local policies and some NICE guidance were reviewed by the committee.
- The monthly cross site departmental team meeting was attended by staff and ward managers to review staffing, risk register, finance, audits, risk assessments. Other items on the agenda included 'journey to outstanding', key messages, IPC, patient satisfaction and complaints, training, clinical governance, policies, and procedures. We noted the February 2019 minutes highlighted that the new blood transfusion audit and pathway were in progress across the hospital.
- The medical advisory committees (MAC) were held quarterly and oversaw the renewing of consultants' practicing privileges, clinical governance issues, key policies and guidance and monitored patient outcomes.
- Practice privileges were granted after submitting a CV and two referees to the executive director who then interviews along with the chairman of the MAC. Privileges were reviewed and renewed annually according to evidence of appraisal, revalidation, GMC membership, mandatory training completion, and sufficient evidence of good conduct.
- The hospital had a new pharmacy manager who had recommenced and chaired the bi-monthly medicines meeting where all medications incidents and action were reviewed.

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 service had clear risk processes and systems for managing performance and identifying and mitigating risks.
- Incidents were reviewed at various governance meeting and minutes of governance meetings we reviewed showed serious incidents, complaints, and quality audit updates were discussed and shared with staff. Actions taken to reduce recurrence and improve service provision were detailed and we noted any potential serious incidents were escalated appropriately.
- The service had arrangements for identifying, recording, and managing risks. The divisional and hospital risk register included a description of each risk, with mitigating actions and assurances.
- We reviewed the hospital wide risk register which contained clinical and no-clinical risks, which was an improvement from the last inspection. The risk register

contained risks which also related to the medical service. It included preventable death or injury through no portable ventilator or defibrillator, facilities (heating and water risk), environment, medical gases, carpets, records, recruitment and retention and failure to meet legislative requirement from regulators (CQC). We observed the risks were reviewed regularly with update of each review documented on the risk register. Staff were aware of the risks on the register and we noted the top hospital five risks were displayed on the wards.

Managing information

- **The service collected, analysed, managed, and used information well to support all its activities, using secure electronic systems with security safeguards.**
- During inspection we observed staff treated patient identifiable information in line with the General Data Protection Regulations (GDPR).
- The hospital had clear performance measures such as audits which were reported and monitored. These included the safety thermometer, dashboard, Friends and Family Test (results and social media. Performance results were discussed at various governance meetings to improve care and patient outcome.
- Medical and nursing staff informed us that they always had access to all the information required to treat patients. The senior nurses informed us that the administrative staff played a big role in ensuring that all the necessary records arrived with the patient or before admission.
- As well as having access to the hospital intranet for all up-to-date policies, MDT staff were aware that policies and pathway information were available in paper format on the wards.

Engagement

- **The service engaged well with patients, staff, stakeholders, the public and local organisations to plan and manage appropriate services, and collaborated with partner organisations effectively.** The service obtained and acted on people's views and experiences to shape and improve the services and patient experience. We saw evidence during inspection that patient feedback was sought to inform changes and improvements to service provision.
- The service obtained patients feedback through various forms such as social media, NHS choices, BMI website, feedback forms, and the patient satisfaction group. The monthly patient satisfaction meeting was a cross site meeting were staff representative from each site were required to attend and meet with patients to discuss patient feedback trends.
- Patient feedback were also monitored and reported monthly through the patient satisfaction dashboard and discussed at monthly management meetings.
- The service engaged well with staff through various initiatives such as monthly staff forums, staff awards, team meetings and you said we did. Staff told us they had a summer ball last year.
- The service also engaged with staff through the staff survey. The December 2018 staff survey showed a low response rate of just under 50%, which was below their corporate average. Senior managers told us that the recent staff survey results showed that bullying and harassment was still an issue across the two hospitals. The results were not broken down by staff site or speciality, so they were unable to identify where the issue was located or whether it was localised. During inspection the executives told us they were working to address the findings of the staff survey over the coming months and discuss the findings at the departmental meetings and how to improve staff experience.

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 priorities for service development and improvement included facilities and refurbishment of the hospital. This focused on the improvement of facilities through the removal of carpets, installation of IPC sinks in all patient rooms and on-going upgrade and refurbishment of all areas including the ward assisted bathrooms. The hospital had a site development meeting in April 2019 to discuss the estate and facilities infrastructure and to develop a five year refurbishment

plan. During inspection we saw work had been done to replace most of the carpet and install some IPC sinks in the hospital to be compliant with the Department of Health (DoH) guidance HBN 04-01.

- The pharmacist had developed and implemented medication record cards for patients living with dementia or those concerned about remembering to take their medications when discharged home.
- The hospital introduced a learning, educating and adapting to falls (LEAF) group in 2016 and the multidisciplinary team met quarterly to assess, plan, discuss potential falls and how to mitigate risk and manage falls.

Requires improvement

Surgery

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

Are surgery services safe?

Inadequate

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 all mandatory training courses. Overall, mandatory training completion rates were 86% for all ward staff and 87% for theatre and recovery staff at BMI The Kings Oak Hospital. Completion rates were worse than the last inspection (91% for ward staff and 95% for theatre and recovery staff). The hospital mandatory training programme included equality and diversity, fire safety training, immediate life support (ILS), infection prevention and control, consent, dementia awareness, waste management, safeguarding and other topics which related to working safely at work.
- Staff across theatres, recovery and the wards were aware when they were due to complete mandatory training. Six months from when training was due, staff were reminded on a monthly basis to complete it. Yearly mandatory training was due at the time of each staff members' annual appraisal. Training was primarily delivered by e-learning modules. Face-to-face training was done for some courses, such as for basic life support or intermediate life support. Staff confirmed the quality of training was good and that there was enough time to complete modules. Staff were given protected time to complete their training. They said if they asked their managers to attend other training or learning sessions, the senior nurse and managers worked to accommodate their request.
- Temporary and locum staff were required to provide evidence of mandatory training compliance from their employers.
- Consultants and clinicians with practising privileges were not required to complete training via the hospital system but assurance of mandatory training was checked by the medical advisory committee.
- The resident medical officers (RMOs) were managed via an agency and received mandatory training via their agency and had access to the hospital on-line training system.

Safeguarding

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

- Staff across theatres, recovery and wards were aware of their responsibilities for safeguarding vulnerable adults and children. The Director of Clinical Services was the location lead for adult and children safeguarding and staff were aware of who to report safeguarding concerns to and felt comfortable doing so. Staff had good understanding on safeguarding including modern day slavery, human trafficking and female genital mutilation (FGM) and knew how to raise or report safeguarding concerns.
- All staff were required to complete safeguarding vulnerable adults levels 1 and 2 and safeguarding children levels 1 and 2. 97% of staff completed

safeguarding vulnerable adults (levels 1 and 2) and 96% of staff completed safeguarding children training (levels 1 and 2). Across BMI The Kings Oak Hospital, 77% of staff completed safeguarding children level 3; an action plan was in place to raise completion rates of consultant level compliance.

- Training rates had improved since our last inspection. The hospital target for safeguarding training was 90%.
- For the period of 2017/18, the hospital reported zero safeguarding incidents across the hospital department.

Cleanliness, infection control and hygiene

- **The service did not always control infection risk well. Although there were improvements from our last inspection and staff mostly kept equipment and the premises clean, they did not always maintain best practice in infection prevention control.**
- We observed the theatre, recovery area and ward to be visibly clean. Staff used 'I am clean' stickers to indicate when equipment was clean and ready for use for the next patient in theatres, the recovery area and the wards. However, in the theatre and recovery area, we found an equipment rack that was dusty even though it had an 'I am clean' sticker.
- Patient rooms and corridors on the ward had been refurbished since our last inspection and there were no longer any carpeted areas. This was in compliance with building requirements of Health Building Notice (HBN) 00-09: Infection control in the built environment.
- Managers identified poor staff compliance with the bare below the elbow requirement on the hospital's risk register. Although the service told us they had acted to improve compliance, we continued to find in theatres and on the wards that not all staff were bare below the elbows in clinical areas. This was not in line with the service's infection prevention and control (IPC) policy and posed a risk of cross infection between patients.
- The service provided a hand hygiene audit for November 2018. Compliance was overall 88% in theatres and 97% compliance on the ward. We saw evidence that infection prevention and control, including hand hygiene was discussed at quarterly IPC meetings. Where there were gaps in hand hygiene facilities, an action plan was in place to address short- and long-term hand hygiene facilities.
- There was access to hand washing facilities, hand sanitiser and a supply of personal protective equipment (PPE), which included sterile gloves, gowns and aprons, in all areas. We observed staff applying hand sanitising gel when they entered clinical areas. We observed staff disinfected their hands between patient contact, in accordance with national guidance
- We observed two surgical cases, one orthopaedic and one gynaecological. At the end of each surgery, we observed the surgeon dispose of clinical waste, including bloody gloves, into the domestic waste bin. This was not in line with the hospital's IPC policy.
- There was no sluice in the recovery area which mean staff had to walk across the theatre department for the closest sluice. This was on the risk register and we saw evidence it was discussed regularly at clinical governance meetings to resolve this issue.
- From January 2018 to December 2018, the service reported 3,780 surgical case episodes with seven total surgical site infections (0.19%). Surgical site infections (SSIs) were reported in primary hip replacement (one case), primary knee replacement (two cases) and other orthopaedic and trauma surgeries (four cases). The service reported SSIs to Public Health England (PHE) as part of the Surgical Site Infection Surveillance Service. They received regular reports from Public Health England summarising rates, trends and risk factors of SSIs in the service. The reports showed that from July to September 2018, the service had similar rates to other hospitals in hip replacements (1.2% compared to average of 1.0%) and higher rates in knee replacements (7.7% compared to average of 1.6%). SSIs were discussed regularly at the hospital's IPC committee meeting. We saw evidence an action plan was in place to address SSIs. Actions included staff using a standardised checklist tool to identify infections on the wards and in outpatients and an analysis was undertaken for all deep surgical site infections to determine the root cause. In the three months prior to our inspection (January 2019 to March 2019), there were no surgical site infections.

Requires improvement

Surgery

- The service had an infection prevention and control (IPC) link nurse who worked with the IPC lead nurse. There were monthly IPC link meetings between the sister hospitals in order to strengthen the link nurse group and provide a forum for training and guidance.
- The hospital used an outside provider for the decontamination of surgical instruments. Staff found the service good and there were no significant issues.
- Patients told us their room had been regularly cleaned by the housekeepers and they observed staff washing their hands regularly and using appropriate PPE. Specific patient comments included; "room was clean and sterile", "well equipped and clean room", "cleanliness was exemplary".
- The hospital took part in the 2018 patient led assessments of the care environment (PLACE) audit. The hospital scored 98.2% for cleanliness which was similar to the national average of 98.5%. The hospital scored and 88.2% for condition, appearance and maintenance which was below the national average of 94.3%. The hospital had an on-going refurbishment plan to improve the hospital environment. The installation of new compliant hand sinks was part of the hospital on-going installation programme due to be completed by the 31 May 2019.
- Cleaning of the ward areas was scheduled daily and in between patient discharge or transfer. Staff requested the deep cleaning of rooms or bed areas if a patient had Methicillin-resistant Staphylococcus aureus (MRSA) or an infected wound. Patients' operations with a known history of MRSA were done at the end of theatre lists to ensure the room could be cleaned properly for the next patient.

Environment and equipment

The service had suitable equipment and looked after it well most of the time. Although the service had recently refurbished some areas, other areas of the environment continued to require improvement. There continued to be challenges around space in the theatre environment.

- There was good security of the theatres and recovery area. The service was secured through key pad controlled door.
- The service had two theatre suites covering a variety of specialities including orthopaedics, cosmetic surgery, ophthalmic, pain management and gynaecology. One of the theatres was equipped with laminar flow which safely filtered air away from the theatre and prevented any bacterial contamination from being recirculated. All orthopaedic procedures were done in the theatre with laminar flow to help prevent surgical site infections.
- Staff tested the defibrillator on the resuscitation trolley in theatres and recovery daily and we saw records that indicated this. The service had an easily accessible difficult airway trolley which was checked regularly and was well-stocked.
- There was appropriate emergency equipment on the ward including resuscitation equipment, fire extinguisher cylinders, fire blankets, defibrillator, emergency eye wash and oxygen cylinders. We checked a range of consumable items from the resuscitation trolley, including syringes, airways and naso-gastric tubes and emergency medicines and noted they were all in-date. All resuscitation trolley drawers seen were secured with a tamper evident tag.
- Sharps bins were easily accessible in theatres, wards and recovery. They were sealed and dated and none were found to be overfull.
- The anaesthetic room in theatres was cluttered and not well-organised. Although most days the anaesthetic machine was checked daily, we saw there were gaps in the log book when the lead anaesthetic nurse was not working. This meant that staff could not always be assured anaesthetic equipment was working correctly fluid and was safe to use with patients.
- Storage and space in the theatre environment continued to be an issue for staff. Although instrument and consumables storage had improved following conversion of a clinical room to a storage room, there was continued limited staff changing facilities.
- The service had four bays in the theatre recovery area. However, one of the recovery bays was very small as it was also where the resuscitation trolley was stored. While staff told us it would be unusual to have a fully occupied recovery area, they also provided little assurance that they could confidently resuscitate a patient in the small recovery bay if needed. For example,

there would be little space on either side of the patient's bed for staff to undertake lifesaving procedures. The service reported no safety incidents around recovery bay space nor was this space issue on the risk register.

- Equipment in the recovery area could provide good monitoring of patients post-procedure and there was access to CO2 monitoring.
- There was no sluice in the recovery area. This meant that staff had to walk across the theatre department for the closest sluice. This was on the risk register and we saw evidence it was discussed regularly at clinical governance meetings to resolve this issue.
- Staff could access all equipment as they needed it. We observed a well-stocked store room with intact sterilised trays. There was clear signage for staff to identify the contents of the trays.
- The theatre department had an implant register in each theatre where details of each implant used were recorded. Implant item stickers were attached to the register book alongside patient details, site of surgery, date of surgery and the names of the scrub practitioner and circulating staff member. When theatres were not in use, staff stored registers in a locked cupboard.

Assessing and responding to patient risk

Although staff completed and updated risk assessments for patients on the ward, staff did not consistently follow best practice for safer surgeries. Staff kept clear records and asked for support when necessary.

- From observations in theatres we found that although the service had processes and procedures in place to keep people safe, staff did not always follow them consistently. For example, staff were not always adhering to the World Health Organisation (WHO) surgical safety checklist and '5 steps to safer surgery'. Not all staff were fully engaged with the process of the WHO checklist and '5 steps to safer surgery'. We observed some staff were busy doing other tasks and were not fully paying attention during safety checks. During the 'time out' part of the WHO checklist and '5 steps to safer surgery', two staff members were doing other tasks and we observed staff filled out paperwork retrospectively. These actions were not challenged by other staff present and there was a lack of accountability for adherence to the WHO checklist. The service provided us with results from an observational audit undertaken in March 2019 which showed overall compliance with the WHO checklist of 98% from 30 observations, however we did not observe similar good practice during our inspection.
- We were told by some staff that BMI had a colour code hat system to identify staff roles, for example yellow for the team leader. However, during one surgery, the team leader wore a blue hat and the radiographer wore a yellow hat. The radiographer was not aware of the colour coded system. It was not clear if staff were not aware of the colour-coding system or if they chose not to use it.
- Although there was good attendance at the theatre team briefing, there was very limited to no discussion of patients' past medical history, allergies and ASA physical status classification (a system used to assess the fitness of patients before surgery).
- In theatres, the monitoring of safety systems was not robust nor consistently understood or delivered by staff. For example, there was a lack of understanding among staff on ownership on disposal of expired fluids in the fluid warming cabinet. Staff did not always engage during the WHO checklist and the anaesthetic room checks and monitoring were not always completed.
- In theatres, we did not always observe staff following best practice for safer surgery. For example, it is best practice for theatres to have a standardised dry wipe count board which states all relevant items used. The theatre had a dry wipe board which had all staff names written on it. Although the dry wipe board had the ability to record the swab count, we observed it was not used. We observed the first swab count was done in the surgical preparation room but these numbers were not recorded on the dry wipe board where it would be easy for all staff to see.
- We observed in theatres that best practice did not take place in relation to the instrument checklist. For example, during the middle of a surgical case, we examined the instrument checklist and found that all three counts were already ticked and signed for before the case was completed. Although we observed that the final count instrument count took place, the documentation was filled out beforehand. This posed a

risk to patient safety in the event that the person completing the list had to be replaced before a procedure was completed and there would be no way for another member of staff to know that final counts were not completed.

- Following the inspection the provider supplied evidence that they had undertaken regular reviews of the operating theatres at Kings Oak Hospital. An internal review of the WHO audit showed a compliance rate of 96%. A specific 'Superior Patient Care' audit was undertaken in September 2018 which at that time showed 100% compliance with good practice.
- The provider told us that in July 2018 the corporate Intergrated Audit Team undertook a detailed review. The review team noted improvements since the last CQC inspection and good compliance with the WHO check list.
- Following a serious incident involving the late detection of sepsis at the sister hospital, the hospitals worked together to roll out sepsis training to all clinical staff. Staff of all grades were aware of the serious incident and the learning from it. Staff had early detection of sepsis reference cards they could refer to if patients' observations were outside of a normal range.
- Staff received training on sepsis and we saw posters of sepsis six (management of sepsis that usually involves three treatments and three tests) and escalation using the internal emergency service during inspection. There was information on the wards that had contact details for emergencies that staff could call where there concerns including out of hours. Staff used the situation, background, assessment and recommendation (SBAR) tool for escalation.
- Prior to accepting a case, the service used tools to risk assess the safety of a surgery. For example, staff considered patients' past medical history and American Society of Anaesthesiologists (ASA) classification. There was an admissions policy to consider which patients the service could safely accept.
- We saw evidence that patients had risk assessments completed during their pre-operative assessment, for example a fall risk assessment, moving and handling assessment, malnutrition risk assessment and pressure ulcer risk assessment. This meant that the service considered patients' individual needs prior to their admission and made sure they could safely meet their needs.
- The service followed National Institute for Health and Care Excellence (NICE) recommendations for pre-operative testing. This meant that the service considered the patient's risk factors when evaluating and preparing the patient for elective surgeries.
- In theatres and recovery, the service held regular emergency response scenarios for training purpose. A cardiac simulation was done once a month and a major haemorrhage scenario was done quarterly.
- Staff in theatres and recovery had access to the urgent provision of blood in cases of life-threatening haemorrhage. There was a blood refrigerator within the surgery department.
- The service used the National Early Warning Score (NEWS), designed to allow early recognition and deterioration in patient by monitoring physical parameters, such as blood pressure, heart rate and temperature. During inspection we observed that nursing staff used the NEWS and knew the threshold for escalation to the RMO. The RMO was available on the wards and ensured prompt identification and managing of deteriorating patients. Staff also carried out further investigations such as blood tests as required. Staff told us there have been improvement in staff competency on NEWS score and managing deteriorating patient.All records we reviewed on the ward showed staff monitored patient's observations using the national early warning score tool (NEWS).
- Staff we spoke with told us they carried out regular clinical observations, such as vital signs post-surgical procedure every 30 minutes to ensure patient safety and recovery.
- There continued to be no formal on-call anaesthetic rota. There was an on-call theatre staff list. There was an informal agreement that anaesthetists in charge of the list were responsible for patients up to 48 hours post-operatively. The RMO told us they hadn't had problems getting in touch with the consultant surgeon or anaesthetist when they needed them. Consultants were required to be within a 30-minute commute to the hospital in case of an emergent return to theatre.There

were three reported unplanned return to theatre incidents and four unplanned transfers to other hospitals incidents from January 2018 to December 2018. During this time, there were 14 unplanned readmissions and one case of a hospital-acquired infection. Staff tracked unplanned admissions and transfers and discussed these incidents at monthly clinical governance meetings.

Nursing and support staffing

While we found the service provided enough nursing staff, with the right mix of qualification and skills, to keep patients safe and provide the right care and treatment, there was a high-dependency on bank and agency staff use.

- On the wards, a corporate nursing staffing planner tool was used to determine staffing levels. The normal staff to patient ratio was 1:6. Senior staff used the tool to allocate staff in advance based on pre-determined nursing demand and acuity of patients. The day unit staffing requirement was determined by the number of hours each patient would be in the unit. The ward sister prepared the staff roster two weeks in advance and it was reviewed daily at the daily communication meeting. Staff we spoke with said there was enough staff to meet acuity.
- During inspection we saw that the required and actual staffing were displayed on the wards which reflected the acuity on the wards. Temporary staff were also used to achieve safe staffing levels.
- Theatres and recovery were reliant on bank and agency staffing. Some staff told us that since our last inspection in 2016 there were difficulties in recruiting and the department relied heavily on bank and agency staff. While there was an increased reliance on agency staff in theatres since our last inspection, the service tried to have consistency with agency staff they used. However, sometimes regular staff would have to do additional work where agency staff may not have experience, for example checking controlled drug record books on days when theatres were not open. From March 2018 to February 2019, the ratio of nurses to operating department practitioners (ODPs) and health care assistants (HCAs) in theatres was 1:1.6 and the staffing ratio of nurses to HCAs on wards was 2.3 to 1. The service in theatres and recovery was reliant on bank and agency staff to fill gaps in skill mix. From March 2018 to February 2019, theatres used bank and agency nursing staff for 35.1% of shift and used bank and agency ODPs and HCAs for 12.7% of shifts. For inpatient wards during the same time, bank and agency nursing staff filled 2.8% of shifts and bank and agency HCAs filled 1.8% of shift. From March 2018 to February 2019, in theatres and recovery the ratio of bank to agency nursing staff was 2.5:1 and the ratio of bank to agency ODPs and HCAs was 0.5:1.
- The service reported that as of February 2019, the vacancy rates in theatres were 27.27% for ODPs and HCAs (3 WTE) and 16.67% for theatre nurses (1 WTE).
- Nursing staff in recovery were well-supported by the anaesthetist. If a list was running late, the anaesthetist would stay until the patient was stable and the nurse was happy with their condition.
- There was no reported unfilled shift for theatres from December 2018 to February 2019. On the day of inspection, we saw staffing levels were safe and there was enough staff allocated to theatres and recovery. The service undertook elective surgeries and was able to plan staff accordingly. If a staff member called in sick, staff were supported to use bank and agency staff to fill the shift.
- Nursing staff used the situation, background, assessment and recommendation (SBAR) technique for handovers. Handovers took place twice daily between staff for patients staying on the ward.
- There was a dedicated fulltime physiotherapist on the ward who worked Monday to Friday, 9am to 5pm. The hospital also had a part time physiotherapist that covered weekend shifts.
- The hospital also had two receptionists that covered the inpatient wards and one receptionist that covered theatres.

Medical staffing

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

- Consultants worked under practising privileges agreements in the service. Under practising privileges, a

medical practitioner is granted permission to work within an independent hospital. The medical advisory committee (MAC) was responsible for granting practice privileges and was overseen by the medical director. Consultants with practicing privileges had their appraisal and revalidation undertaken by their respective NHS trusts. Staff we spoke to told us the process for managing practice privileges and consultant's' scope of practice was robust.

- From March 2018 to February 2019, there were 320 doctors or dentists employed or with practicing privileges for more than six months at the hospital and its sister hospital. During the same time, the hospital reported three cases of suspended practicing privileges of medical staff.
- The service had anaesthetists that covered the wards and procedures in theatre. There was no formal rota for on call consultant surgeons or physicians. The relevant staff would be contacted directly by staff when needed. Staff told us this arrangement worked and no concerns identified.
- The RMOs were provided under contract with an external agency that provided training and support. The RMOs provided 24-hour 7 day a week service on a two-week rotational basis. Senior staff told us that the RMOs were selected specifically to enable them to manage a varied patient caseload and requirements. The hospital had two inpatient RMOs who rotated for at least six months to ensure continuity of care. The resident medical officer (RMO) provided day to day medical service and dealt with any routine and emergency situations in consultation with the relevant consultant. Out of hours, consultants provided either telephone advice or attended in person.
- While consultants had patients under their care in hospital, they were required to be within 30 minutes journey to the hospital or to have suitable stand-in to provide cover. This was in line with best practice for emergency surgery standards.

Records

Staff kept detailed records of most patients' care and treatment, although records were not always clear, up-to-date, or readily available.

- The hospital used a paper and electronic system to record patient needs and care plans, medical decision-making, reviews and risk assessments. The hospital kept and maintained health records for both NHS and private patients.
- Consultants in the service would send a letter to the patient's GP with information and the outcome of a consultation. All patients admitted to the service would have a discharge summary sent from the hospital and consultant to the patient's GP.
- Staff told us all patient notes were kept securely in the hospital following discharge and doctors could have copies of the patient discharge letters. This was an improvement from our last inspection where there were times when consultants would keep patient records.
- Staff had access to the BMI clinician app through a remote log in that allowed real time information to the clinic list, theatre list, booking request and individual patient information. Staff told us they had timely access to patients record on the wards and theatres.
- The hospital data showed all patients were seen by staff with their records readily available in the last three months before inspection. However, sometimes staff experienced problems finding case notes for surgical patients because pre-operative assessments were carried out at the sister hospital and the notes may not be transferred quickly enough before the procedure, which often took place within the next week. Staff told us this occurred about one in 20 sets of patients records. Staff also told us the receptionists were efficient at obtaining and transferring patient records when a delay was identified.
- We saw that staff stored patient records securely, and when electronic records were not in use staff logged off their computer.
- We reviewed nine sets of patient records and their prescription charts. Most parts of the patients' records were completed, however we continued to find that clinic notes did not always have the consultants' signature and did not always provide the time and date of the note. One surgical operation note did not have the surgeon or anaesthetist's name and where the post-operative plan was signed, the signature was not

legible meaning that it was unclear who undertook the procedure by looking at the patient's record. There was evidence of good communication and multidisciplinary team (MDT) working with patients and their families.

- Pre-operative assessments were completed by staff at the nearby BMI sister hospital. Nursing staff filled out a thorough pre-operative assessment, including the patient's history and medications, allergies, patient's understanding of their procedure, fasting instructions for the day of the procedure, where to go on the day of the procedure and discharge instructions.
- Staff told us there continued to be some gaps with consultants not adding to records. Leaders in the hospital told us that most issues were resolved from our last inspection where consultants kept their patient records with them. Hospital policy was that all records were to be retained by the hospital and consultants who wished to view the hospital's patient notes were asked to do so within the hospital and in accordance with data protection legislation and the Caldicott Principles.
- The hospital undertook monthly audits of patients' health records, which included monitoring of risk assessments such as falls and pressure areas. The health record documentation December audit in 2018 audit showed an overall 81% compliance on the four standards audited. Staff achieved 90% compliance on the WHO checklists, 80% on the general standards, 79% on the clinical risk assessments and 70% on the pharmacy prescription chart on allergies and weight standard.

Medicines

Although the service followed best practice when prescribing, giving and recording medicines they did not always follow best practice when storing medicines. Observations during the inspection showed that patients received the right medication at the right dose at the right time.

- The service had robust systems in place for the management and reconciling of medicines in line with national standards and guidelines. The service carried out several audits of medicines to identify and address safety issues, improve patient outcomes and to offer support to staff.
- All clinical staff we spoke with were clear about the arrangements in place for safely managing medicines, including controlled drugs (CDs). CDs are medicines which require additional security. The arrangements were set out in policies and procedures for ordering, recording, storing, dispensing, administering and disposing of medicines.
- A controlled drug audit performed in theatres in February 2019 found areas for improvement. These were: opioid dosing chart not available or visible in theatre, entries missing when the department is closed, amendments and correction not entered correctly and scribbled over and missing entry for time of destroyed excess controlled drugs (CDs). An action plan was devised, and we saw good compliance with CD procedures on inspection.
- In theatres and recovery, we observed staff followed best practice when administering medications.
- Staff checked temperature of the fluid warming cabinet in theatres daily, however when there were variances in temperatures, no actions were taken. When we asked senior nurses, who was responsible for checking the temperatures, there was no clear consensus. Staff were not clear on the expiry date of fluids kept in the warming cabinet. There were some fluids which were several weeks out of date and there were several bags of fluids that had no date on them. Similarly, there was a freezer next to the fluids warming cabinet where there were no explanations on the temperature log when there were variances and what actions were taken when temperatures were too high or low.
- On the ward, fridge temperatures and clinical room ambient temperatures were monitored and recorded daily. During inspection we saw that all fridge and room ambient temperatures were within the expected range.
- Since the last inspection, the pharmacy department had moved from the outpatient department and relocated into to more suitable and appropriate premises with adequate equipment on the lower ground floor. This was an improvement from the last inspection.
- There were effective arrangements in place to facilitate medicines supplies and advice out of hours. Clinical pharmacy services were available every day from 9am to 5pm and the registered medical officers (RMOs) had permission to access the pharmacy out of hours to

obtain any medicines which wards had run out of. There were also labelled pack of to take away (TTA) medicines on the ward which were dispensed by the nurses and checked by RMO during out of pharmacy hours. Nursing and medical staff were required to complete patient details and name of the medicines dispensed in the TTA book on the wards which would be reviewed by the pharmacist the next day.

- Medicines were also stored in locked fridges and trolleys within locked clinical treatment rooms and only relevant clinical staff could access them. During inspection we observed that all medicines stocked on the wards were managed safely. There was system in place on the wards which alerted staff through a red flashing light signal when the medicines room was opened and unsecured. On the ward, all medicines stored in the fridge and cupboards were all in date.
- There was an up to date antibiotic protocol which included first and second choice medicines to use, the dosage, and duration of treatment. The March 2019 antibiotics audit across both BMI The Kings Oak Hospital and its sister hospital showed that 100% prescription were compliant with the local policy and had an allergy status indicated. Although none of the infections were hospital acquired, the clinical indication was documented, and prescribers were contactable when needed. However, 20% antibiotics were prescribed according to antimicrobial sensitivity and only 30% of prescription stated the duration or review date of the antibiotics prescribed. The recommendation for prescribers was to clearly indicate the treatment duration and review date of antibiotics and to undertake antimicrobial sensitivity prescribing rather than empirical treatment to be increased.

Incidents

The service managed patient safety incidents well. Staff recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support.

- The service reported no never events from January 2018 to December 2018. Never events are serious incidents that are wholly preventable as guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and should have been implemented by all healthcare providers.
- Between January 2018 and December 2018, the hospital reported 25 incidents in surgery or inpatient wards. Most incidents were categorised as no harm or low harm.
- There was an up to date incident reporting and management policy which was last reviewed in November 2018 and was due for review in November 2021.
- The service used an electronic incident reporting system. Most staff in theatres and recovery said they had access to the system, however some said that they would ask their managers to fill out the report for them.
- Staff in theatres and recovery demonstrated there was learning from incidents. Any incidents were addressed at daily meetings, for example when there were equipment issues or cancellations.
- We saw evidence that examples and learning from incidents was discussed at the departmental theatre meeting. All staff from administrative to clinical staff could tell about examples of incidents and learning from incidents not only within The Kings Oak Hospital and their sister hospital but also in the wider BMI organisation. For example, staff knew about a wrong site injection and could tell us what action plans were put in place to prevent it from reoccurring.
- From April 2017 to March 2018, there were four reported incidents requiring duty of candour to be demonstrated in accordance with CQC regulation 20. A meeting was held with the patients to apologise, discuss what happened and treatment plans going forward. All staff have duty of candour training as part of their induction programme.
- Staff had a good understanding of the Duty of Candour requirement. Staff apologised when things went wrong and aimed to resolve any issues with patients before the end of their hospital stay. The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant

persons) of certain 'notifiable safety incidents and provide reasonable support to that person, under Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- The hospital had a monthly lesson learned workshop that was chaired by the risk and quality assurance team and where all MDT staff including housekeepers attended. Learning from incidents, risks and complaints were discussed and shared with staff.

Safety Thermometer

The service used safety monitoring results well. The service collected safety information and shared it with staff. Managers used this to improve the service.

- The safety thermometer is used to record the prevalence of patient harm and to provide immediate information and analysis for frontline teams to monitor their performance in delivering harm free care. It measured the proportion of patients that experienced 'harm free' days from pressure ulcers, falls, urinary tract infections in patients with a catheter and venous thromboembolism (VTE). Staff were aware of their duty to report and reduce incidents of pressure ulcers, falls, urinary tract infections in patients with catheters and VTE.
- The service gathered patient information, for example in hospital-acquired infections, falls and venous thromboembolism (VTE) and discussed these at the hospital's clinical governance meetings. In the reporting period of January 2018 to December 2018, there were no reported incidents of hospital-acquired Meticillin-resistant Staphylococcus aureus (MRSA), Meticillin-sensitive staphylococcus aureus (MSSA) or Clostridium difficile (c.diff) and one case of Escherichia coli (E. coli).
- We observed that safety thermometer data were displayed in hospital areas which showed information about incidents and patient satisfaction.
- Patients were risk assessed for venous thromboembolism (VTE) at time of their admission to the hospital. The clinical quality dashboard showed that 100% of patients received a VTE risk assessment. The service had a target rate of 95% screening for VTE risk assessments.
- We reviewed meeting minutes from the hospital's monthly clinical governance meetings where staff discussed the clinical quality dashboard. Staff reviewed quality and safety measures which indicated performance was within or better than safety performance targets. Areas such as falls and incidents for example were monitored.

Are surgery services effective?

Evidence-based care and treatment

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

- We reviewed ten policies including hand hygiene, critical care of adults, resuscitation, induction, pre-operative assessment, complaints, incident management and complaints. All polices were in date and showed recent review by the clinical governance team. Policies were developed in line with national guidelines, such as the Health and Safety Executive, National Institute for Health and Care Excellence (NICE) and the association of surgeons of Great Britain and Ireland.
- Policies were reviewed in line with NICE guidance. For example, the critical care policy was developed following NICE guideline CG50: Implementing the 'acutely ill patient in hospital'. Staff used the National Early Warning Score (NEWS) for the early detection and treatment of the deteriorating patient. Additionally, the critical care policy was developed with NICE guidelines CG83 which meant that staff took a multidisciplinary approach to help improve outcomes in the acutely ill patient.
- The service audited adherence to national guidelines, for example of completion of NEWS and the World Health Organisation (WHO) checklist for safer surgery. The service provided a NEWS audit from December 2018 of patients on the ward where the compliance average was 99%. A WHO observational audit from March 2019 in theatres showed 98% compliance with standards.

- Patient documentation, such as treatment plans, risk assessments and observational charts was developed in line with national guidance such as the Royal College for Nursing standards. Local policies and procedures were developed in line with national guidelines to ensure staff used evidence based systems to deliver care. This ensured staff delivered appropriate interventions and prescribed care.
- Theatre and recovery staff were kept informed of updates to best practice and changes in the hospital's policies in procedures regularly at theatre meetings. New policies were updated on the hospital's elearning system which staff had to read through before continuing onto other training.

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 planned for patients' religious, cultural and other preferences.

- Staff screened and assessed patients' nutrition and hydration on admission, taking their cultural, dietary and religious needs into consideration, to ensure they were not at risk of malnutrition. Staff used the malnutrition universal screening tool (MUST) for assessing patients' nutrition. MUST is a nationally recognised method used to identify the risk level of each patient and this was documented in the set of notes we reviewed. We saw that were risks were identified staff referred patients to the dietitian service.
- Staff gave advice and followed up patients where nutrition and hydration concerns were identified through their weight, blood result such as urea or appeared dehydrated. Where severe dehydration was identified the nurses liaised with the medical staff to prescribe intravenous (IV) fluids.
- Fluid and food chart were used to monitor patient input and output particularly following a surgical procedure.
- Patients had timely access to dietitians following referrals by medical or nursing staff.
- Patients' dietary requirement were communicated to staff including catering staff during handover and using signs in patients' rooms and yellow jugs on the ward. this ensured staff were aware of patients on restricted drinks or food or required assistance with feeding.
- The hospital food was outsourced to a catering company. The 2018 Patient-led assessments of the care environment (PLACE) showed that the hospital scored 97.8% for the ward food which was better than the national average of 90.5%.
- Patients were given fasting instructions at pre-assessment. Nursing staff tested patients' knowledge on their fasting times and gave them reminders when needed. Patients were asked if they had any special dietary requirements during their pre-operative assessment.
- Patients told us they were given adequate food and water regularly. Patients were offered a choice of menu before their surgery. Once the patient recovered and were ready to eat, staff checked to see if their original option was preferred or provided available alternatives. Patients we spoke with were very positive about the food choices and said the quality was good.

Pain relief

Staff assessed and monitored patients regularly to see if they were in pain. They supported patients, used suitable assessment tools and gave additional pain relief to ease pain.

- The hospital completed pain management audits. The audit forms the hospital provided to us for November 2018 was not fully completed. For example, the department the audit took place and who the audit was completed by were not filled in. 95% of patients were prescribed regular analgesia but only 10% of patients' pain was followed up post-pain relief medication. However, the patient satisfaction survey from February 2019 showed 91.6% of patients felt staff did everything to help control pain.
- Pre-operative assessments for post-operative pain relief were completed by staff in pre-assessment. Patients used a scale from zero to three, where zero was no pain and three was the worst pain to indicate the severity of their pain level. Although audit data from November 2018 showed only 25% of patients were advised or

prepared for their post-operative pain management at pre-assessment, the patient satisfaction survey from February 2019 showed 98.3% of patients felt the likelihood of post-operative pain was explained to them.

- Patients were assessed for pain at regular intervals throughout their care journey and records reflected pain relief was given when needed. Patients we spoke with said that their pain was well controlled and staff responded quickly to giving pain relief support. The pain management audit from November 2018 showed 100% of patients had pain relief medication planned for discharge.
- Pharmacy staff supported pain management at ward level and provided advice and support to patients and clinical teams. Medications prescribed at discharge were communicated to the patient's GP through the discharge letter.
- The service used patient feedback forms to gather information on how well pain was controlled in the hospital.

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 audited and reports showing trend analysis were reviewed through the internal governance structure. This included key performance indicators such as unplanned readmissions, unplanned returns to theatre, unplanned transfers out of the service, healthcare associated infections and significant incidents.
- From January 2018 to December 2018, there were 890 inpatient admissions for surgical patients. During that time, there were four unplanned transfers of patients to higher level of care hospitals, 14 unplanned admissions within 28 days of discharge and three unplanned returns to theatre.
- The surgical service participated in several audit programs. These included the national joint registry (NJR) which collects relevant data about joint replacement surgery to provide an early warning of issues relating to patient safety. They also participated in patient reportable outcome measures (PROMs) for hip and knee replacement surgery and cataract surgery, as well as reporting to Public Health England (PHE) and participate in patient led assessment of the clinical environment (PLACE) audits.
- Patient Reported Outcome Measures (PROMs) are a means of collecting information on the effectiveness of care delivered to NHS patients as perceived by the patients themselves. During the reporting period from April 2016 to March 2017, there was too small of a sample size to compare adjusted health gains for patients undergoing hip and knee replacements to both the BMI Healthcare average and the national average.
- The service followed the Royal College of Surgeons (RCS) standards for unscheduled care. For example, we saw evidence of this in the hospital's policy to have consultants be within 30 minutes journey to the hospital in case of an unplanned emergent return to theatre.
- The hospital submitted data to the Private Healthcare Information Network (PHIN). PHIN is an independent patient information network that informs and empowers patients to make informed choices about their care provider.

Competent staff

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

- New staff were required to complete BMI competencies prior to working independently. Competencies were specific to job roles and were signed off by senior members of staff.
- In theatres, we observed a new member of staff was being supervised and observed as part of their induction.
- Staff had annual appraisals and were notified when their appraisal time was coming up six months before. They were then notified on a monthly basis to complete yearly mandatory training in preparation for their appraisal. The service reported 70% of theatre staff completed a yearly appraisal. On the ward, 75% of nursing staff completed a yearly appraisal. Yearly appraisal rates for healthcare assistants was 75% on the ward.

- Nursing staff told us that the hospital helps them with revalidation of their nursing registration.
- 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 clinical experience relevant 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 we reviewed.
- A weekly report was exported from a consultant database to check that documentation such as indemnity insurance and registration with the GMC was up to date, and consultants were contacted where these were due to expire with a set deadline to produce new documents.
- Medical staff had attended an orthopaedic conference for GP's and a monthly GP education event. We noted this was highlighted as one of the hospital 2018 key successes.
- The pharmacy team updated their skills and competency through evidence based practice and best practice. We saw that the pharmacy staff kept up to date with latest medicines guidance, trends through the pharmacy journal which were shared with colleagues and other MDT staff. For example the pharmacy discussed and shared a recent article by the NHS Improvement on medication errors.
- The pharmacy manager was on a Chartered Management Institute (CMI) level 5 course which was funded by the hospital. The manager reported good support with the training from the chief executive.
- The IPC link practitioner had attended an ANTT conference in December and BMI were looking at achieving a gold accreditation in 2020 to improve patient outcome.

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.

- The surgical service multidisciplinary team (MDT) worked together and with external professionals and hospitals to improve patient care and outcomes. Doctors, nurses, pharmacists, operating department practitioners (ODPs), health care assistants, physiotherapist, dietitian and the occupational therapist (OT) supported each other and were involved in assessing, planning and delivering patient care and treatment. We saw there was good liaison and collaborative working between the MDT which was evident in the patient notes reviewed. The service also worked closely with social services, insurance companies and local NHS hospitals.
- There were various meetings attended by MDT staff to discuss and improve patient care, such as the daily morning 'comm cell' meeting, afternoon 'safety call meeting', ward rounds and resuscitation meetings and antibiotics and sepsis meetings. The safety call discussed safety aspects on the ward and the 'comm cell' meeting discussed surgical procedures after 4pm, staffing issues, expected admissions and discharges, equipment issues, incidents and complaints, who the on-call manager was and any other hospital business.
- The daily ward round meetings were attended by the RMO, nurses, nurse in charge, pharmacist and physiotherapist to discuss patient care and progress and agree a discharge plan.
- Receptionists on the ward worked with other MDT staff in improving patient pathway and experience through the booking of patient appointment and porters, arranging ambulance and patient transport, orienting patients on the wards and sending patient discharge information to the GP.
- Pharmacists supported on the ward and provided information to patients on their medications. The pharmacist attended the ward rounds and MDT meetings, such as 'comm cell' meetings.
- There was a dedicated fulltime physiotherapist on the ward who worked Monday to Friday, 9am to 5pm. The physiotherapists were mostly involved with surgical patients that have undergone hips, knees, shoulders or hand surgery. They were also involved in the pre and post-operative assessment and care.
- There was access to an on call occupational therapist (OT) and dietitian on the ward through referrals. Patients

were contacted by the OT before surgery and assessed by the occupational therapist on day two post-surgical procedures with patient ordered equipment delivered before patients discharge home.

Seven-day services

- Theatres and recovery operated Monday through Friday from 8AM to 8PM and on Saturday from 8AM to 4PM. The wards operated seven days a week.
- The pharmacy was open Monday to Friday 9AM to 5PM. There was out-of-hour access to the pharmacy by the resident medical officer and senior nurse in charge. Staff at BMI Kings Oak Hospital had access to remote clinical on call service from another BMI hospital.
- While there was no designated emergency theatre, both theatres at BMI Kings Oak were equipped for all procedures.
- There was an on-call surgical staff rota for out-of-hour emergencies. While consultants had patients at the hospital, they were required to be within a 30 minute commute to the hospital in case of patient emergency or to make necessary arrangements for cover.
- There was registered medical officer (RMO) cover 24 hours a day, seven days a week for patients on the ward.
- The service had access to out-of-hour diagnostic imaging. There was an on-call radiographer rota and staff were aware how to contact out-of-hour radiographers.

Health promotion

- Health promotion materials were available across the ward and waiting areas. Information available included reducing the risk of falls, breast health, hand washing, blood transfusions and smoking cessation.
- In pre-operative assessment, staff advised patients on smoking cessation, weight management and could make referrals for patients to see physical therapists, occupational therapists or dieticians while in hospital.
- Staff supported patients who accessed surgical services to live healthier lives and manage their own health, care and wellbeing. Staff gave health promotion advice with leaflets given in line with national priorities to patients and their relatives on various topics such as smoking cessation, exercise, alcohol reduction and healthy eating.
- Staff on the ward encouraged patients to mobilise early post-surgery to help prevent post-surgical complications and encourage independence.
- After discharge, patients with total hip or knee replacement had regular one to one outpatient appointments with physiotherapy. Staff encourage patients to attend a fortnightly group hip and joint physio session when their pain was under control, their confidence improved and were able to mobilise independently. Physio staff discharged the patient by writing a letter to their consultant and GP. Patients were also given a copy of their discharge letter from physiotherapy.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

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

- We saw consent forms were completed in patients' records in line with BMI policy on consent for examination or treatment. Consents were generally completed the morning of surgery and confirmed with patients in theatre prior to anaesthetisation. We saw evidence that consents addressed the diagnosis, potential risks and benefits, the treatment team and patients' rights. The service provided data from a documentation audit from December 2018 and April 2019 which showed evidence that 100% of patients from 40 records had documented informed consent.
- Staff received training on the Mental Capacity Act (2005) as part of their mandatory training. The BMI consent policy was created with current legislation for patients who lack mental capacity. Staff were able to give clear explanations of their roles and responsibilities under the Mental Capacity Act 2005 (MCA) regarding mental capacity assessments and DoLS.
- The service undertook regular audits for completion of consent forms as part of their health documentation audit. The service completed these audits quarterly.

- The service reported no breeches in the two-week cooling off period required for cosmetic surgeries in the 12 months prior to our inspection.

Are surgery services caring?

Good

Compassionate care

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

- In theatres and the recovery area, staff were consistently friendly and caring to patients. Staff explained steps as they went along and patients told us they felt well-informed of their care and included in decision making.
- While in theatres, we observed a patient that was anxious about their surgery. Theatre staff approached the patient with a caring and reassuring attitude. Following the procedure, the patient provided positive feedback about staff and overall very happy with the care they received.
- We saw several examples of thank you cards to staff for the excellent and compassionate care they received as a patient.
- Patients told us that all staff introduced themselves by their first name and they remembered the names of staff involved in their care. This was also evident in the thank you cards and feedback cards we reviewed.
- The hospital 2018 PLACE audit showed the hospital scored 89% for privacy, dignity and wellbeing which was better than the national average of 84.2%. Patients' privacy and dignity was respected, especially during physical or intimate care. All patient rooms on the ward were private and chaperones were used when necessary.
- The 2018 patient satisfaction scores showed 97.6% patient said they were likely or extremely likely to recommend, 96.7% said the quality of care were very good or excellent and while 96.8% felt their expectation were met or exceeded. Several patients we spoke with said they have used the service on several different occasions and have recommended the service to friends and family.

Emotional support

Staff provided emotional support to patients to minimise their distress.

- A card from a patient on the ward thanked staff for the emotional support during their stay, "Thank you for comforting me when I was upset, calming me down when in theatre. For being so informative and caring about my surgery".
- Staff told us they had time to spend with patients to reassure them and provide emotional support. We saw staff provided emotional support to patients and always reassured and encouraged patients to achieve their goals.
- All the patients and their relatives and carers we spoke with told us they felt supported throughout their journey from consultation, pre-assessment through treatment and therapies.
- Patients consistently said that they had been offered emotional support and that it was available if they needed it. Patients could call staff on the wards seven days a week for support, even after discharge.

Understanding and involvement of patients and those close to them

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

- Patients told us that staff introduced themselves and they knew who their nursing staff was each shift. Patients knew who their consultants were.
- Patients felt that conversations about finances were handled sensitively. We heard from patients and staff that NHS and non-NHS patients were not treated differently in any way.
- During our inspection we saw evidence that staff involved and discussed with patients and their loved ones on the choices of their care and treatment.
- Staff on the ward spoke passionately about the importance of updating patients and their relatives

about the care, recovery and discharge process and how it impacted on patient care and experience. All the patients we spoke with were aware of what to do if they felt unwell during admission and when discharged home.

- We observed patient clinical procedures and handover and noted the consultant had clear communication with patients on the ward. After surgery, consultants explained their findings and treatment plans in detail in a way patients understood. We saw that staff took their time to explain information to patients and involved them in their treatment plans.
- Specific comments from patient thank you cards and feedback cards for surgical patients included: "thank you so much to all who looked after me last Saturday when I had my surgery, you all made me feel like a princess and made my stay in hospital an enjoyable one".
- The 2018/19 hospital satisfaction score was displayed on the ward which showed decrease in hospital performance from the previous year on information given by consultant, discussion on proposed treatment, information pack, decision to treat and delayed discharge. The hospital satisfaction score mirrored the top complaints made about the service.

Are surgery services responsive?

Good

Service delivery to meet the needs of local people

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

- The service was adapted to meet the needs of its population. The hospital offered elective surgeries to NHS and private patients. There were a variety of surgical procedures available, including orthopaedic, gynaecology, urology, and cosmetic. There service planned to hold lists and clinics on certain days for Turkish speaking patients.
- The hospital had a commitment to private patients as well as agreements with the local commissioners to provide services for NHS patients, and it ensured that services commissioned from them were safe and of a good quality. The commissioners included several CCG groups such as Enfield CCG and Barnet CCG, NHS England and NHS hospitals. Staff told us that all patients were treated equally.
- Senior managers reported good relationship with their local clinical commissioning group (CCG) in the planning and delivery of care. This was highlighted as one of the hospital strengths and achievement in the hospital 2018 business plan.
- Some patients were offered a telephone pre-assessment. This meant that they would not have to make additional journeys to the hospital. This was offered to patients who were assessed as appropriate for a telephone consultation.
- The BMI website had an on-line query form and a life support webchat which was encrypted which patients could contact the hospital for advice, query and support about the service or care.

Meeting people's individual needs

The service took account of patients' individual needs.

- Staff had access to a new interpreting service, although while this was advertised in the theatres, most staff had not used it. The interpreting service provided British Sign Language interpreters and spoken language interpreters of over 200 languages and dialects. The need for an interpreter was normally identified at the time of referral to pre-assessment and the service could arrange for an interpreter to be booked in person for their appointments.
- Leaflets on the wards were in English, but we were told they could obtain them in languages other than English.
- Nursing staff discussed discharge planning with patients at pre-assessment, including expected discharge day, planning transport to get home and if patients would need assistance once home, for example from a friend or family member.
- Follow-up appointments were given to patients in a timely manner during clinic consultation and we saw that staff accommodated patient preferences and commitments.

- Patients could access wheelchairs and there were lifts available if needed. Theatres, recovery, wards and reception were all on the same floor which made it easily accessible for patients to get around the hospital.
- Physiotherapy was involved in patient care. Nursing staff in pre-assessment could make referrals to physiotherapy and occupational therapy.
- Patients who underwent total hip or knee replacement were seen on the ward by physiotherapy and nursing team members. They were given patient-specific instructions and education on basic bed mobility, gait re-educated using walking aids, stair training and home exercise plans. On discharge, all patients were given a pre-booked post-operative outpatient appointment with physiotherapy.
- When patients arrived at reception, reception staff or ward administrative staff would collect and walk the patient to their room. Staff acquainted patients to their room and showed them where other relevant rooms were, for example the room where family or friends could wait.
- The service had a separate family room where patients' relatives or carers could wait on the ward. There was a water cooler in the room that visitors could use.
- During our inspection, we saw that staff promptly answered patients' call bells and responded to their individual needs. Most patients told us their care felt individualised to them.
- The service did not often admit patients living with dementia or learning disabilities, however this would be identified in the pre-operative assessment. Staff would ensure that the patients' family or carers were involved with the care plan.
- Staff catered to patients' individual dietary needs. Dietary preferences would be assessed during the pre-operative assessment and catered for during the patient's stay. Patients told us there was a good variety of food and that the quality was good.
- The service continued to implement intentional hourly rounding. Patients sometimes felt isolated because they were all in private rooms. Staff rounded on patients hourly to ensure their pain was well-controlled, personal items were within reach, help the patient if they needed to use the toilet, and ensure that they were in a comfortable position.

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 mostly in line with good practice.

- During our inspection, there were surgical and medical patients on the ward. The surgical patients included two inpatient admissions, four overnight admissions, 13-day cases and four possible discharges.
- We spoke with patients who had been attending the service for several years and those who had visited for the first time. All patients said they waited only for a short time for their procedure.
- Patients were pre-operatively assessed in a nurse-led clinic prior to surgery or by a telephone pre-operative assessment depending on if they met certain criteria. The National Institute of Health and Care Excellence (NICE) guidelines were used to assess patient's anaesthetic risk in the clinic. The service had strict admission criteria and did not admit patients with complex co-morbidity or bariatric patients. Discharge planning was addressed at time of pre-assessment so any specific needs could be met and planned for.
- The service held a weekly planning meeting to discuss staggered admission times for morning and evening surgery lists. Patients were informed on admission the order of the theatre lists and waiting times. Most patients told us they felt well-informed of waiting times once admitted.
- Theatre staff remained on site until the patient was appropriately recovered and ready to return to the ward. There were enough beds on the ward for patients that unexpectedly needed to stay the night, for example for patients undergoing a day case surgery.
- The service maintained an on-call theatre team in case of emergencies. Consultant surgeons were required to be within 30 minutes transportation to the hospital.

Although there was no service level agreement (SLA) in place with a local NHS trust, the service did not have difficulties transferring out patients in need of more complex care and treatment.

- The referral to treatment (RTT) target for NHS-funded patients was within 18 weeks (admitted pathway) of referral. The overall average of NHS-funded patients meeting the target 18-week RTT from April 2018 to February 2019 was 88.8%. This was better than the national average of 72% of patients meeting the 18-week RTT.
- There were a total of 20 cancelled procedures for non-clinical reasons from March 2018 to February 2019. Of these, 90% of patients were offered another appointment within 28 days of the cancelled appointment. Staff we spoke to told us they had few cancellations and reasons were related to non-compliance of patients, such as nil by mouth before surgery, did not attend (DNA) and use of aspirin before coming for surgery.
- Bed capacity planning meetings took place weekly and representatives from each clinical area were present. This ensured that heads from all clinical areas were aware of the issues around the hospital and could offer further assistance by way of additional staff if need be.
- Staff told us the discharge process was effective and they had few cases of delayed discharge. The normal length of stay for surgical and orthopaedic patients such as hip or knee replacement procedures was three days.

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.

- Patients were provided with information on how to make complaints. There were leaflets and posters available on the ward on the process of making complaints and providing feedback.
- Complaint trends were discussed at the clinical governance meetings and at theatre and ward meetings.
- From September 2018 to February 2019, there were 23 complaints reported at BMI Kings Oak Hospital which were all resolved at hospital level. The top trends identified for complaints during that time were around communication and clinical care/treatment. The service kept a log of planned dates for responding to complaints, lessons learned and if the complaint was resolved. We saw evidence that complaints were investigated and that staff apologised when something went wrong.
- Most patients we spoke with were aware of how they could make a complaint and felt that they could bring up complaints with staff if necessary. Staff aimed to address and resolve complaints each shift or before patients' discharge.
- The service encouraged patients to complete patient satisfaction questionnaires.

Are surgery services well-led?

Requires improvement

Leadership

Most managers in the service had the right skills and abilities to run a service providing high-quality sustainable care.

- The hospital was led by a senior management team consisting of an executive director (ED), director of operations, director of clinical services and a quality and risk manager. Surgical services had a theatre manager and ward manager who worked across sites with the sister hospital. The hospital had a local deputy theatre manager. At the time of our inspection, the theatre manager was absent due to sickness and the deputy theatre manager provided cover.
- The executive director reported to the corporate regional director. They had a bimonthly one to one meeting and a bimonthly meeting of all regional executive directors.
- Leaders prioritised safe, high quality, compassionate care and promoted equality and diversity. The leadership model of the service encourages cooperative and supportive relationship among staff and patients so that they felt respected, valued and supported.
- Since the last inspection, the hospital had recruited new executives such as a quality and risk manager and

director of clinical service to strengthen the governance framework and leadership. The hospital introduced an on-call rota in April 2019 for the hospital mangers to support staff and be present in clinical areas on Saturdays. This was an improvement since the last inspection.

- Staff, including the senior nurses and ward managers, told us the executives were visible, accessible and supportive, and encouraged their career progression. Staff felt the management team were interested in the surgical service.
- The executive director (ED) told us that medical supervision had improved since the appointment of a new Medical Advisory Committee (MAC) chair person in 2018. They were a senior consultant at a local NHS trust. They said there was an issue with getting enough doctors to be part of the MAC and were trying to encourage new members. The ED said they aimed to ensure the MAC was representative of the consultant body and that they had a good range of consultants including anaesthetists and surgeons of different specialties. However, the MAC was currently all-male. The ED said they were working to change this and two female consultants were about to join.

Vision and strategy

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

- The hospital had a five-year vision for 2015 to 2020 which was achieved through their eight strategic objectives and priorities. The objectives and priorities included patients, people, communications, growth, governance, efficiency, facilities and information. This was achieved through their strategies which included delivering the best clinical outcomes through best practice pathways. The hospital aimed at having a clear evidence of meeting standards through integrated audit results, improving patient experience, investment in new medical technology and equipment and improving the look of the hospital through refurbishment.
- The hospital vision was to deliver the best patient experience. They aimed at delivering the best possible patient outcomes and experience across all groups by consistently delivering quality care and services in a cost-effective way.
- The six Cs initiatives was displayed throughout the hospital, which encouraged staff to embrace the values of compassion, competence, care, communication, courage, and commitment.
- Leaders worked on consolidating services across the two hospital sites (BMI The Kings Oak and its sister hospital). For example, theatre utilisation was about 50% across the two sites and the services were considering consolidating day case procedures at one location and inpatient procedures at another location with the aim to use resources more effectively.
- The clinical vision for the hospital and its sister hospital continued to aspire to have a high dependency unit (HDU). Having a HDU meant the hospital could take on more complex surgeries. Staff were also aware of the plans add a sluice room in recovery.
- Senior leaders shared the hospital vision with staff through monthly staff forums chaired by executive director leads. Staff forums were an opportunity for staff to get information on the hospital's and company's performance and key issues. It was also an opportunity for staff to voice concerns and raise issues.
- There was a monthly staff newsletter delivered by email to staff across both of the BMI hospital sites where the service's vision was shared. As well, staff newsletters were printed and displayed in staff rooms.

Culture

Although most managers across the service promoted a positive culture that supported and valued staff, we found there were areas requiring improvement in theatres for creating a culture of safety and supporting staff to challenge poor practice.

- Staff did not always challenge the behaviour of consultants. For example, in one theatre observation, the consultant surgeon was pressing staff to get the next patient when the first patient procedure was beginning. The operating department practitioner (ODP) then left to get the next patient while leaving the anaesthetist unsupported. We also observed that staff left theatre at key times, such as for the sign out (part of the '5 steps to safer surgery'). Other staff present did not challenge this behaviour.

- Staff did not always display a culture of commitment to safer surgery in theatres. Although staff had access to a dry wipe board in theatres to ensure best practice of swab counts, we did not see this in practice. During the time out in the world health organisation (WHO) checklist, a period of time where all staff should be paying attention and verifying the right surgery and site for the patient, we observed all staff were not listening. One member of staff interrupted the scrub nurse during the time out to add to the scrub trolley. We also observed during the time out that paperwork was filled out retrospectively. We observed staff complete instrument count documentation prior to the counts being completed. There was a lack of leadership to ensure that safety was a priority.
- In theatres, we observed a consultant surgeon repeatedly asking other staff to do tasks quickly and move the theatre list along. It was not apparent if the theatre list was being managed by the team leader and it did not appear that staff could challenge a consultant surgeon to slow down.
- The provider had identified poor clinical practice in a small number of consultants and had a system in place to address and improve practice using the MAC committee as a focus.There was a process in place for staff to identify poor practice and raise the issue with the provider who had an improvement process in place.
- The executive director (ED) told us that the recent staff survey results showed that bullying and harassment were still an issue across the two hospitals. The results were not broken down by staff site or speciality so they were unable to identify if the issue was localised. The ED said they planned to work with staff to address the issue, and that it had improved slightly since the last survey.
- In the recent staff survey, the number of staff who responded to say they would recommend the hospitals to family and friends as both a place to work and for treatment had increased.
- Most theatre and recovery staff were consistently positive about their job roles and felt happy working in the service. Staff told us they felt well-supported by the deputy theatre manager. Although many staff worked in the service for several years, most could not voice why they enjoyed working there other than it is where they had always been.
- The hospital celebrated staff and team success through various star awards and displaying of team success. Staff success were also celebrated at the daily communication meeting and hospital newsletter. The hospital newsletter also highlighted and celebrated staff that were newly recruited, or maternity leave or retired.
- BMI The Kings Oak participated in a survey for the BMI Healthcare Limited organisation which looked at workforce race equality standards (WRES). The results for the BMI Healthcare Limited organisation in 2017/18 showed that 14.5% of staff identified as black and minority ethnic (BME), 76.3% identified as white and 8.2% identified as unknown or did not answer. Across the organisation, 91.9% of board members were white and 9.1% were BME. Across all BMI sites, 65% of white staff and 55% of BME staff thought there was equal opportunity for career progression or promotion, 13% of white staff and 20% of BME staff said they experienced bullying, harassment or abuse from staff in the 12 months prior to the survey, and 9% of white staff and 17% of BME staff said they personally experienced discrimination at work from their manager/team leader or other colleague.

Governance

Although the service had systems in place to improve improve service quality, in practice we found that these systems were not always effective.

- The service worked to gain assurance through various governance meetings such as the clinical governance committee, health and safety committee, medical advisory committee (MAC) meeting, senior management meeting, infection prevention control (IPC) meeting and the cross site departmental meeting. However, while we saw evidence IPC including staff being bare below the elbows was discussed at quarterly IPC meetings, this best practice was not always observed on wards or in theatre.
- Hospital governance meetings were held regularly to review all incidents, significant events, audits, complaints, compliments, patient satisfaction and practice privilege.

- The clinical governance committee meeting: was a cross site meetings and held monthly. This meeting was attended by all hospital departmental leads and executive director, director of clinical services and pharmacists. The agenda included the CQC action plan, updates from the local hospital clinical governance reports, updates from the hospital quality and risk management report, incidents case reviews and learning, pre-assessment, medicines management, staffing, policies, health promotion, clinical bulletin, national safety alerts, dashboards, complaints, risk register, patient satisfaction and unplanned transfers. In the February 2019 meeting minutes, we saw that local policies and some NICE guidance were reviewed by the committee.
- The monthly cross-site departmental team meeting was attended by staff and ward managers to review staffing, risk register, finance, audits, risk assessments. Other items on the agenda included journey to outstanding, key messages, IPC, patient satisfaction and complaints, training, clinical governance, policies and procedures. We noted that the February 2019 minutes highlighted that the new blood transfusion audit and pathway were in progress across the hospital.
- The medical advisory committee (MAC) was held quarterly and oversaw the renewing of consultants' practicing privileges, clinical governance issues, key policies and guidance and monitored patient outcomes.
- Practicing privileges were granted after submitting a CV and two references to the executive director who then interviews along with the chairman of the MAC. Privileges were reviewed and renewed annually according to evidence of appraisal, revalidation, GMC membership, mandatory training completion, and enough evidence of good conduct.
- We found that although the observational audit for the WHO checklist showed good compliance, in practice this was not always the case. Our observations showed a relaxed attitude and inattentiveness at times.

Managing risks, issues and performance

Although the service had systems to identify risks, plans to eliminate or reduce them, and cope with both the expected and unexpected, we found in theatres these were not always put into practice.

- There were eight risks on the hospital risk register that were specific to issues in theatres and the wards. Mostly, we found that the risks on the risk register matched the risks that we observed on inspection, however it was not identified that there were risks around compliance of safer surgery checks and attitude toward challenging poor practice.
- The top risks for theatres and recovery were displayed in the staff lounge for theatre and recovery. Although some staff were aware of the risks, there were several who did not know them.
- Senior leaders of the service, including the executive director, ward manager, theatre manager and infection prevention control lead nurse attended clinical governance committee meetings monthly. We saw that risks were discussed regularly at clinical governance committee meetings. Outstanding actions and updates were regularly addressed at these meetings.
- Staff were able to enter potential risks within the service on the electronic reporting system. Initially the ward manager or theatre manager would review the risk and investigate if they needed to be escalated to the head of the department and quality and risk manager. This meant that staff could directly be part of risk management within the organisation.

Managing information

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

- During inspection we observed staff treated patient identifiable information in line with the General Data Protection Regulations (GDPR).
- 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.
- As well as having access to the hospital intranet for all up-to-date policies, staff were aware that policies and pathway information was kept in paper format on the wards.

- Information technology systems were used effectively to monitor and improve the quality of care. For example, the corporate risk and incident recording system provided the hospital with a platform to monitor and assess risks and assess trends.

Engagement

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

- The hospital actively gathered people's views and experiences through questionnaires. The corporate introduction of an online patient satisfaction questionnaire and friends and family test (FFT) in October 2017 to replace paper versions resulted in a reduction in patient participation. The hospital reintroduced paper questionnaires only a couple months later in December 2017 which improved participation rates. From September 2018 to February 2019, the response rate for the friends and family test was 65% with a score of 98% would recommend the service to others.
- The senior leadership team across the hospital and its sister hospital engaged with staff by being visible and walking around on wards and through theatres and recovery. Senior leaders supported teams, provided an on-call role, provided a 'lessons learnt' workshop monthly and encouraged staff across departments to attend, feedback to staff on complaints and near misses and encourage openness across the hospitals.
- The service obtained patients feedback through various forms such as social media, NHS choices, BMI website, feedback forms, and the patient satisfaction group. The monthly patient satisfaction meeting was a cross site meeting were staff representative from each site were required to attend and meet with patients to discuss patient feedback trends.
- The physiotherapist team started a 'joint school' for hip and knee patients requiring surgery. The joint school was available for patients undergoing total hip and knee replacement. If a patient was on this pathway they were pre-assessed and had the opportunity to meet the multidisciplinary team. Physio staff gave a one-hour presentation explaining exactly what the procedure involved, how long patients could expect the incision to be, what type of prosthesis would be used, medications to be prescribed, what exercises to do, how long it could take before normality returns and any particular dos or don'ts associated with the surgery. Patients were given time to ask questions regarding their surgery.
- The hospital and sister hospital had a 'you said, we did' campaign where patients and staff could provide feedback for the hospital to make changes. Some areas where there was improvement included complaints about blinds on some ward bedroom windows were not sufficient for patient privacy. The hospital had a program of blind replacement underway with 80% of blinds already replaced. Another example included that staff noticed dietary requirements were completed as often prior to patient admission. In response, the hospital created a new form for completion in pre-assessment to be sent to the catering team prior to admission to ensure patients' needs were met.

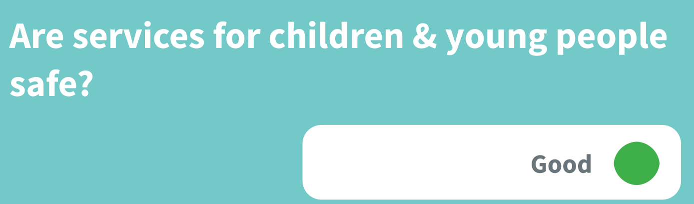
Learning, continuous improvement and innovation

- Pharmacy staff developed and implemented medication record cards for patients who may be living with dementia or were concerned about remembering to take their medications when discharged home. Medication record cards listed the drug name and strength, dose, times to take medication, indication (for example for pain or prevention of deep vein thrombosis) and remarks (such as to take medication only as required or to take medication with a meal).
- Staff from the hospital and sister hospital started a group for learning, educating, and adapting to falls (LEAF) which met quarterly to assess, plan and discussed potential falls and how to manage them. In October 2017, the hospitals worked with the GP liaison officer and the Chartered Society of Physiotherapists (CSP) to hold the 'older people day and LEAF' GP evening where 15 GPs attended the event. A geriatric consultant and the physiotherapy manager gave a falls presents and discussed referral pathways along with a leaflet to demonstrate how to quickly make referrals. This helped to ensure there was a clear pathway for patients at risk for falls and understanding when further referrals were needed for occupational therapy or physiotherapy.

Requires improvement

Services for children & young people

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



Are services for children & young people safe?

Good

Mandatory training

The service provided mandatory training in key skills to all staff but did not ensure everyone completed training in paediatric life support.

- The hospital offered a comprehensive mandatory training package with modules including information governance, infection prevention and control, equality and diversity, health and safety, resuscitation, children and adults safeguarding.
- Mandatory training was completed on the online electronic system within the hospital with some modules carried out face to face. Staff were given a six-month window in which to complete their training once recruited. Protected time was given where staff required additional time to complete their training. The mandatory training co-ordinator emailed a monthly report to the clinical service managers. The report showed training compliance rates, and where training had or was near to expiring.
- Hospital wide mandatory training rates in paediatric basic life support (PBLS) and paediatric intermediate life support (PILS) were low with compliance for PBLS at 81% and PILS at 72% against a provider target of 90%. We saw that children's nurses within the CYP service had up to date PILS training, however, in theatres staff were only 47% compliant.
- An action plan had been implemented to ensure all consultants were up to date with their resuscitation training, although the plan was not dated and had no target date for completion.
- We were told there had been an emphasis on ensuring training was being completed, and that medical practitioners were compliant with both paediatric intermediate life support (PILS) and safeguarding level 3 training. Additional in-house training sessions had been offered to consultants to support this.
- Both the Resident Medical Officer (RMO) and Lead Paediatric Nurse (LPN) were trained in European Paediatric Advanced Life Support.
- Resuscitation simulations were practiced within the hospital three times a year. This was provided through an external provider and simulations were unannounced.

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so

- Staff were aware of who they should escalate safeguarding concerns to within the hospital. The safeguarding lead for the hospital was the director of clinical services. A new director of clinical service had just been recruited, and in the interim all safeguarding concerns had been escalated to the lead paediatric nurse.
- The lead paediatric nurse had good communication, and supervision, with the designated nurse at the

Clinical Commissioning Group (CCG). The named doctor for safeguarding practiced at the hospital on a regular basis and represented the CYP service at the Medical Advisory Committee.

- Staff understood the processes and procedures to take should they identify any safeguarding concerns. The children and young people's safeguarding policy was up to date. It included explanations about female genital mutilation, breast ironing, modern day slavery, radicalisation, human trafficking and warning signs to look out for. A copy of the referral form to social care was contained within the document. Staff showed us how they would access the policy on the hospital intranet.
- An escalation flowchart was available for staff to follow should they have any safeguarding concerns. We saw that this was available on Acorn ward and within outpatients. Telephone numbers for whom to contact at the time of escalation were missing from the flowchart.
- Staff explained they would report safeguarding concerns to their manager, record the concern and make an appropriate referral. We were told that no safeguarding referrals had been made in the twelve months prior to inspection.
- The lead paediatric nurse said that questions were asked in relation to safeguarding at the pre-assessment stage. Where it was identified that a child was on a child protection plan, the lead paediatric nurse would seek advice from the designated nurse at the CCG. At the time of inspection, we were told that the hospital was not aware of receiving any children on a child protection plan.
- Information in relation to each patient was recorded in a care plan. However, there was no section within the care plan to document safeguarding concerns or current involvement from social workers or other professionals.
- The paediatric ward (Acorn ward) was a secure environment with the main doors to the ward kept locked at all times. Staff were present whenever a child was staying on the ward. Although there was no abduction policy in place at the time of our inspection, the corporate children and young people's group were in the process of writing guidelines to include within the safeguarding policy.
- A corporate safeguarding committee meeting was held quarterly which all lead paediatric nurses attended to ensure compliance with guidance and current best practice in relation to safeguarding.
- The lead paediatric nurse attended Enfield Strategic Safeguarding Subcommittee Group which reported to the Local Safeguarding Children's Board (LSCB).
- Staff told us they adhered to the chaperone policy which required that children seen in the outpatient's department were accompanied at all times.
- Nursing staff within the CYP service checked outpatient attendances for the previous day. When children and young people did not attend their appointment, staff contacted the family to ascertain why and to see if a new appointment was needed. If no contact was made, then a letter was sent to the family GP. A flowchart for children "not brought" or who had missed appointments was contained within the safeguarding policy. At the time of inspection there had been three Do Not Attends (DNAs) recorded since the service started to see children for day case procedures in March 2018, with one being a system error.
- Checks were undertaken in radiology for children and young people who might be pregnant. An up to date policy was available for the examination of patients of child bearing potential.
- There was no information on display within the hospital to remind the public to be alert of safeguarding concerns and who to contact in that situation. No leaflets were available to inform the public about safeguarding issues such as female genital mutilation and child sexual exploitation.
- Mandatory training rates for safeguarding children level 1 and 2 were good with compliance at 95% and 97% respectively meeting the hospital target of 90%. Compliance rates for safeguarding level 3 was low at 77%. The resident medical officer and registered children's nurses were trained to safeguarding level 3. The lead paediatric nurse had identified that consultant level compliance had been low, and an action plan had been implemented to raise completion rates. The action plan stated that until consultants had provided evidence of completion of their training they were not permitted to see children and young people.

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.

- There was a lead infection control nurse for the hospital. The lead paediatric nurse was the link infection control nurse for Acorn ward and attended infection control meetings held at the hospital.
- Areas used by children and young people were observed as being generally clean and tidy. However, we found the paediatric resuscitation trolley in outpatients was dirty and covered in dust.
- Between March 2018 and February 2019 there had been no incidence of Clostridium Difficile (C. Difficile) or Escherichia coli (E. Coli) within the children and young people's service. There had been one recent incidence of staphylococcus aureus which had been acquired prior to hospital admission. This had been flagged to the infection control lead, and the patient was being followed up through outpatient appointments.
- We checked the cleaning schedule for Acorn ward which was up to date. Cleaning records were retained and checked by the lead paediatric nurse.
- Distraction toys were cleaned with antibacterial wipes after every use. We saw the cleaning rota for the toys which showed they were cleaned regularly.
- Hand sanitisers were seen throughout the areas that children and young people were cared for. Signs were placed above prompting visitors to the hospital to clean their hands with the appropriate hand washing technique.
- Personal protection equipment including aprons and gloves was available, and we saw staff wearing it when providing clinical care.
- We saw that the disposal of sharps, such as needles followed good practice guidance. Sharps bins were signed and dated when assembled and not overfilled.
- The rooms on the ward did not have clinical basins. The only basins available were those within the en-suite bathroom. We were told that the installation of clinical sinks had been approved and this was due over the following few months.
- Bars of soap were found in the en-suite bathrooms on Acorn ward. This is not considered best practice and was escalated to staff on the ward who said they would be removed.
- Infection control audits were undertaken throughout the hospital. We viewed the infection control audit for March 2019 completed by the lead paediatric nurse, which showed that Acorn ward scored 91%. The one standard that was not met was PPE being removed and disposed of at point of use. An action plan was in place to address areas of non-compliance, and this was discussed at the infection control meetings.
- The Acorn ward was not included in the hand hygiene observation audits undertaken within the hospital. Although the lead paediatric nurse said they could ask for an audit to take place on the ward if they felt it necessary.

Environment and equipment

The service had suitable premises and equipment, although we found some areas that needed improvement.

- The ward designed for children and young people was a four bedded unit and was a quiet, bright and calm area.
- A daily check list was recorded to ensure equipment checks were completed and the environment was safe. This included environment and toy cleaning schedules, equipment checks and resuscitation trolley checks.
- We saw that risk assessments of the environment on Acorn Ward and outpatients had taken place in May 2018 and were due to be reviewed after a year. Risks addressed included access to open windows, uncovered plug sockets and to clinical rooms. Controls were in place and where any risks were identified an action plan was implemented. There had been no assessment of ligature risk undertaken.
- Bath tubs were located within the en-suite bathrooms on Acorn ward with a shower hose in place. There were no bath mats in place and no signs to warn patients of slippery surfaces and potential risk of slipping or falling. There had been no risk assessment undertaken for patient falls within the bathrooms.

- Staff checked rooms on the ward and in outpatients for any risks prior to children attending, for example ensuring sharps bins were not accessible and that hazardous substances were locked away.
- A treatment room on Acorn ward was used for drawing up oral medicines. The room was also used to store equipment and there were plans in place for further storage and re-organisation. The room was locked when not in use to prevent unauthorised access.
- Equipment checks were carried out regularly, however we noted there was no review date or calibration for the measuring scales on Acorn ward.
- The paediatric resuscitation trolleys were located in the outpatient's department, theatre recovery and on Acorn ward. We saw that all equipment was age appropriate and was in date. Checks of the equipment within the resuscitation trolleys were carried out daily and these were recorded appropriately.
- The Resuscitation Council (UK) guidelines: Acute care - equipment and drug lists. Quality standards for cardiopulmonary resuscitation practice and training, (updated March 2018) states, "Standardisation of the equipment used for cardiopulmonary resuscitation (including defibrillators and emergency suction equipment), and the layout of equipment and drugs throughout an organisation is recommended.". We found equipment drawers in the paediatric resuscitation trolleys did not follow standard order (airways, breathing, circulation), and were in a different layout to those on the adult resuscitation trolleys. Information provided by the provider indicated that standardisation of the trolleys was due be completed shortly after our inspection.
- The resuscitation trolley information folders had no structure and were disorganised, and we found different contents contained within the resuscitation folders in each area.This meant that in an emergency staff would not be able to access documentation quickly, particularly those who were new to the service. Following our inspection, the provider informed us that the folders had been reviewed and arranged in a clear and concise order.
- A paediatric "grab bag" was stored in the radiology department. This was a bag containing emergency equipment to use if a child or young person should suddenly become unwell. The bag was security tagged and checked daily for tampering and opened weekly, and contents and expiry dates checked. Records were complete and up to date.
- In radiology a paediatric exposure chart was available for radiographers to use when children and young people were referred for an x-ray. We noted that the exposure guidelines were dated 2014 and required updating.
- Paediatric pulse oximeter ear probes used in the theatre recovery area to measure oxygen saturation were all one size, and therefore did not allow for children and young people of differing weight and size.

Assessing and responding to patient risk

Staff completed and updated risk assessments for each patient.

- The BMI CYP manual set out the agreed admission criteria and exclusions for admission. The hospital admitted children over three years of age for day case procedures. Children aged between three years and 16 years were separated from adults. Children aged between 16 years and 18 years could be treated on the adult pathway following a risk assessment. The lead paediatric nurse was always available for advice at times when children were admitted to the adult pathway.
- The registered children's nurses undertook pre-assessments with all children and young people being admitted to the hospital as a day case. Areas assessed included medical history, pain management, known allergies, dietary requirements, anaesthetic history and discharge arrangements, and current medical observations were taken. Children and young people, and their carers, also had an opportunity to ask questions about their procedure.
- Staff explained that if any medical risks such as mild pulmonary stenosis (a heart condition) were identified during the pre-assessment this would be discussed with the anaesthetist who would confirm whether admission was appropriate and whether any further information was required.
- Young people aged sixteen and seventeen years could choose to be cared for on an adult ward where a risk assessment had indicated this was appropriate. Where

any concerns were identified, such as a child who was unable to carry out self-care, where there were low weight and height measurements, or a young person had a learning disability then they would be cared for on Acorn ward separately from adults.

- The RMO and children's senior nurse were trained in European Paediatric Advanced Life Support (EPALS) and were available on site when children and young people were admitted. The children's nurse who had recently been recruited was booked to undertake their EPALS training.
- The service recorded paediatric early warning scores (PEWS) to identify when a patient was deteriorating. A PEWS Escalation Aid was available to staff and could be found on the reverse of the PEWS chart. This indicated whose responsibility it was to review the patient depending upon their PEWS score.
- A sepsis screening and action tool was available for staff to use for children who had a suspected infection or clinical observations outside of normal limits. Separate screening tools were available for children under five years of age, between five and 11 years, and children over 12 years old who were not pregnant.
- The automated external defibrillator (AED) was located on the adult ward which was separate but close to Acorn ward. We were told this was mitigated as children normally go in to respiratory arrest before cardiac arrest. In such a situation the airway would be managed, and alarm raised at which time staff would bring the AED with them. This had been practiced during resuscitation simulations. We were told that children with an underlying heart condition were not normally seen at the hospital under their admission criteria.
- A process was in place for children who became very sick or unwell. The hospital had a service level agreement with the Children's Acute Transport Service (CATS) to transfer a deteriorating patient to a nearby NHS hospital. Staff said that they would keep the patient on the ward whilst stabilising them and then transfer them to the theatre recovery area to monitor. The CATS electronic calculator was printed off and available for use in such circumstances. We saw an up to date policy for "the transfer of paediatric patients to level 2/3 care.". The service had made no transfers in the twelve months prior to inspection.
- A telephone number was provided on discharge for parents and carers to call should their child's health deteriorate following surgery. Where surgery had taken place just prior to the weekend, the lead paediatric nurse would update staff on the ward.
- A post-operative call was made to children, young people and their parents and carers up to 48 hours following their discharge to check how the patient was recovering following their surgery and any concerns they may have.

Nurse staffing

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

- The children and young people's service was staffed by one lead paediatric nurse full time equivalent (FTE) who worked four days a week, and one children's nurse who worked twenty hours over three days a week. The service was fully staffed.
- Children between three and 16 years were cared for by registered children's nurses during their stay. Children between 16 and 18 years who were admitted to the adult pathway were cared for by registered nurses (adult branch) with the lead paediatric nurse available for advice.
- The children and young people's policy required two registered children's nurses to be present when children were admitted as an inpatient. Staffing was planned around dates of surgery. There was normally five days' notice for surgery to take place which ensured that two children's nurses would be on the rota that day.
- Bank staff had been used regularly within the service prior to the recruitment of the registered children's nurse, after which they had been used only occasionally to cover annual leave or to ensure enough cover on days where day case procedures were taking place.
- Children between three and 16 years who attended outpatient's consultations were cared for by registered nurses (adult branch). Outpatient nurses did not complete paediatric competencies, but received

training in paediatric intermediate life support (PILS) and safeguarding children level 3. When outpatient bookings were made the lead paediatric nurse ensured that they were available for advice.

- In theatre recovery there was one permanent nurse in post. The nurse had up-to-date training in paediatric intermediate life support, had completed an introduction to paediatric recovery training and had completed the BMI paediatric competencies which were signed off by the paediatric anaesthetist. The competencies were to be renewed every three years, and were in date at the time of inspection.

Medical staffing

The service had enough medical staff to keep people safe from avoidable harm and to provide the right care and treatment.

- There was 24-hour, seven day a week RMO (resident medical officer) cover for the children and young people's service, which was shared with adult patients. RMOs were arranged through an agency rather than employed by the hospital. The RMO had paediatric advanced life support training to provide immediate support in life threatening situations.
- Consultants held practising privileges for the treatment of children. Practising privileges is a term used when doctors have been granted the right to practice at an independent hospital. At the time of our inspection we were told that there were 84 consultants who held practising privileges to work with children and young people at the hospital. Staff explained that around six surgeons performed day case surgery at the hospital.
- Most consultants held substantive posts in NHS hospitals or had recently retired after working in the NHS for several years. As part of their practising privileges, consultants were expected to provide evidence of their competence to undertake surgical procedures on children and young people, and were only able to perform procedures they regularly carried out in their roles within the NHS.
- Young people aged 16 and 17 who chose to follow the adult pathway might stay overnight in the hospital. There were no formal arrangements for a consultant paediatrician to be contacted out of hours under these circumstances. However, we were told that there would normally be a paediatrician in clinic during the afternoon or evening who could check the patient's status before leaving.
- The CYP service was supported by a named consultant paediatrician who attended for clinics at the hospital regularly and could be contacted by telephone or email.

Records

Staff kept detailed records of patients' care and treatment. Records were clear, up-to-date and easily available to all staff providing care. However, we found that where paediatric early warning scores were escalated, actions were not always documented.

- Patient records contained information of the patient's journey through the service including, pre-assessments, investigations, test results and treatment and care provided. Records were paper based and securely stored in locked rooms.
- Administrative staff helped to manage the records system. At the time of inspection, the hospital was in the process of merging inpatient and outpatient medical records.
- Records maintained by nursing and medical staff were legible, dated and signed.
- We viewed eight sets of records and found that pain management, nutrition and hydration status and consent were document consistently throughout.
- Paediatric Early Warning Scores (PEWS) were documented within the patient records. The PEWS Escalation Aid indicated that when a PEWS score of four was reached the nurse in charge and RMO should review and inform a consultant or obtain a second opinion. However, in five of the records where the PEWS score was triggered as four the actions taken were not documented. The lead paediatric nurse told us that they had a good working relationship with the consultants and that cases were always escalated at the trigger point. There was no audit of PEWS within the service.
- The records documented discussion with the family. However, there was nowhere in the care pathway for the voice or involvement of the child or young person to be recorded.

- A hospital wide documentation wide audit was undertaken of patient records; however, this was not specific to CYP.
- A copy of all consultant notes were now kept on the paper-based patient record which meant they were easily accessed if necessary.
- Patient records were kept for six months following discharge, after which they were sent for scanning and archiving.

Medicines

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

- There had been no medicine incidents within the children and young people's service in the 12 months prior to inspection.
- Oral medicines were drawn up in the treatment room on Acorn ward. Medicines were stored securely in a locked cupboard, the key for which stayed in the possession of the lead paediatric nurse. All other medication was kept in the treatment room on the adult ward.
- Ambient temperature was recorded within the clinical areas of Acorn ward on a daily basis. Staff understood the procedures to follow if the temperatures were out of range.
- We checked eight drug charts and saw that prescriptions were dated and signed, and children's weight was recorded consistently.
- Allergies were recorded so that staff were aware of any before prescribing medication.
- The children and young people's service had access to a pharmacist and pharmacy assistant based at the hospital. The lead paediatric nurse advised of any medicines required and these were ordered from the supplier if not in stock.
- The British National Formulary for children was available for staff to refer to for guidance on medicine prescribing and dispensing.
- The lead paediatric nurse had implemented the use of the CATS (Children's Acute Transport Service) electronic drug calculator. This helped to ensure the correct drug dosage for deteriorating patients being retrieved by CATS.
- There were no medicine audits for the children and young people's service scheduled.
- Email alerts from the Medicines and Healthcare Regulatory Agency (MHRA) were sent through to the pharmacist and these were kept in a folder for staff reference. Any specific medicines held at the hospital were flagged through the electronic system.
- A medicines management forum was held every two months by BMI and was attended by the clinical service manager for paediatrics and a children's nurse for Kings Oak Hospital.
- An antimicrobial data collection form was in place. Data was collected monthly for inpatients but not for day case patients.

Incidents

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

- There had been no 'never events' in the children and young people's service in the 12 months prior to inspection. 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.
- There had been no serious incidents for the children and young people's service in the 12 months prior to inspection.
- There were six clinical incidents within the service between March 2018 and March 2019. These fell into the following categories: four for clinical communication, one for patient deterioration in recovery, and one for surgery cancelled due to equipment not being available.
- Incidents were recorded on to the electronic reporting system within the hospital and allocated to the relevant manager for investigation. The quality and risk manager had overall accountability for incidents, and these were discussed monthly at the clinical governance meeting.
- A 'comm cell' was held every day, a meeting which included service managers from BMI Kings Oak and BMI

Cavell and enabled information to be shared across the sites in relation to incidents, deteriorating patients, major cases going to theatre after 4pm, equipment problems, staff changes and complaints.

- A hospital wide lessons learnt meeting was held monthly where any lessons from incidents could be shared between departments. Staff within the children and young people service attended when time allowed. Staff were also able to view details of incidents that had occurred on the intranet.
- Staff within the service demonstrated an understanding of the duty of candour and how this applied to children, young people, carers and other service users. 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. We were told that the service had not needed to use the duty of candour since its admission of children to day case surgery in March 2018. The duty of candour policy was in date.

Safety Thermometer (or equivalent)

- The safety thermometer is a collection of data submitted by hospitals. The data collected is 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. Whilst the safety thermometer was not seen on Acorn ward, it was displayed within other areas of the hospital.

Are services for children & young people effective?

Good

Evidence-based care and treatment

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

- Policies and guidelines could be accessed quickly via the staff intranet.
- New policies and guidelines were considered by the clinical governance meeting for approval before being implemented.
- There was a BMI Children and Young People's (CYP) policy (September 2017) which demonstrated the hospital had taken steps to ensure CYP were cared for in line with best practice. For example, care was provided based on the Royal College of Nursing (RCN) guidelines on staffing, and the use of Gillick competence. This is a term that is used to assess whether a child (16 years or younger) can consent to their own medical treatment.
- The service had a children and young people's manual which adhered to the National Institute of Care and Excellence (NICE) guidelines. The corporate children and young people's group reviewed any new guidelines introduced by NICE and made updated policies and procedures where appropriate.
- A corporate CYP audit had been undertaken for the service at BMI King's Oak. We saw the latest audit carried out in January 2019 where the service scored 97%. An action plan was in place to address the area of non-compliance in relation to staff meeting the hospital target (90%) for safeguarding training.

Nutrition and hydration

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

- Children and young people and their parents and carers were advised about pre-operative fasting prior to their procedure. As children were listed first on the list for theatre, this ensured that they were not without food or drink for longer than necessary.
- Nursing staff offered children and young people water and a variety of food options following their return from theatre. Meals were ordered prior to the child going to theatre so there was no delay. Parents and carers were also able to bring food and juice that they knew their children would enjoy, to encourage them to eat and drink following their procedure.
- The service had access to a dietician who worked with both adult and children at the hospital. Referrals were made if any concerns were identified, for example children that were underweight, and when any special dietary advice was required.

Requires improvement

Services for children & young people

Pain relief

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

- Pain management was discussed with patients from pre-assessment, through pre- and post-recovery and at discharge. During pre-assessment parents and carers of children and young people being admitted to the hospital were advised to have over the counter pain relieving medication available at home in time for discharge.
- A pain assessment tool was used to record the level of patient's pain which was scored between 0-10. This included a visual tool of smiley faces so that children could point out the one they felt was most relevant to them. Oral analgesia was given to manage the pain and any additional medication prescribed by the surgeon.
- The registered children's nurse was in the process of creating a new paediatric pain tool which was more child friendly and included space to document heart rate, respiratory rate and sedation rate, views of the parents on how pain was being managed and any intervention being received. This had been discussed at the medicine's management committee meeting.
- Parents and carers we spoke with said they felt that their children's pain was well managed, and that information about medication on discharge was clearly explained.
- There were no pain audits carried out within the service.

Patient outcomes

The service did not routinely collect patient outcomes for children and young people.

- The hospital did not participate in national audits in relation to children and young people. Changes to practice were put in place to promote good patient outcomes. For example, all children and young people attended a face-to-face pre-assessment to assess their suitability for surgical intervention.
- The hospital wide audit schedule included documentation and pain management audits, however these were not specific to the children and young people's department.
- There had been no unplanned readmissions or returns to theatre for children and young people in the twelve months prior to inspection.

Competent staff

The service made sure staff were competent for their roles.

- A safer recruitment policy was in place that outlined the requirements for staff to have appropriate disclosure and barring clearance and that staff employed were registered children's nurses.
- 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 February 2019 we reviewed.
- A weekly report was exported from a consultant database to check that documentation such as indemnity insurance and registration with the GMC was up to date, and consultants were contacted where these were due to expire with a set deadline to produce new documents.
- There were 84 consultants who had practising privileges to care for children and young people within the hospital. When an appointment was being made in outpatients it was booked with a consultant who had the appropriate paediatric experience.
- The lead paediatric nurse had received their appraisal the previous year and was yet to have their appraisal for the current year. They had monthly 1:1 conversations with the clinical service manager for wards during which time they discussed performance and opportunities for development. They had been able to access external courses in European Paediatric Advanced Life Support (EPALS) as well as safeguarding level 4 training through the local clinical commissioning group. No formal

clinical supervision was provided, but the lead paediatric nurse told us that she was able to obtain advice from her counterparts at other BMI hospitals whenever necessary.

- The registered children's nurse had recently been recruited to post. Induction had included an orientation of the service, shadowing on different departments and attendance at various meetings. They had worked as a bank nurse within the service previously and were therefore aware of the systems and processes.
- The lead paediatric nurse supervised the children's nurse on Acorn ward. No formal arrangement was in place, however the children's nurse told us that she worked alongside her manager on a daily basis and was always able to gain advice and support where necessary.
- When bank staff were used by the service, checks were undertaken to ensure they were a registered children's nurse and there were no restrictions on their practice. The service had a comprehensive orientation list to use with all bank nurses used on Acorn ward.
- A high number of agency nurses were used in the theatre recovery area. Specific paediatric nurses and operational departmental practitioners were requested from the nursing agency to work within the recovery area. An induction pack was in use to familiarise staff with equipment and the recovery area, and to ensure that staff were competent in their practice.
- There was one healthcare assistant (HCA) who undertook phlebotomy procedures (the taking of blood) for children and young people. The HCA had up to date training in paediatric basic life support. They had also completed training in the theory and simulated practice in paediatric venepuncture. However, the training was completed in 2010, and there was no evidence of skills being updated since that time. The HCA had only completed safeguarding children training to level 2. We were told that there were plans for both registered children's nurses to become trained in phlebotomy.
- A paediatric radiologist reported on plain film and ultrasound images, along with three other radiologists within the service.

Multidisciplinary working

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

- Nursing staff within the children and young people's service had a supportive working relationship. They described good communication with the medical staff at the hospital, and able to escalate any concerns where necessary.
- The service had access to advice from a dietician and physiotherapist based on the adult ward at the hospital. The physiotherapy department was based at a nearby BMI hospital where children were not seen, but there was potential for a physiotherapist to see a child at BMI Kings Oak.
- Discharge letters were sent out to GPs following a patient's surgery detailing the procedure undertaken and any medication prescribed, and we saw evidence of this on the patient records that we viewed. A GP was based at the hospital for advice should staff require it.

Seven-day services

- The pharmacy was available Monday to Friday 9am to 5pm with an on-call rota out of hours during evenings and weekends to provide advice. Out of hours access to the pharmacy was via the resident medical officer (RMO) and senior nurse in charge.
- The imaging and outpatient's department offered appointments to children and young people on a Saturday morning for consultations and diagnostic tests. The RMO was available during these hours for medical advice and support and the lead paediatric nurse could be contacted by telephone.

Health promotion

- The lead paediatric nurse had recently introduced an information board within the outpatient's department specifically aimed at children, young people, their parents and carers. The board provided information in relation to spotting the signs of sepsis, the importance of vaccinations, healthy eating and being 'sugar smart'. We were told that the intention was to change the information on a seasonal basis and update with relevant health topics.
- A lack of health promotion material specific to children and young people was seen on the paediatric ward and within other areas of the hospital.

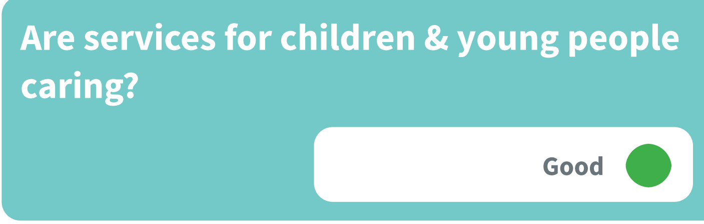
Requires improvement

Services for children & young people

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care.

- We looked at eight patient records and saw that consent forms were appropriately completed, signed and dated by the patient/parent. The benefits and risks of surgery were discussed with children and young people, their parents and carers prior to it taking place. Consent was taken on the day of surgery which is not optimal practice as it does not allow for a 'cooling off' period prior to the procedure taking place.
- An additional consent form (consent form 2) was available which provided opportunity for the young person to give consent where appropriate in addition to their parent or carer.
- The consent for examination or treatment policy set out specific guidelines for obtaining consent from children and young people. The policy stated that a child's capacity to consent should be evaluated using the Gillick competence. This assesses whether a child under the age of 16 "understood the nature, purpose and consequences of having the proposed treatment.". Where a child was not deemed Gillick competent parental consent would be required. Staff understood their responsibilities regarding the Gillick competence.
- Compliance in consent mandatory training was 97% hospital wide. We were told that The Mental Capacity Act (2005) formed part of the safeguarding e-learning training.
- Staff were not aware of the Royal College of Nursing guidelines (2017) on "Restrictive Physical Intervention and therapeutic holding for young people", and the hospital did not have a related policy in place.



Compassionate care

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

- Parents told us staff treated their children with compassion, kindness, and respect. During our inspection we saw that privacy and dignity of children and young people was maintained at all times. On Acorn ward staff kept room doors closed when discussing personal medical information with patients so that conversations could not be overheard by others on the ward.
- Parents spoke very highly of the care they received during outpatient consultations and during inpatient stays and were very complimentary about the caring nature of staff.
- Staff discussed with parents the most appropriate method of comforting their child during procedures such as phlebotomy to reduce their anxiety and optimise their safety.
- Staff used distraction toys during procedures to minimise the child's distress and keep them preoccupied. A small electric car was available for children to ride to theatre in with the aim of relaxing them before their procedure.
- Young children admitted as a day case were asked to pick out a soft toy which was given to them on their day of admission. The child's name band was placed on the soft toy before their discharge from hospital for them to have as a keepsake.
- Children were given stickers and certificates as recognition of their bravery when they had completed their surgery procedure.
- Children and young people, their parents and carers could leave feedback by completing patient satisfaction forms which were available in outpatients and on Acorn ward. We looked at 19 surveys completed by parents or carers between 3 January 2019 and 12 April 2019. All respondents had indicated that they were extremely likely to recommend the service. Comments included, "My daughter has been treated with wonderful care.", "Nurses were very friendly and took their time." And, "Very professional, caring service.".
- The service had introduced a more child friendly format for patient surveys completed on Acorn ward although

they were not so suitable for the younger age group. We reviewed 16 comments left by children and young people between 3 January 2019 and 19 March 2019. All responses were very positive about their care and stay at the hospital. When asked about the most important thing staff did comments included, "Nurses were very caring and nice.", "Smiled and being kind." and, "Fantastic nurses and staff.".

- The service had received very few negative feedback comments. One negative comment had stated that the menu did not have enough variety and as a response the service had changed the menu to offer more options. Children and young people could also choose from the adult menu should they prefer.

Emotional support

Staff provided emotional support to patients to minimise their distress.

- Staff provided emotional support to children, young people, their parents and carers. One parent we spoke with said that whenever she had concerns about her child going to theatre the nursing staff were caring and took time to reassure her.
- Pre-assessments were undertaken on the paediatric unit to enable children to become familiar with the environment so that it did not feel so strange on the day of their procedure. Toys were put out for children to play with and parents were asked to bring the child's favourite toys to help make the child feel more relaxed and "at home".
- During pre-assessment children and young people were asked questions about their mental health, schooling, and anxiety. Any concerns were recorded within the patient's care plan. Where concerns were identified staff would make a referral to the community adolescent mental health service (CAMHS).
- Parents and carers were encouraged to stay with their children throughout their admission. Parents were able to accompany their child to the anaesthetic room prior to surgery, and be there in recovery when their child woke up. This met the needs of both the parents and the child.

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.

- Parents said they had enough information about the procedure being undertaken. They felt fully involved in the care and treatment of their child.
- Staff were very aware of the importance of being open and fully explaining information to children, young people, and their parents and carers.
- Staff discussed procedures with parents, children and young people during pre-assessments and on the day of surgery. This involved explaining what would happen during the procedure in an age appropriate manner and in a way that was understood. Time was given to allow questions to be asked.

Are services for children & young people responsive?

Requires improvement

Service delivery to meet the needs of local people

The service did not always plan and provide services in a way that met the needs of local children and young people.

- The service did not undertake acute or emergency surgical admissions for children and young people. All surgical interventions were undertaken as day cases. The hospital had no critical care facilities and children and young people were screened at pre-assessment to ensure the hospital had suitable facilities to treat them.
- Children and young people under the age of 16 were admitted for day case procedures to a four bedded ward separate to adult areas. The ward had been subject to an environmental risk assessment in May 2018.
- There was no designated waiting area for children in the outpatient's department. Children, young people and their parents and carers were seated within the main area along with other adults. There was a small table and limited selection of toys for children to play with.
- Other areas within the hospital where children and young people were seen lacked a child friendly environment and atmosphere. For example, the minor

operations room in the outpatient department was designed in a more adult theme and had little to make younger children feel welcome. The lead paediatric nurse told us they planned to purchase some bed quilts to make the rooms on Acorn ward brighter and have more of a homely feel.

- There was a separate cubicle in theatre recovery used for children which was across the room from the adult cubicles.
- A hot drinks machine was available for parents and carers to use free of charge within the outpatients and radiology departments. There was signage requesting individuals to keep a lid on their drink and advising parents to supervise their children within these areas.
- When children were admitted for procedures, parents were provided with a voucher which enabled them to have a complimentary drink and snack from the cafeteria. Parents were also able to order food from the menu on Acorn ward.
- There was free Wi-Fi within the hospital, so adolescents could keep in contact with their friends and family via social media. DVDs were also available for children and young people enabling them to watch a film to pass time.

Meeting people's individual needs

- Nursing staff discussed individual needs during the pre-assessment. This included disabilities that the patient may have and any requirements that may be needed for example, a longer preparation time before theatre, and discussions around appropriate pain management.
- Staff made adjustments where possible so that patient's individual needs were catered for to ensure safe care and treatment. Staff gave an example of how they had cared for a non-verbal patient by writing down information and using hand movements, as well as having ongoing discussions with the child's parents.
- We were told that where patients had complex medical needs then a decision might be made not to admit in line with their admissions policy. Final decision would be made by the consultant.
- There was level access to Acorn ward and all rooms were spacious with room to move around the bed. However, the en-suite bathrooms were not accessible for patients who used a wheelchair as there was no specialist equipment available to use the bath or toilet.
- Staff said that there had not been any patients or young people using the service who had a sensory disability, and explained that their needs would be discussed during the pre-assessment.
- Staff were able to use language line for interpreting for people whose first language was not English, although we were told that there had been no families with this need using the service.
- Religious and spiritual needs were documented within the patient's care plan. A Bible and Koran were available on the ward for patients and their families to use. A quiet room could be made available for prayer if required.
- There was a lack of child friendly or easy read information available in the hospital. Information relating specifically to children's health was not seen in any areas of the hospital.
- A variety of dietary requirements were catered for. Dietary preferences for example halal and kosher, were recorded at the pre-assessment stage and catering staff were made aware so that dietary needs were catered for during the patient's stay.

Access and flow

People could access the service when they needed it.

- All children and young people cared for and treated at the hospital were privately funded. In the first instance a consultation could be booked through the appointments system, or through the national enquiries corporate contact telephone number. Booking staff would ensure that appointments were made with consultants within the appropriate speciality and who had the skills to work with children and young people.
- Appointments were offered depending on consultant availability and we were told this was often within a matter of days wherever possible. The hospital was flexible with appointments and would try to fit in with family commitments, for example, offering appointments outside of school time.

Requires improvement

Services for children & young people

- The lead paediatric nurse had undertaken their own local audit of how long children and young people were having to wait before going in for their clinic appointment when arriving in the outpatient's department. They had found that waiting time was no longer than 15 minutes.
- Following pre-assessment the lead paediatric nurse arranged a time for the surgery to take place. Children and young people were always placed first on the theatre list, and we saw that this happened during inspection. This meant the wait for children and young people was minimised, and they were discharged in a timely manner.
- Letters were sent out to inform parents the confirmed date of surgery and fasting instructions.
- Bed occupancy on Acorn ward for day case procedures was low. From March 2018 to February 2019 there were 68 patients between the age of three and 17 years treated as a day case at the hospital. There had been one patient aged 16 to 17 years old who had been treated as an inpatient. Within the same period there were 1,622 outpatient attendances for children aged between three and 17 years.
- Between January and March 2019 there were three minor operations performed on children and young people in the outpatient's department. Where a minor operation was needed the consultant completed the referral form during consultation. This was copied to the receptionist, outpatients nurse and lead paediatric nurse so that an appropriate date could be agreed and ensure the appropriate staffing and resources would be available.
- There was one cancelled day case procedure in the twelve months prior to inspection. This was due to part of the equipment required not being appropriately sterilised, and was reported as an incident. The situation was explained to the patient and their parent/ carer and the procedure rebooked for the following week.
- A discharge pack was provided to children and young people at the point of discharge from the service. This contained medication information, a patient satisfaction form, and follow up appointments and a telephone number should any medical advice be needed.
- A telephone call was also made to the patient and/or their parent or carer up to 48 hours following discharge to check upon their recovery.

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.

- Formal complaints were normally received on the complaints form, or by letter or email to the director of clinical services. The complaint was recorded upon the electronic reporting system and allocated to the relevant service to be investigated.
- There had been no complaints received about the children and young people's service in the twelve months prior to our inspection. Prior to this, only occasional complaints had been received the main theme of which was about communication, with key messages for staff to provide children, young people, parents and carers a full explanation of what to expect during their appointment and procedure.

Are services for children & young people well-led?

Requires improvement

Leadership

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

- The hospital was led by a senior management team consisting of an executive director, director of operations, director of clinical services and a quality and risk manager.
- The children and young people's service was managed by the lead paediatric nurse who planned for and cared for children and young people throughout departments within the hospital. They were passionate and committed to their work, and had the appropriate skills and experience for the role. They reported to the clinical service manager for wards, who in turn reported to the director of clinical services.

- The lead paediatric nurse had taken a pivotal role in the implementation of the children and young people's service at the hospital with a high level of responsibility and accountability. They were able to seek advice from their line manager regarding hospital wide issues, but for specific paediatric concerns advice was sought externally through BMI counterparts and the Clinical Commissioning Group (CCG).
- The lead paediatric nurse oversaw all admissions to the hospital of children and young people and was available when children and young people attended for consultations, diagnostic tests or day case procedures. Staff throughout the hospital indicated that the lead paediatric nurse was always accessible, and valued their clinical expertise knowledge.
- Senior managers were visible and approachable, and staff within the CYP service said they felt able to escalate concerns.
- A consultant paediatrician supported the role of the lead paediatric nurse in decisions made about care and treatment within the service.

Vision and strategy

The service had a vision for what it wanted to achieve.

- The corporate children and young people's vision was to "Provide the best quality care to children and young people in a child and family focused service". Staff we spoke with were clear about the vision and committed to delivering it. The children and young people service had a mission statement displayed in every room stating how they would manage to deliver a high quality of care to each child seen at the hospital.
- The one-page five-year plan for the children and young people's service set out objectives and priorities in eight areas: information; growth; communication; patients; efficiency, facilities; people and governance. However, the document was not dated and there was no formal monitoring of the objectives set out. It was therefore unclear how senior managers were assured that objectives were being met or what actions were in place to meet them.
- The director of clinical services and clinical service manager for wards had developed a "patient journey to outstanding" noticeboard which had the patient at the centre surrounded by the CQC five key questions. The children's nurses had started to populate the board with ideas of how the journey to outstanding would be achieved within the CYP service.
- Staff we spoke with about the strategy told us about making improvements within the service, for example by introducing a waiting area within the outpatient department and introducing other areas of practise such as skin prick tests. There were no written action plans on how the improvements might be achieved. Discussions were in progress about extending the outpatient consultations to include children under three years of age. We saw a proposal to change the statement of purpose to include this, but no action plan or risk assessment was in place.

Culture

Managers across the service promoted a positive culture, creating a sense of common purpose based on shared values.

- During our inspection we saw that staff within the service were enthusiastic and dedicated to their work with children and young people within the hospital.
- Staff we spoke with said they found the service, and hospital a friendly place to work where an open and transparent ethos was encouraged. We were told that staff throughout the hospital were ready to support and offer advice when needed.
- A substantial amount of work had been undertaken since the opening of day case surgery to children at the hospital in March 2018. Whilst staff had been recognised for their work and commitment by the clinical service manager, there was less recognition from the senior management team.
- Senior managers explained that bullying and harassment had been identified as an issue within BMI King's Oak Hospital and BMI Cavell (a local hospital led by the same senior management team). The survey results were not broken down by staff, site or speciality. Senior managers were working with staff to address the issue. We did not identify any concerns in relation to bullying and harassment within the children and young people's service during our inspection.

- The hospital had a Freedom to Speak up Guardian in post. This enabled staff to raise any concerns they had confidentially.

Governance

- There was a daily meeting with the executive team and heads of departments known as 'comm cell'. The comm cell was designed to maintain effective communication at all levels of the hospital, to discuss activity for the day, highlight any issues, and discuss incidents or complaints and any immediate actions to be taken as a result of these. We saw that comm cells were attended by the lead paediatric nurse, however there was no reference to the children and young people's service within the communication brief. Following the inspection we were informed by the provider that they had updated the "comm cell" reports to include all children and young people activity, and staff from Acorn ward were included within the call to feed back information.
- There was a consultant paediatrician who represented the children and young people's service at the Medical Advisory Committee (MAC). The MAC met quarterly to consider surgical and clinical information. Areas of discussion included governance and risk, serious events, screening of new applications for practising privileges, complaints, updates and changes to services. We viewed the MAC meeting minutes for February 2019 and found that consultants wanting to gain practising privileges, scope of practice and consultant behaviour were all items of discussion.
- The lead paediatric nurse attended the clinical governance subcommittee meetings held monthly. This fed in to the hospital governance committee which had oversight from the senior management committee. The clinical governance subcommittee was chaired by the executive director and attended by the director and associate director of clinical services, heads of departments and quality and risk manager. Items discussed at the meetings included incidents, safeguarding, complaints, patient satisfaction, training, new business cases and new policies and procedures. We viewed minutes of the meeting held in January 2019 and saw that the lead paediatric nurse was in attendance. However, there had been no specific agenda item for the children and young people's service so the senior management team did not have oversight of how the service was operating. Following our inspection, we were told that the children and young people's service had been added as an item to the clinical governance subcommittee agenda.
- A corporate children and young people's committee meeting was held quarterly and attended by the head of nursing, clinical service manager for wards and paediatric nurses. We reviewed the meeting minutes for January 2019 which were brief, and there were no actions arising from the minutes. There was no medical representation on the committee such as a paediatrician or paediatric surgeon.
- A resuscitation committee meeting was held monthly where topics including equipment, events and debriefs, training, simulation audits and new guidance were discussed. This was normally attended by the director of clinical services, risk and governance manager and representatives from each area/department within the hospital. We viewed the resuscitation committee meeting minutes for January 2019 and found that both the children's nurses were present and contributed to the meeting. However, there was no attendance from consultants, anaesthetists or resident medical officer.
- There was no safeguarding report for review by the hospital board, so we could not be assured that the senior management team had oversight of safeguarding within the hospital.

Managing risks, issues and performance

- Departmental risks were logged onto the risk register which linked into the hospital risk register. A risk manager and risk owner for each risk was allocated, with the executive director having overall accountability.
- The risk register, and any risks that had been escalated, were reviewed at the clinical governance meeting held monthly, and the health and safety meeting held every other month.
- The children and Young People's service did not have a specific risk register, but recorded risks under ward, outpatients, radiology, theatre or hospital category. At the time of inspection there were no risks logged for the children and young people service despite staff

identifying risks such as there being no separate waiting area for children in outpatients and ensuring that training was up to date for all staff involved in caring for children and young people throughout the hospital.

- During the period in which the children and young people's service was being set up and introduced at the hospital, paediatric leads from other BMI hospitals undertook a review of the service. Two of the three actions arising from the audit had been completed. The third risk related to the lack of waiting area for children in outpatients had a target date of 30 November 2019.
- The hospital submitted safeguarding performance information to the CCG. This provided information on audits, training, supervision and structures that were in place.We saw the 2018/19 Safeguarding Children Key Performance Indicator (KPI) Report which provided data for each of these areas.
- A corporate quality and risk bulletin was circulated to staff monthly to keep staff up to date with any new areas of risk.

Managing information

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

- Children's nurses had use of computer terminals in the office on Acorn ward. This enabled them to access hospital information including the systems where outpatient appointments were made, and day case surgery was planned. Staff were able to see whether appointments had been attended within outpatients the previous day.
- Staff accessed policies and procedures on the intranet. During the inspection staff were able to show us where to find specific policies.
- The registered children's nurses had a communication book so that pertinent information within the service could be shared between them.

Engagement

The service engaged well with patients, staff, the public and local organisations to plan and manage appropriate services, however there was no audit of the feedback provided for the CYP service.

- The children's nurses within the CYP service attended the ward meetings at the hospital where they were kept informed of any operational changes, lessons learnt from incidents, patient feedback and training updates. This was also an opportunity to update staff on any developments within the children and young people's service.
- A hospital newsletter was sent to staff monthly to provide any local updates, with a corporate newsletter distributed to staff on a weekly basis.
- The BMI King's Oak patient satisfaction dashboard February 2019 showed that 99.2% patients would recommend the hospital, however this was not broken down to show feedback specifically from children and young people. Patient satisfactory forms were available in outpatients and on Acorn ward for children and young people, their parents and carers to provide feedback about their care and treatment. Feedback was reviewed by the lead paediatric nurse. However, there was no audit of the feedback provided for children and young people up to the age of 16 years. This meant that the hospital did not have oversight of what they thought was going well, what could be improved and whether they would recommend the service.

Learning, continuous improvement and innovation

The service was committed to improving services by learning from when things went well or wrong.

- The lead paediatric nurse was committed to building upon the current children and young people's service at the hospital and to continue making improvements in those areas where the need had been identified.
- The registered children's nurse was in the process of creating a new paediatric pain tool which was more child friendly and included space to document heart rate, respiratory rate and sedation rate, views of the parent on how pain was being managed and any intervention being used.

Good

Outpatients

Safe	Good
Effective	Not sufficient evidence to rate
Caring	Good
Responsive	Good
Well-led	Good

Are outpatients services safe?

Good

Mandatory Training

The service provided mandatory training in key skills to most staff.

- Staff were trained in a variety of mandatory training subjects that were enough to provide key skills such as equality and diversity, fire safety, moving and handling, aseptic non-touch technique, high impact intervention and care bundles, infection prevention and control, basic life support, safeguarding chaperoning, dementia awareness, consent and female genital mutilation.
- The outpatient manager reported on mandatory training compliance to the heads of department meetings. The March 2019 report showed an overall compliance rate for outpatient staff of 89.6% with new starters and long term leave lowering the reported average. Nearly all long term staff were well above the 90% target completion rate.

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.

- Any issues of concern that related to safeguarding were escalated to the outpatient manager and reported through the online incident reporting system. The director of clinical services was the location lead for adult safeguarding. However, there had not been a director of clinical services in post for three months. In the interim period the director of governance and risk had taken on responsibility for reporting any safeguarding issues outside to the local safeguarding authority.
- Staff were aware of safeguarding principles and how to apply them. We were given a recent example of this process in practice where an issue of patient concern had arisen in outpatients. It was raised by staff, escalated appropriately and reported to the local authority safeguarding team. It involved patient vulnerability due to dementia.
- 95% of staff had been trained in the safeguarding of vulnerable adults to level 2. 97% of staff were trained in the safeguarding of vulnerable children to level 2.

Cleanliness, infection control and hygiene

Staff used control measures to prevent the spread of infection. However, we did find aspects of the premises that were not clean.

- There was an infection prevention and control (IPC) nurse who covered both Cavell and Kings Oak Hospitals. Part of the role was to conduct regular walk arounds on wards and in outpatient areas to check on standards. There was a link nurse for IPC in outpatients. They attended infection control meetings and carried out audits on personal protective equipment, environment and hand hygiene. They had induction with the infection control lead nurse for this role.
- All staff had aseptic non-touch technique (ANTT) competencies which were also covered by the IPC nurse. We were provided with a consulting rooms

hygiene audit dated 21 March 2019. It focussed on supply of personal protective equipment, hand hygiene and the use and disposal of sharps. It showed 100% compliance with all items. We were also provided with a hand hygiene audit dated 21 March 2019 which also showed a compliance rate of 100%.

- On checking with the infection prevention and control lead nurse, we were told that curtains should be changed every six months. In the rooms we checked there were some curtains that had no expiry date stated, some were out of date and some were within date.
- The resuscitation trolleys were dusty on their surfaces and there was a loose pair of scissors on the top of the trolley. There was a label stuck down with sticky tape on top of the trolley.
- In the phlebotomy room one of the chair seat covers was split which was an infection control risk. The red box used for the transportation of samples was stained.
- In the minor operations treatment room cupboards containing dressing packs were stored in drawers with visible dust seen inside the drawer trays.
- In the patient waiting area for urology procedures (rooms 101/102) we found two chair seats were ripped. There were also cloth chairs that were slightly stained. The room itself was dusty on high and low surfaces. The bin was dirty and unemptied with some items consisting of empty cups and tissues on the floor. The toilet cleaning schedule was in date. Following post inspection feedback, we were provided with evidence to show the phlebotomy chair had been recovered.
- Room 101's adjoining toilet had not been checked and had no cleaning schedule in place. There were some green 'I am clean' stickers completed with today's date. The clinical trolley and examination light had no sticker on them to indicate when they had last been cleaned. The consultant chair was split in room 101 was split and in room 102 the clinical trolley was dusty. Rooms 101/102 both had clean toilet facilities to support the urology service.
- The clean utility room's fridge was monitored daily. The fridge was used for storage of samples overnight and was found to have visible dried spillage inside. Signage on the cupboard was not laminated and so not wipe clean.
- In the treatment room we found the trolleys had green stickers with today's date on them. However, they were not clean. There was a tacky residue on their surfaces and visible dust on the lower level. We also found sodium chloride and mouthwash left out on the trolley. There was no date on the curtain around the patient examination couch.
- There was a second waiting area located near to the nursing station; room 103. There were 11 chairs. Two had splits in them. There was dust on high and low surfaces.
- Hand gels were available in corridors and by toilets. All were in working order. There was a daily cleaning schedule in the toilets by reception which stated the toilets were cleaned once a day. Toilets were clean and hygienic with hand soap and hot water and dryer available. There were no cleaning schedules available in other public areas. However, it was confirmed with cleaning staff that their own schedule meant they cleaned the waiting areas and toilets at least three times a day. There were no individual cleaning schedules in consulting rooms or on trolleys.
- We were provided with hygiene audits for March 2019; one for consulting rooms and one for hand hygienewhich both showed 100% compliance. Following post inspection feedback, we were provided with a monitoring sheet relating to a curtain replacement programme. It did not demonstrate a system to routinely monitor curtain condition and replacement.

Environment and equipment

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

- Outpatients had a separate entrance to the main hospital. The reception desk and waiting area were located directly inside the entrance. The waiting area had approximately 30 seats and was spacious enough

for all patients to be seated. It was visibly tidy and the department was fully wheelchair accessible. Treatment and consultation rooms were located in close proximity to the main waiting area.

- There was an online reporting system for logging maintenance work. A maintenance team were based on site and we were told they provided a responsive service, usually responding to maintenance requests on the day.
- Daily checks on the resuscitation trolley were taking place with drawers containing equipment sealed appropriately. The defibrillator label stated it had been serviced on 4 October 2018 and was next due in April 2019 and the team arrived and serviced the machine while we were on site.
- Daily checks on rooms and fridges in the minor operations room, treatment room, clean and dirty utility rooms were taking place.In the phlebotomy room, gloves were available but there were no aprons available from the compartment for storage. There was no oxygen available in the room. If a patient collapsed, oxygen from the resuscitation trolley was utilised. There was a call bell available in the room for use if a patient collapsed.
- The minor operations treatment room daily room temperature checks were up to date and found to be in normal ranges.The room was also used for urology cystoscopies, dermatology minor operations, ENT nasal scopes and small eye procedures. The wheels on the trolleys were rusty. The screws fixing the vacsax canister to the wall were loose and there was plaster/ brick dust on the floor below the cannister.
- Equipment such as acuevac, blood pressure monitor and oxygen were due for electrical equipment testing in the month of our inspection visit. In the treatment room we found the blood glucose checking machine was last tested July 2016 with a due date of July 2017. The suction meter/flow meter was out of date in July 2018.

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.

- We reviewed eight sets of notes, pulled at random from medical records and the bookings team room. Notes and files we reviewed contained basic patient information and assessments. There were outpatient outcome forms that included referral for further assessment, medication management, physiotherapy and for referring back to the patient's GP.
- The patient clinical summary assessment included past medical history, allergies, medication, family history and test results. There was a patient booking form that included a clinical coding form for cardiac, respiratory, renal, endocrine, neurological, orthopaedic and sensory assessment. For new NHS patients, there was also NHS tracker information.
- We followed the pathway for one patient who had their first appointment and required funding for surgery. There were flags on notes for dementia and a stamp on the front of the notes folder for MRSA and infection screening. Patients signed the back of the registration forms that the demographic details were all correct such as address, next of kin and contact details. Referrals went to a central referral service for triage.
- All referrals in to the service were triaged before being accepted for a first appointment. Triage was carried out by senior nurses including the quality and risk manager, outpatient's manager, infection control lead, paediatric lead and ward manager. The referral criteria included a BMI of under 40 and no co morbidities such asasthma or COPD. Following the triage process, the medical notes were located in the online notes system for consultants to check against the proposed procedure. If the patient was judged to not be eligible at any stage of the process, they were referred to their GP. If they were accepted the consultant carried out further assessment and completed the booking form during the consultation and authorised for surgery.
- There were daily briefs at 9.30am and 3.00pm. these took the form of both teleconference and face to face meetings involving senior managers and clinicians from both Cavell and Kings Oak sites. They covered deteriorating patients, incidents, equipment issues, IT issues and any concerns or reportable events. They were forums for information sharing and making decisions to take action. They were minuted in real

time and emailed to all staff. We were told this was an effective means of communication and given examples of how rapidly information discussed had become common knowledge.

- All staff were trained in using the national early warning scores (NEWS) for deteriorating of patients.

Nursing staffing

The service had enough staff with the right qualifications and experience to keep people safe and provide the right care.

- We were told that across BMI Healthcare, the BMI Healthcare Nursing Dependency and Skill Mix Planning Tool was used. This was introduced in 2015 as a guide to assist trained professionals exercise their judgement to ensure the right members of staff are on duty at the right time and with the right skills, to respond to patient acuity and therefore ensure good patient care. We were told this was populated in advance so that staff levels can be reviewed and planned in a timely manner.
- In information provided prior to our inspection visit we were told that as at 1 February 2019, there was a staffing establishment in outpatients of four nurses and four healthcare assistants. They were currently filled to 2.2 and 1.64 whole time equivalent (WTE) respectively. Staff turnover for both groups of staff between March 2018 and February 2019 was stated as 0%. The use of bank staff in outpatients was stated as (between September 2018 and February 2019) an average of 2% for nursing and HCA staff. We were told that between December 2018 and February 2019 there were zero unfilled shifts. Agency staff were not used.
- Staff sickness rates in outpatients were stated as 48% in March 2018 but between April 2018 and February 2019 the average was 2%.
- On site we found that the outpatients’ sister organised the staff roster four weeks in advance. This was then forwarded to the outpatients’ manager for verification of the correct skill mix and for signing off.
- We found the service was organised for there to be two nurses and one to two healthcare assistants on duty depending on the number of clinics running each day. Shifts ran from 7.30 am to 3.30 pm, and from 1 pm to the end of the day which could vary in time depending on the late running of clinics.
- The service had four vacancies; two nurses and two healthcare assistants and was currently organised by utilising three substantive nurses and three substantive healthcare assistants for use across both Kings Oak and Cavell sites. There were currently three bank nurses for the service to call upon and we were told they tried to use the same bank staff for consistency. All bank staff had induction, completed mandatory training, had access to emails and the incident reporting system just as substantive staff. Agency nurses were not used.

Medical staffing

The service had enough medical staff to provide the right care and treatment.

- In information provided prior to our inspection visit we were told that consultants and anaesthetists were engaged under BMI practicing privileges which were also available for their own patients. Consultants and anaesthetists were required to confirm suitable cover arrangements if they were unavailable or on annual leave.
- New Consultants enquiring about practicing privileges were directed to the central executive team and an application pack forwarded for completion which included demonstration of all relevant clinical experience relating to the practice which they wish to bring into the hospital. They were expected to provide several supporting documents including; curriculum vitae, certificates of qualification, annual appraisal, GMC specialist register registration, medical indemnity certificate, and ICO certificate evidencing registration as a data controller with the Information Commissioners Office. References and immunisation status were also requested, and an enhanced DBS check took place. The application was scrutinised by the BMI Medical Advisory Committee (MAC) for it to be fully ratified. Consultants were required to provide updated documentation annually. We were told failure to provide or renew documentation prior to expiry may lead to temporary suspension or withdrawal of practising privileges.

Records

Records were clear, up-to-date and easily available to all staff providing care.

- In information provided prior to our inspection visit we were told that over the last three months no patient had been seen in outpatients without their medical records.There was a dedicated medical records team with responsibility for filing, storing and maintaining an adequate medical record for patients treated. Staff within this department ensured that medical records are readily accessible for each episode of patient care.
- Medical records were prepared in advance of outpatient clinics using the outpatient clinic lists generated from the BMI patient administration system. Records were collated by the medical records team for the appropriate clinical department prior to the patient appointment time.Checking processes took place to ensure that patient notes were confirmed as available and complete in the afternoon before a patient's attendance. To maintain a manageable level of patient records and ensure ease of accessibility, medical records were regularly sent to a secure electronic medical database (EDM) where they were scanned for archiving. Appropriate staff could directly access EDM to review and where required, print archived medical records. Staff within the medical records team were able to provide support, or access EDM at the request of a clinician as required.
- We were told that the outpatient department ensured that test results were appropriately filed in patient records prior to attendance and that medical record tracking and tracing was available through the online records system.
- We reviewed eight sets of notes, pulled at random from medical records and bookings. We found that records were accurate, complete, legible, up-to-date and stored safely. However, patient notes were not being audited. Patient files for self-funded patients began in September 2018 following a review of need based on previous CQC findings. Before this time, consultants used to not complete notes, information or updates, but instead keep their own records, which meant there was insufficient hospital oversight. Implementing this was described as a work in progress with some consultants resistant to the change. Case note sheets were placed in files for ease of completion and placed in consultation rooms for convenience. NHS patients had always had updated files.

Medicines

The service followed best practice when prescribing, giving and recording of medicines. However, we found some issues with the storage of medicines.

- We were told that pharmacy staff pro-actively supported the clinical teams. All medications given on discharge were communicated to the GP on the discharge letter. The pharmacy was open until 5pm from Monday to Friday with no Saturday service. Prescription pads were provided by pharmacy and FP10s were not used. Out of hours, the local community pharmacy could be accessed for private and self-pay prescriptions but not NHS. NHS patients had to return to pharmacy within working hours to obtain their prescription medications. Two-week prescriptions were given to patients. Prescriptions were tracked by the pharmacy team. There were no controlled drugs stored in outpatients.
- Resuscitation trolleys were not temperature monitored which was confirmed with the pharmacist. However, we were told that BMI had requested that the trolleys were kept in temperature-controlled areas or moved away from radiators due to the storage of medicines on them. This was the responsibility of the lead for each department. In outpatients there were two trolleys available, one adult and one paediatric. Both were kept in the corridor beside a radiator.
- The store cupboard contained a small amount of stock that was ordered weekly. In the cupboard, there were several items such as street solutions, compression bandages, melgisorb dressings, lubricating gel and sodium chloride which all required temperature monitoring at below 25 degrees. The room was warm and no temperature checking was taking place. We brought this to the attention of the outpatients manager. We were told that items were stored in this room because the stores team who replenished it were unable to access the minor operations /treatment room.
- In the minor operations /treatment room, daily room temperature checks were up to date and found to be

in normal ranges. However, we found braded sutures in the storage cupboard that were out of date (dated February 2019 and December 2018). This was highlighted to the outpatients' manager, who confirmed these should have been identified in the routine room checks and removed.

- In the phlebotomy room, the room temperature had not been taken over the weekend; since 6 April 2019 (now 8 April). Three blood samples from that morning were sitting in a tray in the room awaiting collection. Daily checks on room temperatures and fridge temperatures had been signed and dated in the minor operations room, treatment room, clean and dirty utility rooms.

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.

- In information provided prior to our inspection visit we were told that in outpatients and diagnostic imaging there were zero never events in the last 12 months and 51 clinical incidents. We were told that the hospital actively encouraged incidents to be reported and that the number of reported incidences had increased as staff confidence in a culture of openness had improved.We were told that all incidents were investigated, with Route Cause Analysis (RCA) being completed as appropriate.
- On site we found incident investigations were allocated to the head of department aligned to the department of origin. We were told that any investigation involved speaking to those directly involved. Any investigation report went to senior management who sent feedback that may advise on further action depending on context and circumstances.
- There was a hospital wide lessons learnt meeting attended by staff of different grades, coordinated by the quality and risk manager. Learning was shared throughout the hospital and other departments within the Kings Oak and Cavell collective. The most recent reportable incident in outpatients related to communication and minor harm regarding a patient who had been seen at both sites. We were told that duty of candour was observed and the patient was apologised to and given an explanation.
- There was an outpatient departmental meeting on the last Tuesday of each month where the service tried to block the time out for 50% of nursing and healthcare assistant staff to attend. This included a lessons learnt briefing.
- There was an online incident reporting system used. This broke down all incidents so that what might be attributable to outpatients could be identified. Monthly clinical governance meetings reviewed incidents reported by both hospital sites, broken down by type of incident rather than by department. We were told that a supplementary report was also presented at clinical governance meetings which further broken-down incidents by teams such as outpatients.
- All staff had an individual log in to the reporting system and it was everyone's responsibility to report incidents. The system also reported on risks and anyone could add a risk but staff were encouraged to discuss risks so they can be correctly categorised. All staff were trained in its use but we were told responsibility to report was usually left to the lead nurse to put it on the system.

Safety thermometer

The service used safety monitoring to improve the service.

- The patient safety thermometer is a national tool to record the prevalence of patient harms and to provide immediate information and analysis for frontline teams to monitor their performance in delivering 'harm free' care. This information is intended to help staff focus their attention on reducing patient harm and improve the safety of the care they provide.
- The safety thermometer tool was not used in outpatients at the hospital as it was not suitable for an outpatient setting. However, we were told that there were several arrangements to promote harm free care. The service had signed up for sepsis prevention and all staff knew how to escalate for sepsis in post-operative wound care. There were posters for

sepsis 6 and staff liaised with infection control lead. There were procedures in the event of sharps injuries. Staff were trained in the monitoring of mobility for patients at risk of falls and referred on to physiotherapy if deterioration was detected. VTE was monitored in assessment.

Are outpatients services effective?

Not sufficient evidence to rate

Evidence based care and treatment

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

- In information provided prior to our inspection visit we were told that practice was linked to NICE guidelines and appropriate best practice. Implementation of NICE guidance was monitored through the corporate clinical governance bulletin supported by a local register/tracker.
- On site we found that the quality and risk manager received updates on new practice and guidance from the corporate BMI team for dissemination to relevant teams. We were told that local NHS trusts with whom there were contracts for work, also advised on practice issues they wanted followed. For instance, a new controlled drug categorisation was disseminated through this channel.

Nutrition and hydration

The service assessed nutritional states and provided food and drink to meet patient need.

- We were told that nutritional states were assessed for each patient on admission using the Malnutritional Screening Tool (MUST) and that food and fluid intake was monitored using food charts and fluid balance charts as necessary.
- In the waiting area, there was a water dispenser available free of charge and a vending machine dispensing cold drinks and snacks. Tea and coffee was also available free of charge from a machine which was also located in the waiting area.

Pain relief

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

- In information provided prior to our inspection visit we were told that pain advice booklets were given to post-operative patients. Any issues regarding pain management were discussed with patients and documented and pain scores were documented in the BMI pain chart in conjunction with the NEWS chart. Patients were asked to complete patient questionnaires upon discharge and through this pain relief was monitored. Specific questions on pain included: 'Were you ever in pain? Was the likelihood of post-operative pain explained to you? How we assessed your level of pain? Did we do everything we could to help control your pain?' On site we found that pain management was addressed in follow up appointments.
- As part of an NHS contract the service carried out pain management clinics that included giving pain injections to patients. Nurses and healthcare assistants had specific competencies to support pain clinics.

Patient outcomes

Managers monitored the effectiveness of care and treatment and used the findings to improve them.

- In information provided prior to our inspection visit we were told that outcomes were monitored following discharge through follow up appointments and physiotherapy sessions. Patients were given the option to receive a follow up telephone call soon after surgery to review progress.
- We were told the service participated in the National Joint Registry and Patient Reportable Outcome Measures (PROMs) and submitted data to the National Joint Registry for all hip, knee & shoulder replacement patients. Patients were given forms in pre- assessment and given a unique identifying number so they could be tracked. We were also told that Commissioning for Quality and Innovation initiatives (CQUINs) were 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.

Good

Outpatients

Competent staff

The service made sure staff were competent for their roles. Managers appraised staff's work performance.

- We were told that the appraisal year ran from September to October and 90% of staff had an appraisal so far in the current appraisal year and 100% in the previous full year. All staff we spoke with told us they had completed their appraisals. Objectives were set and reviewed with their line manager.
- All staff completed competencies for individual skill sets. This information was kept in individual staff folders. We reviewed staff files that covered competencies. This was based on a BMI assessment form and was rated and signed by each staff member.
- Most healthcare assistants had completed a programme to develop them into associate nurse roles. Healthcare assistants had carried out a competency process which, when trained, enabled them to take on extra responsibilities. These included taking bloods, wound care, suture removal and taking off plaster casts. They were also trained in the use of national early warning score (NEWS) assessment of the deteriorating patient and were provided with training for equipment use such as the blood pressure machine.
- These competencies involved shadowing nurses and completing online training. One outpatients nurse told us the associate nurse roles had greatly helped the service, which enhanced the available skill mix to support clinics.
- One healthcare assistant we spoke with told us they had been trained, in house to level 3 and were currently studying for the associate nurse role. They were competent to take bloods, do ECGs, remove sutures, clip removal and wound checks. Learning was via e-learning and practice learning. Their individual staff folder that we checked contained competencies that had been signed off. Healthcare assistants told us they reported to the on-site outpatient sister.
- There was an infection prevention and control nurse. They supervised outpatient staff competencies for dressings and suture removal.
- The healthcare assistants also had the support of the trained nurse on duty. Nurses and healthcare assistants were trained to take bloods as required. A phlebotomist worked 32 hours per week over three days, Wednesday to Friday. Nurses and HCAs were also trained and took blood outside of these times as required. Some patients had booked appointments with the phlebotomist.

Multidisciplinary working

Healthcare professionals supported each other to provide good care.

- The outpatients department was a multidisciplinary team working with specialities of urology, orthopaedic, gynaecology, general surgery, ENT and pain. There was an adequate amount of multidisciplinary team support that included pharmacy, physiotherapy, phlebotomy and infection control. There was an adequate support structure for staff that supported multidisciplinary working. Nurses and healthcare assistants had appropriate competencies to manage the patient specialties.
- We observed positive working relationships between nursing, medical and allied health professional staff. Physiotherapists assisted with clinics by being available from the wards when orthopaedic patients were in need of further assistance. We were told that physiotherapists also linked well with outpatients and would send patients down to outpatients for any dressing changes and suture removal.

Seven-day services

Some support services also ran on a Saturday when other outpatient clinics were running.

- The outpatient department principally ran a service from Monday to Friday with some Saturday clinics. Blood samples could also be taken from Monday to Saturday as and when required. We were told that if orthopaedic consultants were running clinics on a Saturday then other support services would also be available such as x ray. The pharmacy service and pharmacist support, was available from Monday to Friday.

Health promotion

Some health promotion information and advice was available.

Good

Outpatients

- Leaflets were available by reception on patient conditions such as orthopaedics, urology, breast health, varicose veins, physiotherapy and women's health. There was a display board on prostate cancer and urinary problems.
- Health questionnaires and advice was given in clinics on smoking, alcohol intake and mobility. Patients were referred for further help to cessation clinics if required.

Consent, mental capacity act and deprivation of liberty safeguards

Staff followed policy and procedures on consent and on when a patient could not give consent.

- Staff told us that consent was rarely taken in clinic, most often on the day of surgery. Regarding consent for minor procedures, we were told the consultant would take the consent on the day.
- Patients lacking capacity or those with a learning disability could be referred on by the clinician if, following assessment, the decision was made that the individual needed more support than could be provided or if it was assessed as not safe to proceed because more support was needed. In such cases patients were transferred to another hospital or back to the NHS, who could better manage patient need. We were told this did not mean this group of patients were outside of the referral criteria. Private patients who lacked capacity came as day cases. Also, those with the Power of Attorney in place were provided with one to one care.

Are outpatients services caring?

Good

Compassionate care

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

- We spoke with three patients waiting for their appointment. All patients told us they found staff to be friendly and kind. Everyone we spoke with had been before and told us they were confident about being treated with respect and compassion.
- The service told us they had a patient centred culture that put patients at the centre of how services were organised. We were told that importance was placed on treating all patients with dignity and respect. Patients we spoke with gave us positive feedback about the service and all members of staff they had come in to contact with. Some patients told us they had been here numerous times and that staff always treated them with respect. One patient told us that orthopaedic staff were fantastic and that the physiotherapy staff very helpful.
- We observed nurses and healthcare assistants speaking to patients in a kind and polite manner. Reception staff were friendly and considerate in every interaction we observed with patients. We observed medical staff being welcoming and warm towards patients. All healthcare staff we observed introduced themselves to patients.
- We were told the service actively encouraged patients to complete the patient satisfaction questionnaire, so the patient experience could be reviewed and improved. Patient surveys were distributed through an independently managed questionnaire which was available by email and paper form. A monthly report was provided to the hospital for review and analysis. The results were reviewed at the patient satisfaction meeting that occurred monthly, where trends and improvement actions were identified. They were also discussed at the clinical governance, departmental and head of department meetings.
- We were provided with the overall patient satisfaction survey results for the hospital last six months, which averaged 98% satisfaction rate with an average response rate of 60%.
- Patient satisfaction scores for 2018 were on display in reception/waiting area. In the corridor to the consulting rooms a more in depth patient satisfaction dashboard dated February 2019 showed most improved survey results. It stated that satisfaction with the physiotherapy service was up from 28.6% in

February 2018 to 89.3% in February 2019. Pharmacy satisfaction with pharmacy had gone up from 50% to 90.9% over the same period. Response rates were stated as 71.3% for the friends and family card.

Emotional support

Staff provided emotional support to patients to minimise their distress.

- We observed that staff were sensitive and respectful of patients. Patients we spoke with told us that they received emotional support from staff when this was required. One patient told us that when a consultant had delivered bad news, it was in a sensitive and kind way.
- In the clinic rooms there were notices regarding the availability of a chaperone if required. These were placed above the examination couches. We were told that the 'journey to outstanding' corporate initiative included empowering staff to be caring towards patients. There were links to an age related charity and bereavement services which were free services to refer on to where needed. A leaflet of available local services was available to patients who needed it. This was not on general display but was given to appropriate patients.

Understanding and involvement of patients and those close to them

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

- We were told that importance was placed on being respectful and responsive to individual patient preferences and values. We were also told the service ensured that patients were involved in the planning and decisions about their care.
- We spoke with three patients waiting for their appointments. All three had been before and all told us they felt listened to during their consultations and that their preferences had been taken in to account.

Are outpatients services responsive?

Good

Planning and delivering services which meet people's needs

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

- Patients booked in at reception on arrival. The reception desk for the outpatient department was immediately through a separate entrance to the rest of the hospital. Waiting areas provided drinking water, tea and coffee free of charge. There was also a vending machine for cold drinks and snacks.
- Patient information was on display at reception. It included informing patients that children could not be left alone in the waiting area. There was information on disability access and mobility in an emergency which advised people to notify a member of staff. Leaflets were available at reception on 'how well did we do?', which included space for patients to say how likely to recommend the service and to make comments. Additional information on patient conditions were available in the waiting area.
- Patients returned to the reception desk following their appointment to book their next slot. This was done in front of them and they were then provided with a printout of their appointment time. Patients also received a text message reminder of their next appointment. Following appointments, patient outcome slips from clinics went back to the reception for staff to enter the patient outcome of the clinic appointment.
- Some consultants called reception who then notified the patient. Others came to reception and called their own patients. Reception staff told us this was done on individual consultant preference.
- The hospital had its own dedicated car park for which there was no charge. Patients confirmed they could always park easily.
- The service did not have its own transport service but did use a taxi firm they had always found to be reliable when patients required transport home. There were

occasions when transport was needed between the Kings Oak and Cavell hospital sites, which were located one mile apart. We were told that sometimes patients turned up at the wrong hospital for their appointment.

Meeting people's individual needs

The service took account of patients' individual needs.

- Patient notes and files we reviewed demonstrated that identifying individual need was part of the assessment process. They included past medical history, allergies, medication, family history and test results. There was a patient booking form that included a clinical coding form for cardiac, respiratory, renal, endocrine, neurological, orthopaedic and sensory assessment. There were flags on notes for dementia and a stamp on the front of the notes folder for MRSA and infection screening.
- All referrals in to the service were triaged before being accepted for a first appointment. This identified whether patients matched the referral criteria but also identified individual need such as dementia or learning disability. We were told that if this was picked up, the service encouraged family or carers to attend with patients. Where patients had higher levels of need or if they were vulnerable, it could be arranged for them to be seen soon after their arrival to avoid unnecessary anxiety caused by waiting. All staff completed online modules for dementia awareness.
- A loop recorder was available at reception to support patients with hearing impairment.
- The need for an interpreter was picked up during the triage process, so an interpreter could be planned for in most cases. A telephone interpreting service was used. Relatives were not accepted to act as interpreters.
- We were told that in the past space had been given over in treatment rooms for private prayer. This was based on individual need.

Access and flow

People could access the service when they needed it. Waiting times from referral to treatment were in line with good practice.

- All referrals were triaged before being accepted for a first appointment by the service. We were told this was a time-consuming undertaking for the senior nurses involved because of the large volume of referrals. The quality and risk manager, imaging manager, outpatient manager, infection control lead, paediatric lead and ward manager all carried out triaging. Staff were often undertaking this task at weekends when not on duty in order to clear the backlog. The referral criteria included a BMI of under 40 and no comorbidities such as asthma or COPD. We were also told that this rarely resulted in rejecting a referral due to incomplete information often being provided on referrals. This was understood to be an issue but remained the way it was done.
- There was a team of four staff who ensured files were available for appointments for both hospitals. Files were stored on site. When needed, sets of files were sent to or from Cavell Hospital in secured locked boxes which were transported by porters. Lists were produced for clinics in advance and sent to the patient records team for making up the files, usually one day in advance. Staff checked that consultants had confirmed the clinic was going ahead before making up files for each clinic. All NHS 'choose and book' appointments were booked electronically and the referral printed off by the bookings team and placed in case notes, which included the outcome form from the clinic.
- For NHS contract work, the reservations team had access to the NHS e-referral system (choose and book) and were responsible for transferring information on to BMI patient information software, which identified treatment targets and whether 18 week targets were being met. The national enquiry centre for BMI booked patient appointments for self-paying patients and consultant ring fenced these appointment slots. The service also held spot contracts with NHS trusts.
- The NHS 18 week referral to treatment (RTT) key performance indicator target was 92% and the service currently stood at 95%. This was tracked within an RTT dashboard which was shared with the CCG. An overall report was completedby the bookings manager and sent alongside the dashboard.The RTT dashboard also showed DNA rates by outpatient clinic. There was a target rate of under 5% per month. Statistics for the

year to date; April 2018 to February 2019, showed that most clinics were within this target. However, ENT, gynaecology and urology were consistently above this threshold.

- Patient outcome slips from clinics went back to the reception to enter the patient outcome of the clinic appointment. The reception staff entered the outcome live into the patient administration system. Notes were sent to the bookings office after clinic outcomes had been completed, which were then checked by the validation team to ensure the 18-week clock was correct against the clinic outcome and notes. Prior approval forms, booking forms and coding forms were then actioned. For invoicing, charges were added by site and processed by the company's main billing centre, based in Manchester who sent out an invoice. When a patient was unhappy with the invoice, the team contacted the site, to recheck the notes and re-verify the invoice.
- Information on late running clinics were fed into the daily morning meeting. There was a weekly utilisation meeting and we were told that all front facing services attended. Waiting times for clinics were not displayed in waiting areas. There was a notice on display at the reception desk that advised patients to report to reception if they had been waiting more than 20 minutes. This was an action taken from a complaint regarding waiting times. We were also told that the director will write to consultants inviting them in to discuss clinic and theatre waiting times if they consistently arrived late. This was then followed up by letter to the clinician.
- We were told that when consultants were delayed, patients were called by reception and nursing staff and informed of when they were expected. We also witnessed this in practice. However, clinic delays were not communicated to the patients on arrival.
- Speaking to patients, a theme was that waiting beyond appointment times was common. Patients who had attended on a number of occasions told us they had waited for long periods before, sometimes up to an hour. Patients confirmed that when there was a wait to see the consultant, staff and consultants were always apologetic. We were told they felt they received a good service from the doctors and did not mind if the doctor was delayed or overrunning but just wanted to be informed of this.

Learning from complaints and concerns

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

- Patients we spoke with told us that staff were helpful and approachable. We were told that when something was not to their satisfaction and they raised it with staff, the response was very constructive and helpful. Staff we spoke with told us that if they were approached by a patient who was not happy about the service they had received they would, in the first instance, try to resolve the issue there and then for the convenience of the patient.
- Between March 2018 and February 2019 the service received 50 complaints overall. None were referred to referred to the Independent Healthcare Sector Complaints Adjudication service (ISCAS). Staff were able to give us examples of recent complaints and learning. This included clinic delay and not being informed of overrunning clinics. We were told that the notice at reception requesting patients report back to reception had been introduced as a result.
- We were told that other complaints had included unexpectedly incurring extra costs for having bloods taken or a scan carried out. When calling the call centre, self-paying patients were now told they could incur further costs outside of the consultation such as for x ray and bloods tests. This was not however, documented in appointment letters on any leaflet. Lessons learnt was to also add to the 20-minute wait notice at reception, that extra costs could be incurred. However, by this time the patient is already presented for their appointment. This was escalated for action for the bookings team to address and was described as a work in progress.
- Another recent complaint related to if a patient changed hospital site for any reason, from Kings Oak to Cavell or vice versa. Due to having two different hospital numbers, it was a requirement for 'group and save' bloods samples to be retaken. This had been

escalated to the senior BMI leadership team to work with the pathology lab for resolution. Currently, the results of bloods cannot be transferred to the other site.

- We were told that patient complaints followed a three-stage process, with each stage having set timeframes for responses.Stage one involved an investigation and response by the hospital within 20 days, whilst stage two resulted in regional or corporate review and response within 20 days. Stage three provided for an independent, external adjudication.
- All written complaints were received via the executive director's office, who acknowledged receipt to the complainant within 48 hours by letter or email (depending on the method of delivery). Copies of the complaint were then distributed to the relevant head of the department or consultant for investigation.The final response came from the executive director.
- We were told that the hospital had generally been compliant with these timeframes, with a small number of occasions within the last twelve months where the hospital has failed to meet the timescales set out.Instances in which timescales had proved more difficult to achieve were ones where input from a number of individuals was required. In these situations, an update or further holding letter was sent to the complainant to keep them informed of progress.
- We were told that the service also monitored patient feedback received through complaint and compliment letters and responded to feedback that was posted on the national 'NHS Choices' website and other associated websites. Electronic feedback was responded to and shared with the team in the same way as written feedback.

Are outpatients services well-led?

Good

Leadership

Managers had the right skills and abilities to provide sustainable care.

- The Kings Oak Hospital and The Cavell Hospital were located a mile apart from one another and the same hospital leadership team managed both sites. The outpatient manager worked across both sites and there was an outpatient sister in charge at each hospital. The outpatient manager ordinarily reported to the clinical director and associate clinical director. However, both posts had been vacant for three months. There were new starters for both on the first day of our unannounced inspection. In the three-month absence, the outpatient manager had been reporting to the quality and risk manager, who was part of the senior management team.
- We were told a senior nurse in charge was available as a contact point for staff, consultants and patients and was available via bleep or telephone. There was also an on call rota where hospital managers provided on call support for a week at a time and from the 1 April 2019 the manager on call would be in attendance every Saturday, providing support to the teams.

Vision and strategy

The service had a vision for what it wanted to achieve.

- We were told there was a clear vision and strategic goals, driven by quality and safety and aligned to the BMI Healthcare corporate vision and underpinned by BMI behaviours. The strategy was developed by the corporate senior management team, with objectives cascaded to the hospital teams. The clinical strategy encompassed the Care Quality Commission domains used to assess service provision and quality of care in healthcare organisations. Under each domain objectives stated a commitment to quality improvement and how this was to be achieved. We were told that the aim of the strategy was to ensure an integrated approach where risk management, clinical governance and quality improvement were part of the culture and everyday management practice. The objectives of the strategy were to promote an honest, open and blame-free culture where risks were identified and addressed at every level and escalated appropriately.

Culture

Managers looked to promote a positive culture that supported and valued staff.

- We were told 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 was continually improved. The service aimed to promote an open, honest culture whereby staff and consultants could discuss hospital operational improvements through the various forums and meetings scheduled.
- Senior managers told us that the recent staff survey results showed that bullying and harassment was still an issue across the two hospitals. The results were not broken down by staff site or speciality, so they were unable to identify where the issue was located or whether it was localised. The leadership team said they planned to work with staff to address the issue, and that it had improved slightly since the last survey.
- We were told that staff recognition was brought to the daily morning meetings for recognition and that staff received a certificate of commendation. Corporate perks were available to staff. Discounts and discount cards were given to staff. There were long service pins, corporate events and awards evenings. We were told that staff morale had improved lately. We were told that at one stage recently, there was a high turnover of management staff.

Governance

The service used a systematic approach to improve the quality of its services.

- Kings Oak and Cavell hospitals were located a mile apart from one another and worked to a joint governance structure. There was a heads of department meeting that took place monthly and a clinical governance meeting that occurred monthly. The outpatient manager attended both of these meetings and reported on outpatient activity.
- The infection control monthly meeting and the resuscitation monthly meeting were both attended by senior nurses within the outpatient department who reported back to the teams. These were subsidiary to the clinical governance meetings as were transfusion, medicines management, slips/trips, falls and radiation protection meetings.
- Outpatient departmental team meetings occurred on the last Tuesday of each month. The service tried to block the time out for 50% of nursing and healthcare assistant staff to attend. We were told that if team members could not attend the minutes were available to read.

Management of risk, issues and performance

The service had effective systems for identifying risks, planning to eliminate or reduce them, and coping with both the expected and unexpected.

- With both the clinical director and associate clinical director posts having been vacant for three months, the outpatient manager had been reporting to the quality and risk manager. Clinical supervision had taken place with them on a monthly basis. We were told they would also speak to them weekly and on an ‘as and when needed’ basis. We were told they reported on general things such as staffing, issues regarding patient care such as incidents and concerns. Business issues such as volumes of patients, clinical efficiency and flexing the service from one side to the other, safeguarding issues and alerts.
- All heads of departments completed a monthly template for submission to the heads of department monthly meeting. It contained information on staffing, new services, changes in services, changes in outpatient clinics, recruitment, HR issues.
- The outpatient department had its own risk register that was regularly reviewed. The top three risks were the ageing of the defibrillators, there being no dedicated plaster room on both sites, the lack of cleaning stations for scopes on both sites and pre-assessment staffing (down two staff). The risk register was reported to the senior management team meeting and risks were visible to senior managers and corporate head office.

Information management

Good

Outpatients

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

- We were told that patient notes were retained by the hospital and the hospital strongly discouraged the removal of hospital medical records from the site in all circumstances. If a consultant wished to view the hospital's patient notes, they were asked to do so within the hospital and in accordance with data protection legislation and the Caldicott Principles. We were also told that controls were in place to mitigate risk to both patient safety and data protection, which included several 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.
- Consultants who had 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.
- The reservations team had access to the NHS e-referral system (choose and book) and were responsible for transferring NHS patient information on to the BMI patient information software. Secure NHS.net accounts were given to NHS bookings team who received the NHS referrals. The national enquiry centre for BMI booked self-funded patient appointments, where patient information went straight on to the electronic system.
- Patient files were made up in advance of outpatient appointments. Files for both Cavell and Kings Oak hospitals were stored securely at Kings Oak Hospital. Sets of files were sent over to Cavell hospital for outpatient appointments in secure locked boxes. An audit trail was kept so files were signed out and signed in so location of each file was recorded.
- We were told that patient records were available for appointments nearly all the time. If not, basic information was printed off the system for the appointment. If information was not available for self-funding patient appointments, it would often be the case that consultants would hold their own information. Following appointments, files were brought back to reception by consultants and placed securely in the cupboard located behind reception.
- On questioning staff about the General Data Protection Regulation 2016 (GDPR) we were advised that GDPR was managed centrally by BMI. GDPR is a regulation on data protection and privacy for all individuals. Reception staff were not aware of GDPR.
- Nursing staff were not permitted to give test results directly to patients. Patients were advised the results could only be discussed with the consultant. Self-funding patients could contact the clinician's medical secretary for contact with the consultant and to access their results.
- We identified a breach of information privacy which was reported to the outpatient manager. In one treatment room, patient information had been left on the desk from the patient clinic list from the morning. The room was not locked and free for anyone to walk in to.

Engagement

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

- Patient surveys were managed through an independently managed questionnaire which was available by email and paper form. Friends and family leaflets were available at reception on 'how well did we do?' They included how likely to recommend the service, who did you see today, were you self-funded and demographic questions. A monthly report was provided to the hospital for review and analysis. The results were reviewed at the patient satisfaction meeting that occurred monthly, where trends and improvement actions were identified. They were also discussed at the clinical governance, departmental and head of department meetings. There an average response rate of 60%.
- Patient feedback was also gained from patients writing in to the service to say thank you or with issues that have arisen during their contact with the hospital. All comments will be logged as feedback within the online incident and risk reporting system where there

was a feedback section. We were told this information could also be fed in to the morning brief for individual praise. The brief gets emailed to all staff to read. This is found to be effective and the manager often finds that staff are aware of what has been discussed before they make contact with the staff following the meeting.

- The staff survey was completed annually. The most recent was survey was conducted in February/March 2019 and we were told that the results had not yet been seen by staff.

Learning, continuous improvement and innovation

The service learnt by promoting improvement and innovation.

The clinical services managers for outpatient departments within the London BMI group, met quarterly to discuss outpatient issues and business at a wider level. We were told this acted as a good reference point 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

Areas for improvement

Action the provider MUST take to improve

Surgery:

- The provider must ensure that risks to patients are identified, assessed and monitored consistently in theatres through processes of best practice for safer surgery. The provider must ensure that swab counts and instrument counts are updated at the time they happen and enable staff to reduce surgical risks effectively.
- The provider must ensure that systems and processes for safer surgery are operated effectively and ensure staff are clear and consistent with systems to mitigate the risks relating to the health, safety and welfare of service users.

Action the provider SHOULD take to improve

Medical care:

- The provider should ensure all staff complete their mandatory training.
- The provider should ensure all staff had completed their annual appraisal.
- The provider should improve the clinical environment and ensure its compliance with suitable guidance.

Surgery:

- The provider should ensure all staff in clinical areas are bare below the elbow.
- The provider should ensure all medications and fluids are stored in line with best practice guidelines and hospital protocol.
- The provider should ensure staff are supported to challenge poor behaviours in theatres.
- The provider should ensure there is a system in place to improve culture and compliance with the world health organisation (WHO) checklist for safer surgeries.
- The provider should work to improve surgical site infection rates and improve infection prevention and control in theatres with proper disposal of clinical waste.

Services for children and young people:

- The provider should ensure that action plans are monitored to ensure all staff are compliant with mandatory training including modules for paediatric life support and safeguarding level 3.
- The provider should ensure that equipment held within the paediatric resuscitation trolleys is kept in a standard order and that information folders are organised with consistent contents held within each area.
- The provider should undertake assessments for the risk of falls within the patient en-suite bathrooms on Acorn ward and take action to minimise the risks.
- The provider should ensure that staff record on patient records any actions that are taken when a PEWS triggers escalation.
- The provider should ensure that the CYP service are fully embedded in the hospital audit schedule.
- The provider should ensure all areas of the hospital where children and young people are seen are child friendly, and that information is available that is appropriate for all ages.
- The provider should ensure that the CYP service is fully incorporated in the governance structure within the hospital and that performance, risk and improvement plans within the service are monitored.
- The provider should ensure that all risks pertaining to children and young people are recorded on the risk register.
- The provider should audit feedback from children, young people, their parents and carers to have oversight of what is working well and what needs improving.

Outpatients:

Outstanding practice and areas for improvement

- The provider should ensure that all premises and equipment used by the service provider are maintained and meeting standards of hygiene.
- The provider should ensure that aspects of the General Data Protection Regulation 2016 (GDPR) are embedded in to practice.
- The provider should ensure there is a system in place to keep patients informed of delayed appointment times.
- The provider should ensure that the resuscitation trolley and storage cupboard are temperature monitored.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Surgical procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment How the regulation was not being met; Care and treatment must be provided in a safe way for service users. The registered provider must do all that is reasonably practicable to mitigate any such risks. Regulation 12 (1)(2)(b)

Regulated activity	Regulation
Surgical procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance How the regulation was not being met; Systems or processes must be established and operated effectively to ensure compliance with the requirements to assess, monitor and mitigate the risks relating to the health, safety and welfare of services users and others who may be at risk which arise from the carrying on of the regulated activity. Regulation 17(1)(2)(b)