BMI The Shelburne Hospital

Quality Report

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

Ratings

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

Summary of findings

Letter from the Chief Inspector of Hospitals

BMI The Shelburne Hospital is operated by BMI Healthcare. The hospital has 26 beds and is a day case facility operating from 8am to 8pm Monday to Friday only. Facilities include three operating theatres, five outpatient consulting rooms, a physiotherapy department and diagnostic facilities.

The hospital is in the grounds of a NHS trust and utilises a number of its services. These include pathology, cardiology, cardiac catheterisation laboratory, nuclear medicine, magnetic resonance imaging (MRI) and computed tomography (CT) scans.

The Shelburne hospital provides surgery, outpatients and diagnostic imaging to adult patients only. We inspected surgery, outpatients and diagnostics, using our comprehensive inspection methodology. We carried out the unannounced part of the inspection on 15 January 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 core service.

Services we rate

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

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

- The service provided mandatory training in key skills to all staff and processes in place to monitor compliance, but not all staff had completed this training.
- Most equipment was suitable but the paperwork to evidence that equipment had been tested and serviced to ensure it was fit for purpose was not always available, up to date or accurate.
- While staff understood how to protect patients from abuse. However, not all staff had completed the required level of safeguarding training.
- Not all departments had sufficient numbers of nurses with the right qualifications, skills, training and experience to keep people safe from avoidable harm and to provide the right care and treatment.
- While staff recognised incidents, they did not always report these appropriately.
- The service provided care and treatment based on national guidance and evidence of its effectiveness. Whilst managers checked to make sure staff followed guidance, this guidance was not always the most up to date.
- Management for the diagnostic department was still in its infancy and was in the process of developing the right skills and abilities to run a service or had just begun to address some of the challenges in their area.
- The provider had a governance framework which was used to improve their clinical, corporate, staff and financial performance. However, these were not always fully embedded into operational practice.

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

- The service controlled infection risks and kept equipment and the premises clean.

Summary of findings

- Staff completed and updated risk assessments for each patient. They kept clear records and asked for support when necessary.
- The service had enough medical staff with the right qualifications, skills, training and experience to keep people safe from avoidable harm and to provide the right care and treatment.
- Staff kept detailed records of patients' care and treatment. Records were clear, up-to-date and easily available to all staff providing care.
- Managers monitored the effectiveness of care and treatment and used the findings to improve them. They compared local results with those of other BMI services to learn from them.
- Staff 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 hospital planned services around the needs and demands of patients, taking into account patients' individual needs.
- People could access the service when they needed it.
- The service treated concerns and complaints seriously, investigated them and learnt lessons from the results, sharing these both internally and with other BMI hospitals.
- The service had a vision for what it wanted to achieve and workable plans to turn it into action, which it had developed with staff and patients.
- The service engaged well with patients and staff to and manage appropriate services.

  Following this inspection, we told the provider that it should make improvements, even though a regulation had not been breached, to help the service improve. Details are at the end of the report.

Nigel Acheson

Deputy Chief Inspector of Hospitals (London and South Central),

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Surgery	Good 	Surgery was the main activity of the hospital. Where our findings on surgery also apply to other services, we do not repeat the information but cross-refer to the surgery section. Staffing was managed jointly with medical care. We rated this service as good overall and good in each domain because it was safe, effective, caring, responsive and well-led.
Outpatients	Requires improvement 	Outpatients was not the main hospital activity. The main service was day case surgery. Where arrangements were the same, we have reported findings in the surgery section. We rated this service as required improvement in safe and well led. The service was rated as good in the caring and responsive domains. We currently do not rate the effective domain.
Diagnostic imaging	Requires improvement 	Diagnostics were a small proportion of hospital activity. The main service was day case surgery. Where arrangements were the same, we have reported findings in the surgery section. We rated this service as required improvement in safe and well led in relation to the services oversight on equipment safety. The service was rated as good in the caring and responsive domains. We currently do not rate the effective domain.

Summary of findings

Contents

Requires improvement

BMI The Shelburne Hospital

Services we looked at

Surgery; Outpatients and Diagnostic imaging;

Summary of this inspection

Background to BMI The Shelburne Hospital

BMI The Shelburne Hospital is operated by BMI Healthcare. The hospital opened in August 2000. It is a private hospital in High Wycombe, Buckinghamshire located in the grounds of Wycombe General Hospital and has some service level agreements for services including pathology, cardiology and cardiac catheterization with the trust. The hospital primarily delivers care to self-funding and insured patients but also has contracts with a local NHS trust to deliver specific treatments. The hospital offers day surgery, outpatients, x-ray and diagnostics to adults only.

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

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

Our inspection team

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

Information about BMI The Shelburne Hospital

The hospital has one ward and is registered to provide the following regulated activities:

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

During the inspection, we visited the ward, theatres, consulting rooms and x-ray. We spoke with 17 staff including; registered nurses, health care assistants, reception staff, medical staff, and senior managers. We spoke with 15 patients and one relative. During our inspection, we reviewed 14 sets of patient records.

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

Activity

- In the reporting period August 2017 to July 2018, there were 1730 inpatient and day case episodes of care recorded at the hospital; of these 20% were NHS-funded and 80% other funded.
- During this period 2% of all NHS-funded patients and 8% of all other funded patients stayed overnight at the hospital.
- There were 4082 outpatient total attendances in the reporting period; of these 81% were other funded and 19% were NHS-funded.

There were 241 surgeons, anaesthetists and physicians worked at the hospital under practising privileges. The hospital employed 6.9 whole time equivalents (WTE) registered nurses, two WTE care assistants and two WTE operating department practitioners, as well as using bank and agency staff when necessary. Three regular agency resident medical officer (RMO) worked on a weekly rota, they cover 24 hours a day for seven consecutive days.

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

Summary of this inspection

Track record on safety

- 0 Never events
- 91 clinical incidents 55 no harm, 34 low harm, two moderate harm, 0 severe harm, 0 death
- 0 serious injuries

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

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

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

0 incidences of hospital acquired E-Coli

11 complaints

Services accredited by a national body:

- At the time of our inspection none of the services were accredited by a national body.

Services provided at the hospital under service level agreement:

- Pathology and histology
- High dependency and intensive care
- Clinical and or non-clinical waste removal
- RMO provision
- Resuscitation team
- Grounds Maintenance
- Interpreting services
- Laser protection service
- Maintenance of medical equipment

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

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

- The service provided mandatory training in key skills to all staff and processes in place to monitor compliance, but not all staff had completed this training.
- Most equipment was suitable but the paperwork to evidence that equipment had been tested and serviced to ensure it was fit for purpose was not always available, up to date or accurate.
- While staff understood how to protect patients from abuse. However, not all staff had completed the required level of safeguarding training.
- Not all departments had sufficient numbers of nurses. However, those staff in post were experienced and had the right qualifications and skills.
- While staff had a good understanding of incidents and managers investigated these, they did not always report incidents

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

- The service controlled infection risk well. Staff kept equipment and the premises clean. They used control measures to prevent the spread of infection.
- The service had enough medical staff with the right qualifications, skills, training and experience to keep people safe from avoidable harm and to provide the right care and treatment.
- Staff kept detailed records of patients' care and treatment. Records were clear, up-to-date and easily available to all staff providing care.

Are services effective?

Good

Are services effective?

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

- Managers monitored the effectiveness of care and treatment and used the findings to improve them. They compared local results with other BMI services to learn from them
- The service made sure that staff were competent for their roles.
- Staff gave patients enough food and drink to meet their needs and improve their health.

Summary of this inspection

- Staff assessed and monitored patients regularly to see if they were in pain.
- Staff of different kinds worked together as a team to benefit patients.

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

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

Are services caring?

Good

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

- 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

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

- The service took account of patients' individual needs.
- People could access the service when they needed it. Waiting times from referral to treatment and arrangements for admission, treatment and discharge were in line with good practice.
- The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with all staff.

Are services well-led?

Requires improvement

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

- Some management teams were in their infancy and were in the process of developing the right skills and abilities to run a service.
- The department had systems to improve the quality of its services and safeguarding however they were not fully embedded at all levels.

Summary of this inspection

- While staff felt able to raise concerns, they did not feel action was taken to address these or if it was not possible to take action feedback was received.

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

- The service had a vision for what it wanted to achieve and workable plans to turn it into action, which it developed with staff and patients.
- The provider had systems to identify risks, plan to eliminate or reduce them, and cope with both the expected and unexpected.

Detailed findings from this inspection

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Surgery	Good	Good	Good	Good	Good	Good
Outpatients	Requires improvement	N/A	Good	Good	Requires improvement	Requires improvement
Diagnostic imaging	Requires improvement	N/A	Good	Good	Requires improvement	Requires improvement
Overall	Requires improvement	Good	Good	Good	Requires improvement	Requires improvement

Good

Surgery

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

Information about the service

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

The hospital did not treat provide surgical services for children and young people at this hospital.

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

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

The hospital is one floor of a building located within the grounds of an NHS hospital. There is direct access via corridor and lifts to NHS surgical wards and facilities.

The hospital is licensed for 24 inpatient beds, all were in single, en suite rooms across one ward;

Shelburne Ward – 24 rooms day case patients only

The surgical service had three operating theatres, two with laminar flow, the third operating theatre was not in use at the time of the inspection. There was a four bedded recovery area. The department operates between 8am to 5.30pm Monday to Friday dependent on activity.

The inpatient and day-case activity for the period August 2017 to July 2018 comprised both non-NHS funded and NHS funded patients. Activity was 80% non-NHS funded and 20% NHS funded patients. Should a patient require an overnight stay then they were transfer to an NHS ward which was located within the same building. The proportion of patients that required an overnight stay was 8% non-NHS funded and 2% NHS funded.

During the period August 2017 to July 2018 the surgical department saw 118 inpatients and 1,612 day-case patients.

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

Are surgery services safe?

Good

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

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

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

- The BMI healthcare corporate mandatory training policy defined the mandatory training requirements of staff including bank workers. This included a mandatory training matrix which identified the mandatory training required dependent on job role.
- Agency staff completed training with the agency for which they worked.
- Staff completed training through the corporate learning system 'BMILearn'; which was an online resource of training modules, e-learning courses, and some face-to-face sessions.
- Staff could view their individual training needs, current compliance and access e-learning courses through the hospital's electronic training system. The system also alerted both managers and staff when mandatory training was due to be completed. They could access e-learning courses at work or home, and were compensated for training they completed in excess of their contracted hours.
- Staff we spoke with told us they were up-to-date with most of the statutory and mandatory training.
- As of October 2018, compliance with mandatory training for staff working across the whole hospital was 93%. The hospital target was 85% compliance.
- The resident medical officers (RMOs) received their mandatory training from their agency and were not allowed to work at the hospital unless this had been completed.
- The RMOs were trained in advanced life support (ALS) and other clinical staff trained in immediate life support (ILS). Non-clinical staff completed basic adult life support training (BLS).
- Hospital-wide data provided by the hospital following the inspection showed that 89% of theatre clinical staff and 86% of clinical ward staff were compliant with immediate life support training which did not meet the hospital target of 90%.
- All theatre staff had competency and mandatory training files. We reviewed the files and, found they were all up-to-date, and provided evidence of completion of mandatory training and competencies. This was a significant improvement since our last inspection.
- Agency staff working in the surgery services had a local induction which covered the layout of the department, emergency procedures, paperwork and where to access essential information. Agency staff we spoke with told us the local induction was useful and provided them with the information they required to work effectively and safely.
- Senior staff within the service monitored mandatory training compliance and arranged both external courses and in-house training to provide multiple platforms for learning. We heard about scenario based training life support training provided by an external organisation which staff found useful. Staff received formal feedback from these training sessions. We reviewed one report which was detailed and provided areas for improved as well as praise.

Safeguarding

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

- The service had a corporate safeguarding policy which incorporated Mental Capacity, Deprivation of Liberty Safeguards and PREVENT advice. PREVENT aims to safeguard vulnerable people from being radicalised to supporting terrorism or becoming terrorists themselves. The policy included what action staff should take if they had concerns a patient had undergone female genital mutilation (FGM).
- The required level of safeguarding training for staffing working at the hospital was included in the BMI healthcare corporate mandatory training policy. All staff required safeguarding adults level one, clinicians and all non-clinical staff in a managerial role required level two training and the director of clinical services, who was the safeguarding lead for adults required level three training.
- Consultants had to submit evidence they had completed their mandatory safeguarding training in their substantive post, for their practising privileges to be renewed.
- Staff told us they completed safeguarding children and vulnerable adults modules in their mandatory training. Evidence provided by the hospital showed 88.24% of relevant staff had completed level one safeguarding

children training, 84.62 had completed level two safeguarding children training and 100% had completed level three safeguarding children training. For adults safeguarding training the completion rates were; level one 88.24%, level two 92.31% and level three 100%.

- The director of clinical services (DCS) was the hospital safeguarding lead for vulnerable adults and children, and trained to level three. Staff also had access to the BMI regional safeguarding lead trained to level four.
- Staff we spoke with had a good understanding of their responsibilities in relation to safeguarding of vulnerable adults and children and could explain how to respond to and escalate a concern or make a referral.
- The ward at the hospital had folders containing safeguarding information. Staff displayed safeguarding information posters on office walls, which contained information on how to contact the local safeguarding authority.
- All staff were subject to Disclosure and Barring Service (DBS) checks. DBS helps employers make safer recruitment decisions and prevent unsuitable people from working with vulnerable groups.
- The hospital had a chaperoning policy and staff knew how to access it. We saw signs instructing patients to request a chaperone if they wanted one.

Cleanliness, infection control and hygiene

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

- The service had corporate policies to manage infection prevention and control (IPC). Staff demonstrated how to access policies easily.
- There was a BMI healthcare corporate waste management policy which the hospital and staff followed. During the inspection we saw the correct management of containers for sharps and the use of coloured bags to correctly segregate of hazardous and non-hazardous waste.
- All clinical areas we visited in theatres and on the wards, were visibly clean, well maintained and tidy. The wards, theatre rooms, reception and other areas we inspected were visibly clean and well maintained.
- Staff followed the hospital's policy on infection control, for example, complying with 'arms bare below the elbow' not wearing jewellery and the use of personal protective equipment (PPE), for example the use of gloves and aprons. PPE was available and hand wash gel was easily accessible in the clinical areas, individual patient rooms and the corridors. All hand wash dispensers that we checked were full and in working order.
- Housekeeping staff followed a weekly cleaning schedule. Ward managers checked and signed off the weekly cleaning schedules. Staff escalated any concerns or issues to them.
- The hospital had an IPC lead nurse and link nurses in clinical areas. The link nurses were responsible for collating audit data of cleaning schedules and producing actions to address compliance when necessary. For example, involvement in hand hygiene audits.
- The hospital had recorded four surgical site infections in the reporting period August 2017 to July 2018. We were not provided with evidence to demonstrate how this compared with other BMI hospitals.
- The hospital followed current Department of Health guidance 'Who to Screen' for MRSA on the taking of swabs prior to admission. During the reporting period August 2017 to July 2018 the hospital reported no incidences of hospital acquired Methicillin-resistant Staphylococcus aureus (MRSA), Methicillin-sensitive staphylococcus aureus (MSSA), Clostridium difficile (c.diff), E-Coli.
- Staff completed annual training on infection prevention and control (IPC) as part of their mandatory training. Theatre and ward staff were required to complete two IPC training modules; IPC in healthcare and IPC high impact interventions. Hospital-wide data provided after the inspection for these two modules showed theatre based staff compliance rates were 86% and 93%, and ward based staff compliance rates were 91% and 100% respectively.
- During our inspection we reviewed monthly infection prevention and control audits from the ward and theatres from the three months prior to our inspection.

These covered hand hygiene, patient equipment, invasive device management and theatre asepsis. All achieved 100% compliance. This was an improvement since our last inspection.

- The hospital had a contract in place for decontamination and sterilisation of surgical instruments, which took place off-site. The BMI organisation, and this hospital, used a track and trace system to trace all reusable accessories to ensure appropriate maintenance, correct decontamination and traceability to associated patients.
- Quarterly IPC meetings took place, with performance in IPC audits such as hand hygiene discussed at these meetings and other areas of concern found at the hospital.
- IPC audit highlighted there were carpets in all the inpatient rooms, ward areas and main corridors of the hospital. The hospital had recognised this was an infection control risk and, at the time of the inspection, these were in the process of being replaced. We observed the carpets were clean and staff signed and dated to show carpet-cleaning schedules were complete, including when a deep clean was completed. There was a policy for management of spillages on carpets, with a steam clean taking place.
- Emergency equipment, including the emergency suction equipment and the defibrillator kept on in theatre and inpatient wards were visibly clean, tidy and dust free.
- The hospital provided patients with a leaflet in their pre-admission information pack that explained how good hand hygiene prevented and controlled infection. It included information about hand washing, good hand washing technique and when the use of hand sanitiser gel was appropriate.
- Also included in the pre-admission information pack was a leaflet about surgical site infection. This included information for the patient on how to spot the signs and symptoms of an infection and what action needed to be taken.
- The hospital had a water safety committee that met every three months. There was a set agenda which included water flushing round the hospital, the results of water testing and risk assessments for legionella and pseudomonas. We reviewed documentation that showed that regular water testing was being carried out.
- The hospital had a microbiologist on call to give advice and who attended the IPC committee meetings and the water safety committee. From the minutes we reviewed we could see the microbiologist attended these meetings.

Environment and equipment

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

- The ward and theatre environments were suitable for the level and type of care delivered. In-patients had an individual room with ensuite bathroom and toilet facilities. The rooms were comfortably furnished which patients said met their needs and included a bedside nurse call bell system.
- Both the ward and the theatre suite had resuscitation trolleys for emergency use secured with tamper proof tags. Staff performed daily checks on the resuscitation equipment stored on top of the resuscitation trolleys and weekly checks on the contents. We reviewed a section of the records for trolley checks and found that they were consistently recorded for the two-month period prior to our inspection. There was clear indication when the hospital was closed and therefore when checks did not need to be performed.
- The theatre suite had a difficult airways trolley with records confirming that this was checked weekly.
- Equipment and consumable items such as dressings were neatly stored on shelves raised off the floor which enabled cleaning of the storage areas. Staff maintained stock levels well for both reusable and single use items. Equipment in general was stored appropriately, with clear labelling in storage rooms.
- The theatre department ordered operating equipment sets from a BMI central hub. If equipment was unavailable they had a good relationship with the local NHS trust to 'borrow' equipment sets in an emergency.
- Staff understood their responsibility to ensure they segregated and disposed of clinical waste appropriately. Clinical waste bins were clearly labelled and we

observed staff kept the rooms used to store clinical waste clean and tidy to minimise infection risk. There was a contract in place with an external supplier to dispose of clinical waste, which was stored securely until collected.

- Staff had access to the use of a hoist for transferring patients. The hospital provided disposable slings for individual patient use. Staff received training on the use of equipment as part of the contract held with the supplier. The hospital serviced and tested clinical equipment according to manufacturer's guidance; there were a number of service level agreements in place for servicing of equipment.
- The theatre suite was accessed from a corridor at the end of the outpatient's area. During our previous inspection we had found access to the theatre suite was not restricted. At this inspection we found security measures were in place, with keypad entry, to restrict unauthorised access to theatres.
- The hospital participated in the Patient-Led Assessments of the Care Environment (PLACE) assessments. PLACE assessments provide a framework for assessing quality against common guidelines and standards to quantify the environment's cleanliness, food and hydration provision, the extent to which the provision of care with privacy and dignity is supported, and whether the premises are equipped to meet the needs of people with dementia or with a disability. The hospital's PLACE scores for 2018 were better than the England average and the BMI corporate score in all but two domains, the condition, appearance and maintenance of the hospital and ward food which was better than the national average but not as good as the BMI corporate score.
- There was sufficient equipment to maintain safe and effective care, such as anaesthetic equipment, theatre instruments, blood pressure and temperature monitors, commodes and bedpans.
- Theatre staff checked anaesthetic machines daily and the tubing weekly. Records we reviewed during the inspection showed that these checks were carried out.
- Theatre ventilation complied with national guidance HTM 03-01. This meant that there were sufficient air changes to reduce the risk of infection.
- The hospital had its own maintenance team who worked across both hospital sites. They kept records of equipment across all departments, this included current service history, and when the next service was needed.
- Equipment was labelled to show purchase, service and calibration dates where appropriate. We checked a random selection of equipment across the ward and theatres, including blood pressure monitors, hoists, scales and operating and anaesthetic equipment and found they all had current electrical testing and maintenance dates displayed.
- The hospital had a tracking system for details of specific implants and equipment to be recorded and reported to the national joint registry. We saw that all equipment, implants and prosthesis were tracked and traced. All records that we looked at had clear evidence of this with batch numbers recorded.
- Clinical specimens were labelled and stored securely in monitored specimen fridges. Both the theatre and ward specimen fridges had consistent records of daily high and low temperature to provide assurance that they were operating correctly.

Assessing and responding to patient risk.

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.

- Risk assessments were carried out for people who used the hospital and risk management plans were developed in line with national guidance.
- The service had a current corporate admission policy with a strict admission criterion. Patients with complex co-morbidity and bariatric patients were not accepted as the service did not have the facilities for complex care.
- Patients were required to complete apre-admission questionnaire to assess if there were any health risks that may compromise their treatment. Nurses discussed the health questionnaires with patients in the pre-admission clinics. If staff identified a patient as being at risk, they discussed these concerns with the patient's consultant, the resident medical officer (RMO) or anaesthetist as appropriate. If a patient's ECG result indicated abnormalities, the RMO reviewed the results and they arranged a referral to a cardiologist.

- Consultant anaesthetists reviewed pre-admission records on a weekly basis and patients identified as being slightly more complex were risk assessed by an anaesthetist to confirm their suitability for surgery at the hospital. Patients booked for endoscopy or local anaesthetic received a telephone pre-assessment.
- All patients having a general anaesthetic were assessed in a nurse led pre-operative assessment clinic prior to their surgery. Pre-operative assessments took place at BMI The Chiltern hospital. Pre-operative assessment is a clinical risk assessment where the health of a patient is considered to ensure that they are fit to undergo an anaesthetic and therefore the planned surgical operation. It also provides an opportunity to ensure that patients are fully informed about the surgical procedure and the post-operative recovery period and can arrange for post-operative care at home.
- Staff assessed patients for key risks at their pre-assessment and continued to monitor these before and after their surgery. These included risks about mobility, medical history, skin damage and VTE. Patients had to meet certain criteria before they hospital would accept them for surgery, these minimised the risk of harm to the patient due to lack of appropriate facilities.
- Patients were swabbed to assess for any colonisation of MRSA at the pre-assessment clinic as per hospital policy. If results were found to be positive the patient was provided with a treatment protocol to use at home, according to the hospital's MRSA policy. If necessary surgery would be deferred until patient had a negative swab result.
- Staff completed patient risk assessments using nationally recognised tools, such as the Waterlow score to assess patients risk related to pressure ulcers, mobility, moving and handling, venous thromboembolism (VTE) and the national early warning score (NEWS2). VTE compliance was audited quarterly and records showed that this was 100%. Records we reviewed during our inspection confirmed this was the case.
- The NEWS2 is a scoring system applied to a patient's physiological measurements to indicate early signs of deterioration in their condition. We saw that these were documented in the patient's records and included actions to escalate for review. This meant that patients who were deteriorating or at risk of deteriorating were recognised and treated appropriately.
- Staff could describe how they would escalate concerns about a deteriorating patient. The hospital had an RMO on duty 24 hours a day to provide medical attention and attend any emergencies. Staff said that they were always responsive and attended when needed. The consultant medical staff were also available by telephone in the event of any concerns about patient care.
- The RMO was the doctor responsible for the care of the patients in the absence of the consultant. The RMO was trained in advanced life support and held a bleep for immediate response, for example, in the case of cardiac arrest.
- At our last inspection we had concerns that staff were not fully engaged with the WHO 5-steps to safer surgery process and did not recognise the importance of its completion for ensuring patient safety.
- During this inspection we observed the theatre team used the World Health Organisation (WHO) 5 steps to safer surgery, surgical checklist, and the Surgical Safety Checklist for Cataract Surgery which were designed to prevent avoidable mistakes. This included checks such as patient identify, allergies and ensuring the consent form had been signed. We observed staff using the checklist prior to surgery during the inspection. The 5 steps to safer surgery checklist was audited monthly and we reviewed the audits during our inspection and saw that they were 100% compliant.
- We observed and reviewed two WHO 5 steps to safer surgery surgical checklists and saw that it included all steps to assure patient safety during the anaesthetic and surgery period. We also observed patients being transferred from theatre to the recovery area, and saw that the anaesthetist, surgeon and scrub nurse verbally handed over the care and treatment carried out in theatre and discussed medication which had been prescribed for both recovery and the ward.
- The hospital had a sepsis screening tool and sepsis care pathway for staff to use if they suspected a patient had sepsis. The tool was line with current best practice principles from The UK Sepsis Trust. Staff we spoke with

were aware of the screening tool and pathway and told us they would escalate any patients displaying these symptoms to the RMO. Sepsis training was part of the mandatory training Care and Communication of the Deteriorating Patient (CCDP) module. It is acknowledged that this was a relatively new course and the hospital were in the process of training all clinical staff. After the inspection we received hospital-wide training rates which showed 62% of theatre staff and 89% of ward staff had completed the training.

- Staff had immediate access to blood products, to stabilise patients with life threatening haemorrhage. Staff also had access to on-call facilities which included a radiographer, theatre team, engineer, senior practitioner and senior manager if required in an emergency.
- The practising privileges agreement, that all consultant staff worked under, stated that consultants should be available to attend the hospital to respond to any urgent concerns within 30 minutes. The RMO and nurses told us that consultants were easily contactable 'out of hours', such as at night or over a weekend, should staff be concerned with a patient's condition. Individual consultants remained responsible for the overall care of their admitted patients and made arrangements for colleagues to cover in their absence.
- There were arrangements in place with a local NHS trust to provide 24-hour emergency support should patients require high dependency nursing or urgent diagnostics.
- If a patient's condition deteriorated, service level agreements were in place for transfer of the patient to the local NHS trust, in which ground the hospital was located. There were strict guidelines for staff to follow which described processes for stabilising a critically ill patient prior to transfer to another hospital. Nursing staff and the RMO were aware of the correct process to follow to ensure prompt and timely intervention for a patient who required additional medical treatment.
- During the 12 months prior to our inspection there had been one transfer of a patient to another hospital.
- A small proportion of surgery was cosmetic. A senior staff member told us the consultant would manage their patients from admission to discharge allowing for a 'cooling off' period and refer for any psychological assessment prior to surgery. A 'cooling period' is an agreed length of time in which someone can decide on whether to proceed with surgery or not. This is in line with nationally accepted best practice.
- Patients who had concerns following discharge, including day surgery) could call the hospital or the corporate BMI 24-hour telephone advice line or access 'live support' on the BMI website.
- The hospital also had a 48 hour follow up call service and staff on the ward were scheduled to provide this.
- The hospital carried out scenarios with staff for emergency situations such as fire and cardiac arrest. Staff were provided with feedback and any lessons learnt were shared with the department.
- The hospital's resuscitation team's responsibilities were reviewed at the daily comms cell meeting. Each member of the team was allocated a specific role such as leader, airway management, defibrillation, recorder and runner. This was in line with best practice guidance issued by the Resus Council (UK).
- Nursing staff on the ward had to complete acute illness management training, every three years as part of their mandatory training. Hospital-wide data provided by the hospital after the inspection showed, as of January 2019, 89% of ward staff had completed this training against a target of 85%.
- All staff completed adult basic life support, immediate or advanced life support training depending on their role. Hospital-wide data provided by the hospital after the inspection showed, as of January 2019, 75% of theatre based staff and 100% of ward based staff had completed adult basic life support training, and 89% of theatre based staff and 86% of ward based staff had completed adult immediate life support.
- Theatre staff attended a safety huddle each morning, where the operating list was discussed. This was to ensure all patient needs and risks for that day were identified. We observed a huddle during our inspection and noted effective communication with all staff involved.

- Nursing staff on the ward undertook a handover between each shift, which included an update on all patients currently admitted and highlighted any specific concerns, such as infection risks or safeguarding concerns to all staff.
- The hospital had an in date major incident policy and a business continuity plan. These included the loss of mains electricity and generator power, fire alarm activation or system failure, and loss of staffing. We saw business continuity action cards for each major incident which detailed the actions staff should take, and useful contacts and telephone numbers. Action cards were held on reception desks to provide immediate guidance to staff should a major incident arise.

Nursing and support staffing

The service had enough nursing staff, with the right mix of qualification and skills, to keep patients safe and provide the right care and treatment. However, there was high usage of bank and agency staff within the service.

- The hospital manager met with heads of department on a daily and weekly basis to review staffing, to ensure it met the needs and dependency of patients.
- Any shortages in staffing were discussed at the daily 'comms cell,' which was attended by a representative from all hospital departments. The comms cell was a meeting held at 9am every morning to review hospital activity and raise any concerns, staffing brief, emails, governance and team meetings, newsletters and noticeboards. We attended a comms cell during our inspection and noted effective communication with staff from all departments involved.
- At the last inspection we had concerns regarding staffing levels and competencies in theatres. Staff used in the role of surgical first assistant (SFA) had not been assessed as competent We saw the role of SFA had not been identified correctly on the theatre rota. During this inspection we found that this situation had improved. We saw evidence of staff competencies for the SFA role. We saw theatre rota's clearly showing the role of SFA identified and staffed accordingly.
- The theatre department staffing comprised of 6.3 WTE and part time staff made up of nursing staff, operating department practitioners (ODPs) and HCAs.
- Senior staff at the hospital told us that there were ongoing difficulties with recruitment and this was recorded on the risk register. Theatre staffing was planned using the theatre TM1 Tool. This tool is designed to automate analysis of a number of key theatre department process measures. The TM1 increases the efficiency of the department by refining staff allocation to patient numbers and procedure mix and therefore reducing staffing costs, creating capacity for additional caseload, improving patient safety and ultimately increasing satisfaction for patients, consultants and staff. The theatre department also used the BMI Resource Model in theatres which incorporated the Association for Perioperative Practice (AfPP) guidelines for safer staffing. The AfPP is a professional body for healthcare workers setting standards and guidance on best practice in operating departments
- The theatre manager provided the theatre rotas two-three weeks in advance. We reviewed staff rotas from September to October 2018 and saw that all shifts were filled. The theatre department used regular bank staff and agency staff although the numbers were low.
- Nursing staff levels and skill mix were planned according to patient admissions which were known in advance. Staffing levels were calculated using the electronic BMI Healthcare Nursing Dependency and Skill Mix Planning Tool. This is an evidence based electronic patient acuity and dependency monitoring tool and ensured safe staffing numbers were planned according to the number of patients. The tool could be manually adjusted to take account of individual patient needs. The tool was populated five days in advance and reviewed daily.
- A minimum of two registered nurses were always on duty on the ward, one of whom was always a substantive member of staff, plus an HCA. Nurse staffing was determined by the numbers of patients booked for admission and with the use of the nurse planning tool. There was low usage of agency staff on the ward.
- Evening day case patients sometimes returned late from theatre, after 9pm and some then needed to stay overnight which meant a transfer to the NHS inpatient ward located on the same site. Transfers of this nature were carried out using and agreed pathway between the provider and the NHS trust.

Good

Surgery

Medical staffing

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

- There was a corporate Practising Privileges Policy for Consultant Medical and Dental Practitioners. The policy covered dentists however there were no dentists employed at this hospital. We noted that this was a corporate policy and overdue for renewal in October 2018. Following our inspection the provider submitted a renewed policy dated 10 January 2019 with a renewal date of January 2022.
- The hospital practising privilege agreement set out the requirements for each consultant concerning their indemnity, appraisal, General Medical Council registration, Disclosure and a Barring Service (DBS) check and yearly mandatory and appraisal proof of compliance. DBS assists employers make safer recruitment decisions and prevents unsuitable or unqualified people from working with vulnerable groups, including children.
- Medical care was consultant led under practising privileges. A practising privilege is, "Permission to act as a medical practitioner in that hospital" (Health and Social Care Act, 2008). The hospital had granted 241 consultants/health professionals practising privileges, including but not limited to; specialist surgeons such as orthopaedic, ear nose and throat and urology, and anaesthetists.
- Consultants led and delivered the surgical service at the hospital. Surgeons and anaesthetists were required to be able to attend within 30 minutes' drive of the hospital, in case they needed to urgently visit a patient. All consultants carried out procedures that they would normally carry out within their scope of practice within their substantive post in the NHS.
- The hospital maintained a medical advisory committee (MAC) whose responsibilities included ensuring any new consultant was only granted practising privileges if deemed competent and safe to practice. BMI Healthcare's practising privileges policy required consultants to remain available both by telephone and, if required, in person, or to arrange appropriate alternative named cover if they were unavailable. This was to ensure a consultant was available to provide advice or review patients at all times when there were inpatients in the hospital. Staff we spoke with confirmed this happened.
- The practising privilege agreement also required that the consultant visit inpatients admitted under their care at least daily or more frequently according to clinical need, or at request of the executive director, director of clinical services or resident medical officer (RMO).
- Nursing and theatre staff told us they could contact any consultant, out of hours or when not on-site, if they needed advice about the best care and treatment for a patient. They told us they had a good working relationship with the medical staff, who normally attended the hospital promptly when called in.
- Patients we spoke with told us the consultant and anaesthetist had seen them prior to and after surgery.
- Day to day medical cover was supplied by the RMO who provided a 24 hours a day, seven days a week service, on a rotational basis. RMOs were employed through a formal contract with an agency. They worked a one week on one week off rota. This ensured that their duty weeks were balanced with consolidated periods of rest.
- The RMO provided support to the clinical team in the event of an emergency or with patients requiring additional medical support. The external agency that supplied the RMOs had a standby programme which could supply additional cover if the RMO had been woken during the night and not received enough sleep to continue working during the day or for absence cover.
- The RMO attended the twice daily ward handovers and performed a handover once weekly to their colleague coming on duty.

Records

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

- Patient individual care records were written and managed to ensure that they were accurate, complete, legible, up to date and stored securely. The computers were password protected and we observed that these were locked when not in use. This was in line with the Data Protection Act 1998.

- Patient care records were retained and stored securely within medical records department or an offsite electronic archiving database. As consultants handle sensitive personal data they were required to register with the Information Commissioners Office (ICO) as independent data controllers. They were required to work to the standard set by the Information Commissioner, this included how patients care records were stored and transported.
- Medical records storage had improved since our last inspection with the addition of tracking of notes for traceability. The hospital had set up a tracking system for notes leaving and returning to the secure note storage area.
- The hospital dedicated medical records department had responsibility for filing, storing and maintaining an adequate medical record for patients treated. Staff within this department ensured that medical records were readily accessible for each episode of patient care. Appropriate staff had electronic access to the archived records. Staff within the medical records team provided support, or electronic access at the request of a clinician as required. Evidence provided by the service showed that no patient during the 12 months prior to our inspection had been seen without their records being available.
- All patient care records were in paper format and kept on the ward for three to five days post discharge. This was in case a patient contacted the ward with a question or concern regarding their surgery after returning home.
- Patient care records were stored in a cupboard behind the nurses' station on the ward. The cupboard was locked and there was always staff at the station which meant that records were not accessible to the public. Records not in use were stored on site for a period of one year following discharge in the keycode locked records room.
- All information needed to deliver safe care and treatment was available and easily accessible to the relevant staff for example test and imaging results, care and risk assessments, care plans and case notes.
- We reviewed eight sets of medical records. We found documentation from all staff was completed thoroughly, with risk assessments, treatment plans, consent forms and completed medication charts, which had all been reviewed by a pharmacist.
- All patients received appropriate pre-operative assessments prior to admission for surgery. The service used criteria, based on type of surgery, to determine which patients received initial telephone assessments. The pre-operative assessment paperwork was fully completed and formed part of the paper record.
- Discharge letters were sent electronically to the patients' GPs immediately after discharge, with details of the treatment, including follow up care and medications provided.
- Where appropriate patient care records contained stickers identifying equipment and implants used during surgery. This meant that they could clearly be tracked and traced.
- Staff used specific care pathway paperwork for each patient which ensured they kept records appropriate. For example, patients admitted for hip surgery had their clinical entries recorded in the 'Primary hip replacement care pathway' documentation.
- The care records contained pre-operative assessments, records from the surgical procedure and anaesthetic, recovery observations, nursing and medical staff notes and discharge checklists and assessments. The records also included multidisciplinary clinical notes, including those from physiotherapists.
- Theatre staff maintained a log of implants on their prosthetics register to enable traceability if an incident occurred. Theatre personnel retained a sticker from each implant in the register as well as in the patient notes.

Medicines

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

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

- The pharmacy team completed regular audits including missed dose, controlled drugs and medicines reconciliation. The team shared audit results at the medicines management meetings held every two months, with managers cascading the information at team meetings, confirmed in the minutes we looked at.
- Medicines were appropriately prescribed, administered and supplied to people in line with the relevant legislation, current national guidance and best practise evidence.
- All medication on the ward and in the theatre department was stored securely in locked trolleys, cupboards and fridges with stock medications stored in locked cupboards in the keycode locked clinical room.
- There was a small stock of 'to take out' (TTO) medicines available in the ward. These consisted of antibiotics and pain relief and could be dispensed by the nursing staff following prescription by the RMO or consultant.
- We reviewed a random selection of medications stored on the wards and the theatre department and found all to be neatly stored and within expiry date.
- We checked the controlled drugs (CDs) on the ward and in the theatre department and found that these were correctly stored and matched the register. Two registered nurses checked CDs daily and staff had consistently done this throughout the six-month period reviewed prior to inspection.
- The locked medicine fridges and separate blood fridge in the theatre department were temperature monitored daily to confirm that the fridge temperature was suitable for the storage of medications. We reviewed checklists which showed all anomalies were recorded and the action taken to resolve noted. The ambient temperature of clinical rooms was also monitored and recorded.
- Patients told us nursing and medical staff had given clear instructions and advice about any medications they needed to use at home, prior to discharge from the ward. Patients made staff aware of any allergies at their pre-assessment. The information was recorded on the front page of the care pathway so the information was immediately visible to reduce the risk of harm to patients and patients wore a red wristband to make staff aware they had an allergy.
- Staff had to access medication guidance, for example the hospital's medicines policy and current British National Formularies.
- The resuscitation trolleys contained emergency medicines including those for the treatment of anaphylactic shock. Anaphylaxis is an adverse allergic reaction which can be life threatening and requires immediate treatment.
- There was piped oxygen in all 24 patient rooms and these were set up ready for post-operative patients. Staff told us that oxygen therapy was prescribed as needed and this was confirmed in patient records we reviewed.
- Medical gas cylinders were stored safely and in an upright position in line with best practice.

Incidents

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

- Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support.
- The hospital had a system for recording and reporting incidents. All staff we spoke with understood their responsibilities to raise concerns, record safety incidents, concerns and near misses, and to report them internally and felt confident to do so.
- Staff told us they were encouraged to report incidents and received feedback when they had been involved in an incident. Staff also reported that they received feedback about incidents that had occurred within the hospital and other hospitals within the BMI organisation through the monthly corporate clinical governance and risk bulletin. Information was also cascaded through the daily comms cell meeting, team meetings and at handovers.
- The hospital measured their own safety performance against hospitals of a similar size within the BMI organisation.
- Minutes from the medical advisory committee (MAC) meetings showed the hospital presented a summary of the most recent incidents but this did not include the actions taken, to show how the hospital had shared

learning with medical staff. There was no evidence of sharing of learning from incidents at other BMI hospitals at departmental level, although senior staff discussed these at their meetings, such as the clinical governance group.

- From July 2017 to June 2018, staff had reported 91 hospital-wide clinical incidents, the majority (97.8%) were graded as no or low harm with two incidents graded as moderate harm but none as severe. No deaths had been reported.
- There had been no never events reported during the same period. A never event is a serious incident which is wholly preventable, where guidance or safety recommendations that provide strong systemic protective barriers are available at a national level, and should have been implemented by all healthcare providers.
- There were no regular mortality and morbidity meetings to discuss unexpected deaths or adverse incidents affecting patients. The hospital told us such cases would be included in the clinical governance and medical advisory meetings as required. We reviewed minutes of these minutes which confirmed this to be the case.
- The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support and apology to that person. Staff we spoke with understood their responsibility to be open and honest with the family when something had gone wrong. Senior staff were aware of their role to investigate a notifiable safety incident, keep the family informed and offer support.

Safety Thermometer

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

Are surgery services effective?

Good

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

Evidence-based care and treatment

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

- Staff followed The Royal College of Surgeons' Standards for consultant led surgical care and the recommendations from the Association of Anaesthetists of Great Britain and Ireland (AAGBI).
- Staff assessed patients pre-operatively with investigations and blood tests based on NICE guidelines to ensure they were fit for surgery.
- The National Institute of Health and Care Excellence (NICE) guidelines were reviewed at BMI corporate level, cascaded to the individual hospitals and shared with staff. Policies based on best practice and clinical guidelines were developed nationally and cascaded to the hospitals for implementation. These were reviewed by the clinical governance board and recorded on a local register. Staff were required to sign to say they had read the policies.
- All BMI corporate policies were available on the hospital's electronic system. Staff demonstrated to us how they could locate them easily when required.
- Staff running the pre-operative assessment clinic followed the National Institute for Health and Care Excellence (NICE) guidance CG3 'Preoperative tests for elective surgery', to ensure patients had relevant tests performed prior to surgery, to minimise the risk of complications or harm.
- The hospital offered an advanced recovery programme which meant that patients were mobilised out of bed on the day of their operation to help prevent post-operative complications and to encourage early rehabilitation.

- The hospital had a clinical audit programme, which was set corporately by the BMI Healthcare group. This meant that the hospital could benchmark the results from the audits with other hospitals of a similar size within the BMI Healthcare group. Audits included consent, resuscitation, hand hygiene, health and safety, the WHO safer surgery checklist, and medicines management.
- The hospital participated in national audit programmes for example: Patient Reported Outcome Measures (PROMS), National Joint Registry (NJR) and the surgical site infection surveillance programme conducted by Public Health England. BMI Healthcare participated in the Private Healthcare Information Network (PHIN). This enabled comparison with data available from NHS providers to assist with information transparency and patient choice.
- The hospital used a number of different care pathways depending on the type of surgery a patient was having, to ensure staff followed a set care pathway that met the needs of each patient.

Nutrition and hydration

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

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

Pain relief

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

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

Patient outcomes

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

- The hospital compared results on hip and knee audit and patient outcomes with other locations within the region and across BMI Healthcare group through the corporate quality dashboard. The dashboard compared a number of metrics including but not limited to; return to theatres, unplanned readmissions, transfers out, and infection rates reporting data from similar sized hospitals and the other local BMI locations.
- Monthly PROMs data was also reported on in the quality account, these enabled patient outcomes at the Chiltern Hospital to be compared to the BMI healthcare average and national average.
- As part of the BMI Healthcare organisation the hospital contributed to the Private Healthcare Information Network (PHIN). Data was submitted in accordance with legal requirements which were regulated by the Competition and Markets Authority (CMA).
- From July 2017 to June 2018, there was one unplanned transfer to another hospital, two unplanned readmissions within 28 days of surgery and no unplanned returns to theatre. Information from the hospital showed all staff had taken appropriate action at the time of the incident. Escalation procedures had been effective in managing the risks to patients.

Competent staff

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

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

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

Multidisciplinary working

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

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

Seven-day services

- Routine surgery occurred Monday to Friday, 8.30-5.30pm with some late finishes until 9pm. There was occasional extra or urgent work at weekends. Theatre staff were on-call should there be any unplanned returns to theatre. Nursing cover was available on the ward when the hospital was open during the day. The hospital did not have overnight patients on their wards.
- The RMO was on-call at all times and was based at the hospital, should staff need to escalate concerns about a patient. The RMO told us they were woken at night infrequently and therefore were normally able to rest between midnight and 7am.
- The radiology department provided an on-call service outside of normal working hours and at weekends. Staff could contact the radiologists out of hours to authorise requests and review results but there were no documented on-call arrangements.
- Physiotherapy staff supported effective recovery and rehabilitation by providing sessions to inpatients daily, including at weekends.
- Staff could speak with the trust on-call pharmacist for advice out of hours as needed.

Health promotion

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

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. They followed the service policy and procedures when a patient could not give consent.
- Consent forms were completed correctly within patient records we looked at and appropriately identified the procedure planned and detailed the risks and benefits. The hospital consent forms complied with Department of Health guidance.
- All patients told us they had been able to make an informed decision about surgery, before signing the consent form. The consultant discussed the risks and benefits of surgery with them and these were included on the consent form. The four consent forms we checked confirmed this.
- We observed staff asking patients' verbal consent before performing therapeutic treatment and post-operative observations.
- Patient names were displayed, initial and last name, on the door of their room and on the whiteboard at the nurse's station, which was visible to patients and visitors. Staff told us they gained verbal consent to display this confidential information; there was also a section in the patient pathway to obtain their consent.
- Nursing staff documented on the front of the patient care pathway if there was a do not attempt resuscitation order in place or an advanced decision to refuse treatment and that they had seen the relevant document. This ensured staff respected the patients' wishes should they collapse and need emergency treatment.
- Training on mental capacity and deprivation of liberty safeguards (DoLs) was included in the mandatory safeguarding adults training. Compliance rates for adults safeguarding training was; level one 88.24%, level two 92.31% and level three 100%.
- Staff we spoke with could describe how DoLS might be required and that would contact the director of clinical services and involve the consultant and relatives as appropriate. They also said this was not something that they were likely experience due to the limitations of the admission criteria.

Are surgery services caring?

Good

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

Compassionate care

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

- Throughout our inspection, we saw staff treating patients with compassion, dignity and respect. They told us they felt they were kept well informed about their care and were involved in making decisions about their treatment at each stage.
- Patients told us staff were kind and attentive. We saw staff took the time to interact with people who used the service and those close to them in a respectful and considerate way.
- Staff understood and respected the personal, cultural, social and religious needs of people and how these may be related to care needs. For example, they checked how patients preferred to be addressed and recorded this in the care pathway.
- We observed that patients were spoken to in a polite and courteous manner and staff sought permission before providing treatment.
- The Patient Led Assessment of the Clinical Environment (PLACE) privacy and dignity score was 91.7% which was higher that the BMI Healthcare average of 86%.

Good

Surgery

- We saw notices on display on the wards advising patients to let staff know if they wished for a chaperone.
- The hospital monitored patient feedback from their Patient Satisfaction Survey and the NHS Friends and Family Test (FFT). Between February and July 2018, the FFT inpatient scores were consistently above the England average with an average of 97%.
- Staff at the hospital encouraged patients to complete patient satisfaction questionnaires to review and improve patient experience. The results of the questionnaire were collated by an external company and a monthly report provided to the hospital for view and analysis and cascade to the hospital team. The monthly report showed patient response rates, rating within categories and ranking against all BMI hospitals. At the time of inspection, the hospital was rated 9 out of 55 BMI hospitals nationally.

Emotional support

Staff provided emotional support to patients to minimise their distress.

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

Understanding and involvement of patients and those close to them

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

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

Are surgery services responsive?

Good

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

Service delivery to meet the needs of local people

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

Good

Surgery

- The service was registered with various insurance companies, providing access to treatment for patients who had private healthcare insurance. Additionally, patients could opt to pay for treatment themselves. BMI Healthcare had introduced a BMI card, allowing patients to spread the cost of their treatment over 12 months.
- In addition, the hospital worked with local commissioning groups to support NHS patients treated with a number of procedures including but not limited to cataract eye surgery, joint replacement, hernia repair and endoscopy.
- The hospital participated in the NHS e-Referral Service, allowing local people to receive timely access to treatment. Through this service, NHS patients who require an outpatient appointment or surgical procedure could choose both the hospital they attend and the time and date of their treatment.
- Between August 2017 and July 2018 80% of patients who stayed overnight were non- NHS funded and 20% NHS funded.
- The service admission criteria ensured GPs only referred patients whom the hospital had facilities to care for. For patients needing critical care, the hospital had a contract with the trust to use their facilities, with them transferring patients back to the hospital once well enough.
- There were no facilities for emergency admissions; commissioners and the local NHS trust were aware of this.
- The hospital held weekly bed management meetings where they reviewed admissions for surgery for the following two weeks. The senior clinical and administration teams attended, ensuring a collaborative team approach. This enabled staff to ensure they were prepared and equipped for the patient pathway, discussing staffing, equipment, skill mix, and concerns.
- Theatre lists for elective surgery were planned with the theatre manager and bookings team. This ensured all aspects of patients' requirements were checked and considered before booking a patient on to the list and ensured that operating lists were utilised effectively.
- Patients and relatives attending the hospital had access to limited free car parking within the hospital grounds.

Meeting people's individual needs

The service took account of patients' individual needs.

- Admissions were pre-planned so staff could assess patient needs prior to treatment. This allowed staff to arrange how to meet patients' specific needs, including their cultural, language, mental or physical needs.
- There was a variety of hoists and pressure relieving equipment for the safe management of patients.
- The Shelburne Hospital did not have a pre-assessment department, all patients were referred to BMI The Chiltern Hospital for a pre-assessment appointment. Pre-assessment nurses at The Chiltern Hospital gave patients information leaflets about their planned procedure or treatment during their pre-assessment appointment, or the hospital sent the leaflets to patients with their outpatient appointment letter. The patient information leaflets were written in English but could be provided in other languages or formats.
- The catering arrangements were outsourced to an external provider and there was a variety of meals provided for patients which they said met their needs. Facilities were available for special diets including cultural dietary needs as required. Patients expressed a high degree of satisfaction with the food and drinks and said they were offered choices. The staff provided support with meals as needed and hot and cold drinks and snacks were readily available.
- The hospital used care pathways for surgical patients. These pathways promoted effective patient care based on evidence based practice and ensured that individual patient's needs were recognised. They also provided flexibility to enable patients the option to stay an additional night according to need. This was evidenced in the way they reviewed the needs of older self-funding patients who may not feel safe to return home after two nights and, dependent on individual assessment, offered a third night at no additional charge to the patient.

Access and flow

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

Good

Surgery

- The hospital offered a flexible service that included variable appointment times and choices regarding when patients would like their surgery, subject to consultant availability.
- The hospital admitted both private and NHS patients on a planned basis for elective surgery, and staff provided care in a timely manner.
- The hospital followed corporate and local policies and procedures for the management of the patient's journey, from the time of booking the appointment until discharge and after care. Staff we spoke with were aware of these policies and procedures.
- The hospital had established a clear booking process for appointments and hospital admissions. Patients we spoke with told us the hospital had a good and efficient booking process.
- Patients were added by the booking team to the hospital's patient information management system (PIMs). This meant that patient details and appointments could be tracked by staff working throughout the hospital.
- The hospital had a written inclusion and exclusion criteria for patients. This meant the hospital only admitted patients they had the facilities and expertise to care for.
- Once the patients had been admitted into the hospital for surgery, there was no monitoring about how long they waited for their surgery. Therefore, the service could not identify if there were problems relating to theatre delays and the reasons for them.
- Patients had access to assessment, diagnosis and treatment; the hospital had no waiting lists for surgery for private patients. A cooling off period between booking and surgery allowed patients to cancel or postpone their surgery, if they changed their mind.
- All patients having a general anaesthetic were assessed in a pre-assessment clinic at The Chiltern Hospital prior to their surgery. The hospital used telephone pre-admission clinics for ambulatory local anaesthetic procedures. This ensured that they met strict admission/exclusion criteria as the hospital did not admit patients with complex co-morbidity or bariatric patients.
- Patients' discharge planning began at the pre-admission assessment stage with involvement of allied health professionals as needed including but not limited to pharmacy and physiotherapy
- The operating department followed a planned programme of activity from Monday to Friday, with Saturday operating sessions available on request from clinicians. The hospital assigned consultants theatre time on a sessional basis unless there was a clinical necessity to provide an unplanned session, such as a return to theatre.
- Staff communicated planned changes to the surgical lists via the administration team. The hospital required consultants to give five days' notice of any changes to the list so the hospital could ensure enough staff were working. Senior managers discussed, with consultants who regularly did not comply with this standard.
- There were morning, afternoon and evening operating sessions. The evening session ran from 6pm to 8pm and included both inpatients and day cases. Theatre and ward staff told us the evening surgery session sometimes overran, with patients returning to the ward after 9pm. If a day-case patient required or requested an overnight stay, this could be arranged with the NHS ward. When this occurred, staff told us they recorded this as an incident.
- From January 2018 to December 2018, the hospital cancelled three procedures for non-clinical reasons. When procedures were cancelled or were delayed, this was recorded as a clinical incident and appropriate actions taken. Cancellations were explained to people, and they were offered alternative date within 28 days.
- The hospital provided an on-call theatre team however, in the event of a patient deteriorating and requiring further intervention there was a service level agreement (SLA) in place with the local NHS trust and ambulance service to transfer patients for more complex care and treatment.
- Consultants, or if unavailable the resident medical officer (RMO), authorised the discharge of patients from the hospital. This meant patients could be discharged out of hours if they wished.

Learning from complaints and concerns

Good

Surgery

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

- There was a corporate BMI complaint policy (August 2018). The complaints policy followed a three-stage process in dealing with complaints, with clear timeframes.
- From August 2017 to July 2018, the hospital received 11 complaints. Complaint content varied from costings to staffing.
- The responsibility for all complaints rested with the executive director (ED) in liaison with their executive assistant (EA). On receipt of a new complaint the ED involved the head of the relevant department in the investigation of a complaint. Corporate protocols required that complaints were acknowledged in writing within two working days.
- The EA monitored the response process to ensure that timescales were being adhered to. If a response was not able to be provided within 20 working days a holding letter was sent to the complainant to keep them fully informed of the progress of their complaint.
- All complaints and their accompanying documents were loaded on to the hospitals incident/risk reporting system. Dependent on the nature of the concern, complainants were invited into the hospital for a meeting with the ED and associated manager to discuss the investigation findings. Following the meeting a response was prepared and sent to the complainant.
- If the hospital received a complaint, the executive director aimed to speak directly with the patient to address the concerns promptly. At the same time the executive director spoke with patients and asked them how satisfied they were with the nurses, doctors, food and environment. Using this approach, the hospital endeavoured to correct any issues the patients had before they developed into complaints.
- Patient rooms had Patient Information Guides which included a section outlining the formal complaints procedure. However, patients we spoke with told us they did not know how to make a complaint but would be happy to raise concerns if they had any. We saw comment boxes on the ward for patients to leave feedback cards but did not see specific leaflets on how a patient could make a complaint. The senior staff told us leaflets were available.
- NHS patients who were unhappy with the complaint response had the option of Parliamentary and Health Service Ombudsman, private patients were signposted to the Independent Sector Complaints Adjudication Service (ISCAS). During the reporting period August 2017 to July 2018 two complaints were referred to ICAS.
- Complaints were reviewed at the hospital governance meeting, heads of department (HODS) meeting, medical advisory committee (MAC) and department meetings. They were also discussed at the daily comms cell meeting to ensure that any learning identified was shared.

Are surgery services well-led?

Good

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

Leadership

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

- An executive director (ED) had overall accountability for this hospital and one other location, which was part of the same area group. The ED had overall responsibility for the clinical and operational management of both hospitals, escalating concerns as needed.
- The ED was supported by senior management team members, which included an executive assistant (EA), quality and risk manager, patient liaison officer, director of clinical services (DCS), director of operations (DO) and the medical advisory committee (MAC) chair.
- The senior management team were supported by heads of department (HoDs) or managers for theatres, outpatients, pharmacy, diagnostic imaging, physiotherapy, oncology and the wards.
- The clinical HoDs reported directly to the DCS, and non-clinical HoDs to the DO.

- The leaders had the skills, knowledge, experience and integrity they needed for their roles.
- The local department managers that we spoke with had a good understanding of the challenges to quality and sustainability, and could identify the actions needed to address them.
- Staff we spoke with felt the organisation supported them to deliver the patients' care. They told us that the director of clinical services promoted a positive culture and valued staff.
- Consultant medical staff told us they had a good working relationship with the staff and senior management to deliver care and meet patients' needs.

Vision and strategy

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

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

Culture

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

- The service had a caring culture. Staff told us that they enjoyed working on the wards and in the theatre department and felt well supported by their departmental managers.
- Department managers told us that they had an open-door policy and that they were proud of their staff and their departments.
- Staff told us that they felt departmental managers were approachable. The theatre manager and the ward manager worked clinically and would provide clinical cover for sickness as appropriate.
- The executive director and clinical service director were well respected, visible and supportive.
- Staff told us they enjoyed coming to work. They commented on the strong team work and how the positive feedback from patients had helped during all the management changes.
- Staff were flexible in the hours they worked to meet the needs of the service and patients. They felt valued and well supported by the senior staff at the hospital.
- The hospital was working towards a more open culture and there was a focus on the needs and experiences of patients and staff. BMI had a corporate Freedom to Speak Up Guardian and each hospital had local champions.
- Most staff told us they felt comfortable raising concerns and felt the hospital had a "learning culture, not blame culture". Processes and procedures were in place to meet the duty of candour. Where incidents had caused harm, the duty of candour was applied in accordance with the regulation.
- However, some staff told us they found it difficult to whistleblow due to the small number of staff at the hospital. They felt there was a risk of identification if they raised a concern, even though they could raise this anonymously via an online form or to a central BMI Healthcare email address. Not all staff had confidence in the process and told us they had chosen not to raise concerns.

- All staff we met were welcoming, friendly and helpful. It was evident that staff cared about the services they provided and told us they were proud to work at the hospital. Staff were committed to providing the best possible care for their patients.
- Once a week the hospital held 'Free cake Friday' to encourage staff to meet and acknowledge the work staff had completed that week.

Governance

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

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

Managing risks, issues and performance

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

- The hospital had a corporate risk register across both hospital sites which contained 58 risks and was regularly reviewed and updated to ensure that risks were monitored and appropriately managed.
- There were arrangements for identifying, recording and managing risks. Heads of departments had ownership, and managed departmental risk registers which fed into the hospital's risk register. The ward and theatre documented risks reflected what staff had told us. Risk performance was discussed through the committee meeting structure and there was good engagement from department leaders. It was hospital policy to display risk register in each department. This was an improvement since our last inspection.
- There was a systematic corporate programme of clinical and internal audit to monitor quality, operational and financial processes, and systems to identify where action should be taken.
- The daily comms cell meetings were held at 9am, Monday to Friday, and were attended by representatives for each department across both hospital sites, including managers and staff. The meeting covered a range of subjects including risk review, recent incidents,

health and safety update, training compliance review, and any concerns that affected the hospital. This enabled staff to gain a wider view of risk, issues and general performance within the hospital.

- The hospital manager had built relationships with the different services that the hospital has service level agreements (SLAs) with, particularly the local NHS Trust who provided the critical care, pharmacy, pathology and some diagnostic imaging services. The manager had reviewed the terms of the SLAs and monitored performance of these services to ensure they met the agreed standards.

Managing information

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

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

Engagement

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

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

Learning, continuous improvement and innovation

Good

Surgery

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

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

Requires improvement

Outpatients

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

Information about the service

Outpatient services at The BMI Shelburne Hospital included a wide range of specialties including: orthopaedics; gynaecology; neurology; podiatry; urology; oncology and rheumatology.

The outpatient department has five consulting rooms and a treatment room used predominantly for wound dressings. All clinics are consultant-led with support from a registered nurse or a health care assistant. Between August 2017 and July 2018, the outpatient department had 4084 adult appointments. Of these appointments 1191 were first attendances and 2093 were follow-up appointments. The majority of patients 81% were privately funded patients and 19% were NHS patients.

The patients were seen in outpatient clinics Monday to Friday between the hours of 08.00-20.00 although on occasions these times were extended to meet patient's needs. The BMI Shelburne did not see children in their outpatient department.

During our inspection, we visited the outpatient department. We spoke with six patients and one relative. We spoke with the consultant and nursing staff who were working at The BMI Shelburne that afternoon: and the outpatient clinical services manager. We observed staff providing care to patients and reviewed five patient records.

Are outpatients services safe?

Requires improvement

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

Mandatory training

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

- At our last inspection report (January 2017) we said that the provider should ensure all staff were up-to-date with all their mandatory training. At this inspection they had made improvements and ensured staff were up to date with their mandatory training. Mandatory training for all staff groups was made up of modules accessed through an on-line learning system and face to face sessions. Staff told us it was easy to access but the face to face sessions were harder as they had to be available and there had to have enough staffing in the department on the day to attend.
- Nursing staff presented during our inspection logged onto their online learning and we saw those individuals were 100% compliant, this was indicated by colour per module and the future date it was due. If members of staff could not fit training into their normal working day, they were encouraged by their managers to do their training at home and the service would pay them overtime.
- Consultants completed their mandatory training online, failure to complete training resulted in practising privileges being suspended. Practising

privileges give medical staff the right to work in an independent hospital following approval from the Medical Advisory Committee (MAC). The system sent an email when their training was due. Consultants found it difficult to attend the face to face components of mandatory training due to their clinic schedules and therefore the online training was completed before the face to face.

- The resident medical officer was trained in Advanced Life Support (ALS) and would support the outpatient staff if a cardiac arrest situation arose. All Resident Medical Officers were trained in adult and paediatric life support at basic and intermediate levels.

Safeguarding

Staff understood how to protect patients from abuse and their service but rarely had to work with other agencies. However, not all staff had completed the required level of safeguarding training.

- Staff in outpatients understood their role in identifying and protecting patients from risk of abuse and when abuse had occurred. Staff had training on how to recognise and report abuse and they knew how to make referrals appropriately in line with intercollegiate guidance.
- The BMI Shelburne Hospital's set a standard of 100% compliance rate for mandatory training and new staff 90% compliance within the first three months. All administrative staff were expected to complete level 1 safeguarding adults and level 1 safeguarding children, 88.24% had done so. The compliance for clinical staff across The BMI Shelburne was 92.31% for level 2 safeguarding adults, and 84.62% for level 2 children's safeguarding. The managers and the consultants at The Shelburne had all completed the required Level 3 safeguarding adults and level 3 safeguarding children training. In our last inspection report (January 2017) we said that the provider should ensure all staff complete safeguarding children appropriate to their role and the outpatient staff as a subset of the above figures, were 100% compliant with safeguarding children.
- The director of clinical services was the location lead for Adult and Child Safeguarding. All consultants had level three adult and paediatric safeguarding which was in line with the recommendations from the intercollegiate document.
- Staff were trained in the recognition of female genital mutilation and told us they were confident to escalate a situation if they needed. Staff were also provided with Prevent training and 100% of staff at The BMI Shelburne had completed it. Prevent works to stop individuals from getting involved or supporting terrorism or extremist activity. Radicalisation is a psychological process where vulnerable and/or susceptible individuals are groomed to engage into criminal, terrorist activity.

Cleanliness, infection control and hygiene

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

- The patient areas in outpatients we visited, including waiting areas, treatment rooms and toilets were visibly clean and hygienic. Infection control audits were regularly completed every month and the joint outpatients had shown 100% for standard precautions hand hygiene and patient equipment (November 2018).
- Cleaning schedules were audited. Staff told us that any urgent cleaning was completed quickly.
- Staff did not know if patients had infections before they came to clinic with the exception of the dressings clinic in which case they followed the advice of the infection control lead nurse. If it was apparent that a patient had an infection they would be isolated in a clinic room.
- Cleaning and decontamination of surgical instruments was subcontracted to an offsite provider.
- The staff cleaning rota in the outpatient departments had recently been changed to allocate staff to specific rooms to ensure cleaning was done. We saw the completed check lists on the wall which demonstrated the staff were cleaning their delegated areas daily.
- Hand hygiene and infection control audits were undertaken monthly. The audits for infection

prevention and control in November 2018, most recent result, were 100% for patient equipment, hand hygiene and standard precautions. Standard precautions are the minimum infection prevention practices that are stipulated by the World Health Organisation (WHO 2017).

Environment and equipment

The environment needed to be improved to make it more suited to current patient and staff needs, there were plans to make some improvements. Staff had the equipment they needed and looked after it well.

- There was limited space for staff to use the computer, write notes, make phone calls and talk with patients without being interrupted. Staff worked from the central reception area so that they could observe the patients waiting for appointments.
- The environment of the waiting area needed reconfiguring. Staff in the reception area were not able to observe patients easily. There were plans to change the layout of the waiting area and put the desk against the back wall so the whole area could easily be seen. There was also a plan to reconfigure the central waiting area including a new call bell system in 2019.
- Toilets were clearly signposted and their adapted toilets for people with disability.
- Staff undertook a monthly health and safety audit and sent the audits to the health and safety officer. The sinks in the department were being replaced to meet the Department of Health Technical Memorandum (HTM 64), that specified the requirement of a horizontal waste outlet with no plug to prevent contamination from splashing.
- The staff explained they used 'I am clean labels' on the inside of the door so that it indicated the room and all the equipment had been cleaned but they did not use the labels on every piece of clean equipment.
- The BMI Shelburne Hospital only treated adults but the patient waiting area had a few children's' toys for children of adults attending the department. The waiting area was visibly clean and tidy and there was a water dispenser and magazines available.
- The chairs in the department were wipe-clean and in a good state of repair. There was a range of seating including chairs for bariatric patients.
- The equipment was bar coded, servicing and calibration was managed centrally. Service contracts for equipment were in place, all equipment was tested six monthly and staff reported Portable Appliance Tests (PAT) were done at the same time.
- The resuscitation trolley was dust-free and visibly clean. We saw the completed daily and weekly checklists for the last month.

Assessing and responding to patient risk

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

- At our last inspection (January 2017) we asked that the provider ensured a robust risk assessment for carrying out lumbar punctures in the treatment room was undertaken. This improvement had not been fully completed at the time of our inspection.
- We noted that a copy of the 'Lumbar Puncture Risk Assessment' and the competency 'Work Instruction for Lumbar Puncture in Outpatients' had been approved in January 2019. Staff told us they were in the process of being signed off as competent by their mentor. It was reported there were rarely lumbar punctures performed in outpatients.
- Staff had been trained and knew how and when to use the National Early Warning Score (NEWS) to identify and respond to deteriorating patients. We asked if there had been a patient at The BMI Shelburne who had deteriorated and had been transferred from the outpatient department to the acute NHS trust but the staff member could not remember this situation ever happening.
- Due to the current layout of the outpatient department, patients were left unattended or overseen by a member of inpatient or reception staff when there was only one member of staff on duty. Therefore, it would not always be possible for staff to respond in a timely manner in an emergency. We were told this was the reason for the central reception console being moved to the back wall with a call bell in the main waiting area.

- Staff were not aware of any formal arrangements with the local mental health services as the criteria for patients accessing the services meant that staff did not see people with complex or severe illness.

Nurse staffing

The service did not always have enough nursing staff in outpatients to meet the needs of the department. Staff were experienced and had the right qualifications and skills and kept patients safe and provided the right care and treatment by working flexibly with other colleagues at The BMI Shelburne.

- On our last inspection report (January 2017) The BMI Shelburne hospital was asked to ensure all outpatient clinics had sufficient numbers of staff to meet patients' needs. They were also asked to ensure appropriate arrangements were in place for staff working in the outpatient department during evening clinics. These actions had not been completed at the time of our inspection.
- The establishment in post was 1.6 registered nurses and 1.0 nursing assistant, with a clinical outpatient manager or deputy giving a supportive visit daily whenever possible. The staff had a good relationship with their clinical outpatient manager and could telephone if they had any issues in the interim. These staffing levels were not sufficient to meet the current service demands. This issue had been identified at the previous inspection but action had not been taken to address this issue.
- The clinical services outpatient manager had responsibility for The BMI Chiltern and The BMI Shelburne outpatient departments. We were told there was always a senior manager on site in the hospital who could be contacted at any time.
- On the day of our inspection the staff could fit in a break between clinics, however sometimes the staff said they would be in the department for eleven hours rather than the scheduled 7.5 hours. It was difficult to take a comfort break or chaperone as patients would be left unattended in the waiting area although main reception would be alerted. We were not assured that the provider had acted on our last inspection findings and ensured the department had sufficient staffing or appropriate arrangements in place for lone working However, we were told the one registered nurse would only be in the department during the same working hours of the reception staff who were in the adjoining area.
- As the outpatient department activity was low only a few staff were allocated to work there. The consultants we spoke with said the staffing levels were "adequate" for the numbers of patients they saw. The staff at The BMI Shelburne were experienced and worked flexibly to manage the needs of the service. The staff said they could but did not book bank staff as the clinics needed staff who were very familiar with the needs of the service. However, should they be booked, all bank staff in the trust had the same mandatory training modules to complete as permanent staff. Agency staff were never used and retention and sickness was low.
- A staffing utilisation tool was used to plan the rota. Staff were aware the system needed updating to calculate the staff needed for chaperoning and were waiting for these changes on the system. The tool took into account the need for variable amounts of time for different appointments but not staffing skill mix or other factors that were unique to The BMI Shelburne. On the day we visited there was only one registered nurse on shift with no healthcare assistant. We met the clinical outpatient manager who came over to relieve the nurse from The BMI Chiltern so that she could speak with us.
- The deputy outpatient manager who planned the rotas said that providing adequate staffing was the greatest concern they had and that the lack of staff made any advanced planning very difficult. Staff reported that the staffing rota was usually only finalised and shared with the week before it was due to commence, which staff were unhappy about. The issue of staffing had been raised with the executive leadership team and was on the risk register.
- The staff said they could always access assistance as they had an informal arrangement where they could call a nurse from the inpatient ward or a porter for assistance.

Physiotherapy staffing

Requires improvement

Outpatients

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

- The physiotherapists worked flexibly across The BMI Shelburne Hospital and The BMI Chiltern Hospitals and across the different sub-specialties offered. This ensured patients had the specialty they needed when they needed it and benefited staff as by working across hospitals and specialities they could increase their knowledge, skills and experience.

Medical staffing

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

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

Records

Staff kept detailed records of patient's care and treatment.

- The hospital used paper patient records and were planning on introducing electronic records soon. To manage the storage of paper records 30,000 sets of patient records of patients not seen in the last 12 months had been scanned following the recently closure of hospital in the group.
- Patient records were held securely at The BMI Chiltern Hospital in the medical records department. Records for clinics were collated 24 hours in advance, with clinic lists printed and cross checked to ensure the correct records were available and last-minute patient additions were added to the list. Patient records were transferred by a designated driver to The BMI Shelburne Hospital in a clearly labelled, sealed bag and transferred back to the medical records department by the same mechanism at the end of the clinic.
- The medical records staff at The BMI Chiltern Hospital signed the patient records out of the department and the clinic nurse at The Shelburne Hospital signed for the receipt of the notes and the reverse happened for transferring back to the medical records department. The patient records were logged out on a tracker by the medical records staff until they were returned. For evening clinics, the nurse would keep the patient records in a locked room to transfer back to The BMI Chiltern Hospital the following morning.
- During clinic the patient records were placed in the individual consultant's room and this was constantly manned with no opportunity for patients to view the patient records of others. If the consultant left the room we saw the nurse locking the room.

- The consultants wrote in the patient records when they saw the patient then dictated a letter immediately after each consultation. Outpatient nursing staff entered details in the records by exception, if they were changing a dressing or to document they had chaperoned.
- Clinic notes were typed up within 24 hours of the clinic by the administration team and the hospital had a service level agreement with local GPs that they received the letters within two days of being typed.
- The five sets of patient records we reviewed all legible and complete. We also checked a 'dressings book' where the nursing staffed documented all dressings renewed in the department as well as in the individual patient's records. On reviewing one patient's records we noted that the documentation stated the dressing had been renewed and the type of dressing applied but no comment was made on the condition of the wound.
- The service had employed a new director of operations whose remit included medical records and the process for managing patient records had improved. The manager had converted bank administrative staff to permanent as the manager acknowledged the importance of medical records management. Staff reported in a week there maybe one or two sets of notes missing out of an average of 20 per day, they said the service was "99% better" since the new manager had been in post. However, patients were never seen without patient records as the last clinic letter, pathology and radiology results could be accessed from the electronic systems.
- The staff in the outpatient department ensured that the test results were filed in the patient record prior to attendance. Histology results were received as hard copies and blood results were received via a secure networked printer. Diagnostic results were provided directly to the consultant. Outpatient staff could request urgent results or duplicate records if necessary.
- There was no mechanism for flagging people with specific needs such as learning disability. However, staff reported they did not see patients with specific or complex needs as they would not meet the criteria for accessing the service.

Medicines

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

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

Incidents

Staff had a good understanding of incidents and managers investigated these. However, they did not always report incident and had reported very few.

- We were told incidents were reported using an on-line system although the staff said they had not reported an incident in the last year. We observed that staff did not always report incidents. For example, when a patient with a disability bypassed the normal triage and had an appointment at The BMI Shelburne Hospital, which could not meet their individual needs.

If they had needed to use the disabled toilet facilities, they would not have been able to do so in the outpatient department as there was only one nurse and no hoist in the department. There was no evidence that this incident had been investigated.

- Managers investigated incidents across both sites, the BMI Chiltern and Shelburne Hospitals and shared lessons learnt with the whole team and the wider service. If things went wrong, staff said they would apologise and give patients honest information and suitable support.
- Staff understood their responsibilities under Duty of Candour, but stated they had not had any safety incident that resulted in moderate, severe harm or death and therefore had not invoked this. The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain notifiable safety incidents and provide reasonable support to that person, under Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.
- The outpatient department and diagnostic imaging department reported 10 clinical incidents between July 2017 – March 2018 and no non-clinical incidents in this period.

Are outpatients services effective?

We do not rate effective for this core service

Evidence-based care and treatment

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

- The BMI Shelburne Hospital did not have a tissue viability nurse and staff told us they had difficulties accessing NHS tissue viability advice from the acute trust as they did not have a SLA for this service. Staff told us that they relied on their training as a nurse to decide what dressings should be applied to a wound. Staff did not demonstrate an awareness of the link that was available to them to access The Marsden Manual (this online reference guide provides up-to-date, evidence based information on over 200 nursing procedures).
- There were arrangements in place such as training courses, feedback, in-service training and accredited courses to ensure staff use evidence based guidance for extended roles such as urodynamics and venepuncture.
- Different specialities within outpatients participated in national audits such as: The National Joint Registry (NJR) which reports on outcomes of joint replacement surgery; Patient Reportable Outcome Measures (PROMs) measurement of a patient's health status before and after a procedure; CQUINs are set by the commissioners to promote improvements in patient care; Public Health England (PHE) National Mandatory Orthopaedic Surgical Site Infection (SSI) ; Patient Led Assessment of the Clinical Environment (PLACE) assessing the quality of the hospital environment, this ensured that the consultants kept up with best practice and evidenced based care nationally and internationally. The consultants staff told us that their submission input was 100% to the National Joint Registry. The service only uses 10 star rated implants to ensure there are no avoidable problems post-surgery.

Nutrition and hydration

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

- There was a water dispenser and coffee and tea available in the outpatient department. However, we noted there was no food available for a patient awaiting NHS transport. The staff member once alerted to the fact that a patient was hungry due to a long wait for transport, said that they would order sandwiches from the kitchen.

Pain relief

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

- In our last inspection report we asked the provider to ensure there were clear protocols and guidance for pain management in the outpatient department. We

did not observe nursing staff using protocols for pain management and they were not aware of any pain assessment tool. Therefore, we were not assured they had acted on this finding.

- The nursing staff did not routinely assess the patient's pain but the consultants always explored this during the patient's consultation. The consultants were observed asking the nature, location, duration, pattern, aggravating factors and associated symptoms of the pain using a pain scale. We observed consultants giving advice to the patient on managing their pain with their current medication.
- One patient was in pain, waiting for an appointment in the outpatient waiting are and had forgotten to bring their analgesia with them. Once the relative mentioned that the patient was in pain the staff member showed an empathic response and contacted the Resident Medical Officer to write a prescription and the patient was given the medication within 20 minutes.

Patient outcomes

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

- The BMI Shelburne Hospital inputted into PHIN (Private Healthcare Information Network) since 2017. This information gives patients information on which to base their choices of provider if they have privately funded healthcare. PHIN states in regard to outcomes, there was 'Good Participation' by the service (this is not meant to be a quality score itself but provides a useful indicator of the extent the hospital is actively engaged in measuring and improving clinical care).
- The referral to treatment times were monitored for the NHS patients, these ranged from 17 for orthopaedics to 46 days for urology but this data was not collected for the self-funded or insured patients.

Competent staff

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

- The staff could access additional training course identified at their appraisal and the staff we spoke with had identified wound care as the course that they next wanted to access.
- We saw the completed healthcare assistant and nurse induction and competency documents provided for the combined outpatient service (The BMI Shelburne and The BMI Chiltern).
- Competencies in lumbar puncture and urodynamics were specific competencies that had been developed for the nurses running clinics at The BMI Shelburne Hospital. Not all staff had completed these at the time of our inspection.
- The consultants told us that they often took out sutures themselves and that they did not ask for any assistance in their clinics from the nursing staff as they recognised how short staffed they were not because the staff were not competent.

Multidisciplinary working

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

- We observed the medical, diagnostic department and nursing staff in the outpatient department at The BMI Shelburne Hospital working well together. However, the clinic staff did not demonstrate an awareness of the activity of the physiotherapist working from the same department and we observed no interaction.
- The outpatient team worked flexibly across The BMI Chiltern and The BMI Shelburne Hospitals.
- We observed the outpatient staff working seamlessly with X-ray and diagnostics to ensure a smooth pathway for patients who were primarily seeing their consultant but needed an X-ray the same day. The X-ray was reviewed there and then by the consultant and a plan of care discussed with the patient.
- There was a daily handover and a communication book for staff to write messages between shifts. This promoted the sharing of information.

Seven-day services

Staff in the general outpatients worked in the evenings five days a week to provide a responsive service to patients

Outpatients

- The BMI Shelburne Hospital held the majority of clinics from 08:00-20:00 Monday to Friday. The staff in the department worked flexibly as a team and with The BMI Chiltern Hospital to provide Saturday clinics as required.

Health promotion

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

Consent and Mental Capacity Act

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

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

Are outpatients services caring?

Good

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

Compassionate care

Staff cared for patient with compassion.

- We observed staff approach patients with sensitivity and talked quietly and kindly to patients, friends and family members. Staff displayed understanding and a non-judgemental attitude towards the patients.
- We were told that when intimate personal care and support was being given by a member of the opposite sex they were offered a chaperone. We observed notices in every clinic room offering a chaperone and observed consultants offer this before they examined a patient.
- The overall friends and family patient satisfaction survey had improved since the last CQC inspection and 99% (87% response rate) of patients who said they were likely, or extremely likely to recommend the service to their friends and family.
- The patients were complimentary about the staff. We saw comment cards filled in by service users. Feedback from patients confirmed that the staff treated them well and with kindness and one patient told us that they were "staff were always nice to them".

Emotional support

Staff provided emotional support to patients to minimise their distress.

- It was difficult for staff to pick up on patient distress when there were so many competing demands on one nurse's time.
- There were limited information leaflets available in the outpatient waiting area: 'The Reassurance of Fast results' (no issue or review date); 'Orthopaedics' 2013; 'Gynaecology'v2 12/12 offering generic advice. We did not see any patients reading this information or taking leaflets.
- We saw consultants in clinic giving patients emotional support, giving them clear information, time for questions and discussing options. The consultants often gave additional information and a website address to look up relevant and up to date information and support and gave an open invitation for the patient to telephone them if they had any further questions.

Requires improvement

Outpatients

Understanding and involvement of patients and those close to them

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

- We heard staff at reception dealing with all enquiries with in a friendly manner. They did their best to do what was asked by the patient. If the patient had transport issues (if they were NHS they would book the transport themselves) they did their best to intervene on the patient's behalf to ensure the patient got home without having to wait for a long time.
- We observed the consultants in clinic taking the time to explain their condition to patients, check their understanding and allowing the time needed to make decisions and consent to care and treatment.

Are outpatients services responsive?

Good

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

Service delivery to meet the needs of local people

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

- The BMI Shelburne Hospital had a service level agreement with the NHS acute trust, and saw NHS outpatients when the trust lacked capacity. They also accepted 'spot' contracts from the NHS acute hospital to assist with waiting list initiatives.
- The service was registered with various insurance companies, providing access to treatment for patients who had private healthcare insurance. Additionally, patients could opt to pay for treatment themselves.

The service took account of patients' individual needs and mostly met these.

- There was sufficient car parking and clearly marked disabled spaces providing easy access to the hospital. The outpatient department was clearly signposted and staff greeted patients at the general reception desk directing them to the correct department.
- All patients received a pack prior to their first appointment that was tailored to the treatment or procedure they are going to receive. This ensured they were aware of what to expect and could consider any questions they may have prior to the appointment.
- Staff could not give many examples of meeting the need of individuals. This was mainly due to the patients using the service who had mostly chosen the hospital and the hospital admission criteria was not inclusive and this meant those with complex health needs did not use the service.
- The department had provided seating for bariatric patients as weight-loss surgery was a sub-specialty within surgery.
- The department had access to a portable hearing loop to assist those patients who had hearing loss.
- Staff said an interpreter service was available and if they identified at the patient's first appointment that they needed assistance, they would arrange it for subsequent appointments. However, they had never been in a situation where they had to use it.
- BMI Healthcare offered patients 'live support' on the BMI website. This is an encrypted online chat session into the BMI network via a secure encrypted connection. Patients could also request information via an online query tool.
- We noted the service could not meet the needs of a patient with complex needs who came for an appointment without a walking frame and the department had no hoist. If the patient had needed to use the toilet on this occasion we observed that would not have been possible due to staffing levels and lack of equipment.

Access and flow

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

- Consultants sometimes added patients to the clinic list, which along with the national contact centre

adding additional patients to lists during a day impacted on the flow through the department. If any patient waited more than 15 minutes they were informed of the reason why.

- NHS patients told us that they booked their appointment on the national choose and book portal, this gave them a choice of appointment time and they chose BMI Shelburne for the shorter waiting times. Self-funding or those with health insurance booked appointments by telephoning the hospital or through the centralised team in Scotland or via the BMI website, the website included a 'live chat' support to patients. This approach ensured patients were able to book an appointment that met their individual needs.

Learning from complaints and concerns

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

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

Are outpatients services well-led?

Requires improvement

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

Leadership

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

- The staff in the outpatient department were managed by a clinical services manager and a deputy clinical services manager. They managed The BMI Chiltern and The BMI Shelburne outpatient departments as one clinical unit, they also managed the pathology

and phlebotomy services. The deputy clinical services manager reported to the clinical services manager who reported to the director of clinical services who reported to the executive director.

- The outpatient clinical services manager and a deputy clinical services manager were mindful that they needed to be visible at The BMI Shelburne Hospital as well as The BMI Chiltern Hospital and tried to ensure that they visited the hospitals daily. The BMI Shelburne Hospital were included in the 'comm cell' remotely by conference call and participated in departmental meetings.
- The two senior managers were providing cover for phlebotomy at The BMI Chiltern and this impacted on the time they had to come over to The BMI Shelburne to work with staff on the improvements they had planned to make.
- Staff in outpatients told us that the executive director was "very visible", "approachable" and had "an open-door policy". However, some staff felt that although they could raise issues with the outpatient manager, "nothing was done" to resolve them and there was little feedback.
- Some nursing staff felt there should be more investment from the executive leadership in training, development and upskilling of staff to improve retention in the department.

Vision and strategy

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

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

Culture

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

- Staff told us that there was a good ethos within the hospital and that things had changed with the executive leadership that genuinely wanted to change things for the better for patients.
- There was a mixed culture, some staff felt the managers gave "a lot of empty promises" and "no-one listens". There were several disgruntled members of staff who were in the minority but had well-reasoned evidence for their sense of injustice.
- The majority of staff we spoke with told us that the culture encouraged honesty at all levels of the organisation, including with people who used services, in response to incidents.
- The staff understood their responsibilities under duty of candour and had been trained in this and we saw a laminated flow chart illustrating the process. The conversations we had with staff supported the strategic aim to promote an honest, open and blame-free culture where risks were identified and addressed at every level and escalated appropriately.

- Staff told us that there had been one situation in 2018 when a consultant did not adhere to the values of the organisation. BMI Healthcare removed their practising privileges due to behavioural issues and the consultant no longer worked there.

Governance

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

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

Managing risks, issues and performance

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

- The managers leading the outpatient's department understood the risks and had escalated these appropriately.
- The outpatient manager told us that the number one risk was staffing. Other known risks such as the need for new sinks, a new call bell system and reconfiguration and regeneration of The BMI Shelburne outpatient department had started and flooring was being replaced on the day we visited.
- Action had not been taken on the findings of our previous inspection, such as staffing issues and the introduction of a pain assessment tool.

Managing information

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

- The BMI Shelburne Hospital had a good information security culture. BMI Healthcare was compliant to the international standard for best practice information management (ISO/IEC27001:2013). The site has a dedicated Information Security Officer, who conducted audits which were reported locally and corporately. Staff were trained and confident their practices conformed to the required standards of General Data Protection Regulation and training had been updated accordingly.
- We were told by staff that fax machines were still in use to receive information at The BMI Shelburne Hospital. However, staff were aware this was not best practice and Department of Health guidance for NHS organisations is to phase out fax machines by the end of March 2020.

Engagement

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

- We saw patients filling in feedback cards and posting them into the collection boxes. We attended the 'daily comms cell' meeting where the feedback from service users was reported to the group the same day as it was received. This promoted the timely sharing of patient feedback.
- Staff were encouraged to make suggestions at any time. The minutes of the outpatient department stated that agenda items were discussed with staff but it was difficult to identify where their suggestions and views had been incorporated.

Outpatients

- Patients were encouraged to come back for a walk around the department and suggest any improvements, however we were not given examples of changes brought about from direct patient feedback.

Learning, continuous improvement and innovation

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

- The outpatient manager's main project this year was reported to be the utilisation of the available space. We were told that there were plans to move specialist services for outpatients from the Chiltern Hospital to the Shelburne Hospital.
- The hospital had been allocated significant financial investment in 2019 which included a rolling refurbishment programme that was observed during our visit. This ensured that the building conformed to infection control standards and would improve patient safety.
- The outpatient department was committed to working with the executive leadership to learn from things that did not go well and from listening to patients to continuously improve their services. Allocation of the billing codes to the clinical staff, was an example of listening to patients' dissatisfaction when they were sent a bill for the incorrect procedure.
- The medical records department were committed to scanning all the current medical records of patients who had not used the service in the last 12 months so that transfer to an electronic patient record could happen as soon as BMI had rolled out the software.

Requires improvement

Diagnostic imaging

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

Information about the service

The diagnostic imaging department at BMI The Shelburne Hospital provides plain x-ray and diagnostic ultrasound. A mobile image intensifier is used in the operating theatre for limited interventional procedures requiring fluoroscopy. A mammogram machine is also available but due to its age used only for checking of guide wires and was due for replacement.

Magnetic resonance imaging(MRI) scans and computerised tomography (CT) scans are referred to the Chiltern Hospital and any nuclear medicine procedures are sent to the local NHS Trust hospital.

Radiologists and radiographers worked across both the Shelburne and the Chiltern Hospitals, however, the main service was at the Chiltern Hospital and it was here that the radiology manager and staff were based and carried out the majority of their work.

The radiology department at the Shelburne Hospital was available for day care patients and referrals Monday to Friday 08.30-17.00. Diagnostic services at the Shelburne Hospital were provided for adults only, children were seen at the Chiltern Hospital. Some days there were no patients seen in the radiology department, therefore the unit would be closed.

If an emergency x-ray was required for a day case patient then a staff member would travel from the Chiltern Hospital to perform the investigation. If the service was unavailable or inappropriate, due to staffing or acuity then patients would be transferred across to the Chiltern Hospital or the local NHS trust.

During our inspection there was only one patient seen in the unit. We spoke with the hospital lead, the radiology manager and the radiographer who had travelled to complete the x-ray.

Are diagnostic imaging services safe?

Requires improvement

We rated safe as **requires improvement.**

Mandatory training

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

- Staff received effective training in safety systems, processes and practices in line with schedule 3, Ionising Radiation (Medical Exposure) Regulations 2017 (IR(ME)R) The service ensured staff who administered radiation were appropriately trained to do so. All staff had completed competency booklets which confirmed this and included a sign off form confirming the local rules and policies had been read. This ensured staff could safely perform examinations involving radiation.
- Mandatory training rates for staff in the diagnostics department across both sites was 94.30%. Staff completed training through the corporate learning system, which was an online resource of training modules, e-learning courses. Staff viewed their individual training needs, current compliance and

accessed e-learning courses through the hospital's electronic training system. The system also alerted staff when mandatory training was due to be completed.

- All radiographers were expected to have completed adult basic life support training, at the time of our inspection this had been completed by 100% of staff.
- All radiology staff were expected to have completed paediatric basic life support (PBLS) and basic life support (BLS) training. However, at the time of our inspection only 60% of staff had completed their PBLS.

Safeguarding

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

- Staff could describe the escalation process if they were to have safeguarding concerns and were aware of the corporate safeguarding policy and where to locate it. The policy incorporated Mental Capacity, Deprivation of Liberty Safeguards and PREVENT advice. PREVENT aims to safeguard vulnerable people from being radicalised to supporting terrorism or becoming terrorists themselves. The policy included what action staff should take if they had concerns a patient had undergone female genital mutilation (FGM).
- Information was displayed across the department of who to contact should staff have any concerns. Staff also received child sexual exploitation training as part of the children's safeguarding training.
- Staff in the department were trained to level two children's safeguarding. This was in line with safeguarding children and young people the intercollegiate document.

Cleanliness, infection control and hygiene

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

- We observed staff decontaminate their hands in line with the World Health Organisations five moments for hand hygiene and NICE guidance (QS 61 statement three). This standard states people should receive healthcare from healthcare workers who decontaminate their hands immediately before and after every episode of direct contact or care.
- The imaging department at the Shelburne hospital submitted hand hygiene observational audits every two months. This included condition of skin, decontamination at the point of care, if staff were bare below the elbows and if the six-step technique was followed correctly. Results from February to December 2018 showed results were 93% and above.
- Hand gels were available at the entrance to every department and were easily accessible; we witnessed all staff using the gel on entry to and on leaving departments. The radiographer on the unit adhered to the infection control policy and wore minimal jewellery; hair was tied back and off the collar. The radiographer adhered to the hospital's bare below the elbow policy. Personal protective equipment such as gloves and aprons were available to staff.
- Clinical and patient waiting areas were visibly clean and free from dust and debris. There were cleaning schedules in place, which were completed by housekeeping staff and this included sign off by the house keeping supervisors.
- A process of logging the cleaning of equipment prior to and after use was in place and facilitated monitoring as pre-and post-cleaning was logged in a record book. We reviewed one of these books and saw how each day the cleaning of the equipment was logged, alongside patient details and when the equipment had been cleaned post use.
- Staff identified when equipment such as weighing scales had been cleaned by using 'I am clean' green stickers. We saw all equipment had green labels which indicated the date and by whom the item had been cleaned.

Environment and equipment

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

- The diagnostic imaging department at the Shelburne Hospital provided plain x-ray and diagnostic ultrasound. A mobile image intensifier was used in the

operating theatre for interventional procedures requiring fluoroscopy. A mammogram machine was available but only used for checking guide wires for chemotherapy treatment and pathological specimen checks. Staff told us that a business case was being prepared for the replacement of the mammography machine, until further notice all mammograms were to be carried out at the Chiltern Hospital.

- Where actions had been identified in QA processes, actions were not always completed in a timely manner. A physics report dated February 2018 indicated that the automatic exposure device (AEC) was 11% out of tolerance and should be investigated by an engineer, however this was not followed up until November 2018, nine months later. The QA process had identified in October 2018 the image intensifier required labelling, this had not been completed at the time of our inspection. Although the mammography machine was only used to check guide wires and specimens there was no QA records. This meant that staff could not be assured that the equipment they used was always checked and safe.
- We saw some evidence of engineer's servicing/ maintenance and handover forms for the x-ray, image intensifier and ultrasound equipment. However, the records were not always complete. As there was often no radiographer on site during an engineer's visit sometimes handover sheets/forms were not always signed as completed. Therefore, the record was not always complete and assurance could not always be guaranteed. This was identified during the radiation protection audit (RPA) which recommended senior staff remind all staff at the Shelburne Hospital when radiographers were not there, of the handover procedure that must be followed on all service engineer and medical physics testing visits. However, this had not been added into the action plan and there was no assurance the handover procedure had improved.
- Staff wore lead aprons where appropriate and new lead aprons had just been delivered to the unit as the old ones had frayed. Aprons were not systematically tested and we did not see any evidence of a numbering system to help monitor the condition of aprons over time. This meant that staff may not be protected from the risk of radiation.
- Equipment had folders with information such as fault codes, telephone numbers of suppliers, and a fault record which we reviewed and all faults had been completed and closed.
- The service monitored staff for radiation exposure. All staff wore radiation exposure devices to ensure staff were not over exposed and results were shared if a reading was above zero. Records of these dose badges were kept on the internal drive.
- Patient doses were monitored however, during the radiation protection meeting it was identified that due to staffing changes and a new method of recording, staff were not always recording in the correct units on the clinical record interactive system (CRIS). Teaching on how to record on CRIS was in the process of being completed.
- The hospital had risk assessments for rooms which housed scanning units. Room risk assessments and updated policies were seen and evidence was provided regarding how this information was disseminated to staff for example, group emails detailing changes in policies and mention in staff meeting minutes.
- Adult resuscitation trolleys were available and located close to the unit, checks were shared across the departments, weekly and daily checks were fully completed for the month. The trollies were tamper evident, sealed clean and had an 'I am clean' green sticker on them.
- Equipment which was maintained by the hospital such as suction machines and the warming unit for the contrast and had a pat test and next service due label, all of which were in date.
- The radiology department had working radiation warning signs outside all rooms for safety and to prevent unauthorised access.
- The service used a Picture Archiving and Communication System (PACS) which was a system used to store patient images. This enabled the service to eliminate the expense of film processing and storage and gave staff faster access to images. In case of internet and IT outage, the service had a business continuity policy. The service told us that PACS servers, and the BMI IT network was monitored 24

hours a day, seven days a week and in the event of a failure engineers would be alerted immediately. There were two main PACS servers – if one went down then the service would automatically switch to the other.

Assessing and responding to patient risk

Staff completed and updated risk assessments for each patient.

- Staff told us what action they would take if a patient became unwell or distressed while waiting for, or during an investigation. All rooms were fitted with emergency bells to alert other staff of concerns. Staff told us they would phone 2222 and alert the emergency response team.
- The service had the support of a radiation protection advisor (RPA) through an advice service contract with a radiation protection centre, we saw the contract to substantiate this. The service also had one radiation protection supervisor (RPS) who worked at the Chiltern Hospital and provided guidance and support to staff in each area.
- There were processes in place to ensure the right person received the right scan at the right time. Staff completed a six-point check of name, date of birth, address, body part, clinical information and previous imaging checks in line with the legal requirements of IR(ME)R to safeguard patients against experiencing the wrong investigations.
- As required by the Health and Safety Executive (HSE) who regulate the Ionising Radiations Regulations 2017 (IRR99), all areas where medical radiation is used in hospitals are required to have written and displayed local rules which set out a framework of work instructions for staff. These local rules were displayed throughout the department.
- Relatives or staff who chaperoned/comforted patients had to sign a record to document they agreed and understood the risks and level of radiation exposure. For women there was a declaration to sign to establish if pregnant or not.
- There were posters and signs which informed patients who were or could be pregnant to let a member of staff know. Staff questioned all patients who were 18 to 55 years of age to identify if they could be pregnant. However, there was no audit of compliance undertaken. The service had a policy accessible on line which had expired in November 2018.

Staffing

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

- A new manager had been appointed in September 2018 who was supported by a new experienced deputy manager who had recently started following a long gap where the service did not have a deputy manager. At the time of our inspection the service had one fulltime radiographer vacancy and one 10-hour radiographer vacancy. The service was actively advertising using social media networks and the local radio station to recruit to these vacancies.
- The service had a total of 14 radiographers all with current Health Professions Council (HPC) registration. Radiographers were based at the Chiltern Hospital and when required to complete scans would work at the Shelburne. The Shelburne Hospital did not have overnight patients and so an on-call service was not required. Agency staff were not used in the diagnostic suite at the Shelburne hospital.
- A utilisation tool helped the service understand how effectively they used their staffing in relation to their throughput of patients across both sites. This was then discussed at the daily communications cell meeting at the Chiltern Hospital. During our inspection utilisation was at 102% which staff explained was due to short term sickness the aim was 65% and from the month of December to January it had averaged at 85% senior staff had explained that this was due to the staff vacancies and sickness. To cover these shortfalls, the managers and deputy manager stepped in, this did however impact on their non-clinical time.
- Sickness was reported as 1.5% over the previous year which was below the BMI corporate target of 3%.

Medical staffing

Requires improvement

Diagnostic imaging

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

- The service had 14 radiologists working under practicing privileges across the two hospital sites.
- Senior management completed a number of checks prior to granting consultants practising privileges at the hospital. The term 'practising privileges' refers to medical practitioners being granted the right to practice in a hospital. To maintain their practising privileges consultant medical staff were required to supply copies of current insurance, a disclosure and barring scheme check, their registration, last appraisal for their main place of work and evidence of completion of the required mandatory training. The hospital were up-to-date with these annual checks and reviews of clinical performance which took place biennially with the Medical Advisory Committee (MAC), in keeping with the BMI Healthcare 'Practising privileges policy' (2015). The policy contained a standard agenda that the MAC should adopt which included biennial review of practising privileges.
- Radiographers told us they had good access to radiologists for advice and they were contactable out of hours.
- Radiologists were based at the Chiltern Hospital and would report x-rays in the reporting suite at the Chiltern.

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 service provided electronically encrypted reports within a picture archiving and communication system (PACS) system to store data and prevent unauthorised access. PACS is a medical imaging technology which provides economical storage and convenient access to images from multiple modalities. This enabled appropriate sharing of information should a patient be referred to another clinical team or to the local acute trust, to their GP for review or discharged. This arrangement was in line with NICE QS15 Statement 2, competency in communication skills.
- All computers observed were password protected and locked when not in use. We saw computers were generally out of view of patients

Medicines

- The only medication stored in the unit was contrast which was used in theatres and administered by surgical consultants during specific procedures.

Incidents

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

- From August 2017 to January 2019, the service had not reported any incidents classified as never events taking place in their diagnostics services. Never events are serious patient safety incidents which should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.
- Over the previous 12 months, there were no ionising radiation incidents reported at the Shelburne Hospital.
- Incidents were identified in the quality and risk reports. Action plans and lessons learnt were documented along with themes and trends. We reviewed the minutes for the clinical governance meetings and saw how incidents and themes were discussed. External safety alerts and recalls of medications/ equipment were also discussed at this meeting. As this was attended by the heads of all departments then information would be filtered down into the individual departments.
- Incidents within radiology were discussed during the staff meeting and this would include incidents at both the Chiltern and the Shelburne Hospitals.

Requires improvement

Diagnostic imaging

Are diagnostic imaging services effective?

We currently do not rate effective for this core service.

Evidence-based care and treatment

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

- In line with Ionising Radiations Regulations 2017 (IRR99), the service appointed a radiation protection supervisor (RPS) who ensured staff followed the services standard operating procedures and adhered to the radiation protection procedures. The RPS worked across both sites, however it had been identified that protected time was required to achieve compliance with IRMER regulations as for example SOPs were not always in date. The mammography machine at the Shelburne Hospital did not have a SOP at the time of our inspection, the service told us that this was in the process of being written.
- The service worked to the IR(ME)R and guidelines from the National Institute for Health and Care Excellence (NICE), the Royal College of Radiologists (RCR), the College of Radiographers and other national bodies. The service adopted and used the diagnostic reference levels (DRLs) as an aid to optimisation in medical exposure. Local DRLs were in place and referenced to national DRLs and were recorded on the hospitals PACs system and audited annually by the appointed radiation physics advisor.

Nutrition and hydration

- Patients attending the diagnostics service did not require food as they were normally only there for a short time. Tea, coffee and water was available for patients and relatives.

Pain relief

- Radiology staff did not routinely use pain relief in diagnostic imaging at the Shelburne Hospital. If a patient attending for day surgery required an x-ray than staff on the wards would administer analgesia prior to the patent attending the department.
- We saw how staff asked if the patient was comfortable during their x-ray.

Patient outcomes

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

Clinical Quality Dashboard.

- The service monitored safety via an electronic database, which enabled the hospital to compare its performance against other BMI hospitals. The hospital used the results to improve practice and we saw evidence of incident discussions as a standard agenda item in meeting minutes such as management team meetings, the clinical governance committee and if relevant, medical advisory committee.
- The radiology department at the Shelburne Hospital submitted audit data and this was added into the quality and risk reports. Audits included imaging and general radiation, and infection prevention and control (IPC). We reviewed the IPC results for October to December 2018 all of which scored above 95%.
- The Shelburne Hospital had a yearly radiation protection audit (RPA) completed in September 2018. This identified that areas of improvement were required. We reviewed the action plan which included ensuring all theatre staff were trained in the local rules for radiation safety. Actions were allocated with time frames, the majority of which had been completed or were in progress.
- The RPA audit highlighted the need to develop a local audit plan for the Shelburne Hospital. The diagnostic service had undergone a recent change in its local management with a new manager starting in September 2018 and a new deputy manager in December 2018. The service planned to improve the effectiveness of its auditing programme and shared with us the new audit programme for both the Chiltern and the Shelburne hospitals for 2019.

Requires improvement

Diagnostic imaging

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

Competent staff

The service made sure staff were competent for their roles.

- Radiographers had competency assessments for the equipment they used, which were completed and up to date. All competencies were paper based at the time of our inspection. We looked at a selection of these which included training records for x-ray. All competency booklets had been signed off for all members of staff. These were reviewed yearly during the appraisal process.
- The Shelburne and Chiltern hospitals shared a radiation protection supervisor who was responsible for the compliance of the service. It was identified in the radiation protection audit that due to staff changes RPS duties such as review of personal dosimetry, contribution to incident investigations, staff training and records of radiation protection supervision were not always being achieved. As identified in the RPA it was now a legal requirement under IRR17 for RPS to be given sufficient time to complete their duties. The action plan reflected this and administration time was allocated to the RPS every two weeks.
- Appraisals data was submitted and showed an 85% completion rate at the time of our inspection. Those staff who had not had a recent appraisal either were not currently working or had a date booked in for completion.
- All consultant radiologists working at the hospital had practising privileges which gave them the authority to undertake private practice within the hospital.All consultant radiologists underwent an annual appraisal system performed by the medical director of radiology.
- We saw audit evidence that radiographers had in date health and care professional council registration (HCPC). This was in line with the society of radiographers' recommendation that radiology service managers ensured all staff were appropriately registered.

Multidisciplinary working

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

- We observed effective team working, with strong working relationships between all staff groups across both hospital sites.
- Staff told us radiologists had a good working relationship with consultants. Radiologists contacted the patient's consultant directly if they found abnormalities on scans or x-rays.

Seven-day services

- The Shelburne Hospital treated day case patients only and did not have an out of hours service.

Consent and Mental Capacity Act

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

- Staff had received training on mental capacity and told us they would not be likely to see patients with mental capacity issues in their service. However, should they have concerns about a patient's mental health or capacity to consent verbally to scan they would bring this up with the unit manager, the radiologists and should it be necessary contact the patients GP. There were online policies which were accessible to all staff for example on mental capacity and the deprivation of liberty which were version controlled and in date.

Are diagnostic imaging services caring?

Good

Insufficient evidence to rate.

During our inspection we to only one patient attended the department. Therefore, we did not see enough evidence of caring to rate this domain.

Compassionate care

Staff cared for patients with compassion.

Requires improvement

Diagnostic imaging

- We observed how staff demonstrated a kind and caring attitude to the patient and took time to speak with them in a respectful, patient and considerate way.
- Staff introduced themselves and explained their role and went on to fully describe what would happen during the procedure.
- Staff ensured they maintained the patient's privacy and dignity during their time in the department. of The Patient-Led Assessments of the Care Environment (PLACE) are annual assessments of the non-clinical aspects of the patient environment, how it supports patients' privacy and dignity, and its suitability for patients with specific needs e.g. disability or dementia. PLACE results for 2018 for privacy, dignity and wellbeing were above the England average.

Emotional support

- We observed how staff supported the patient through their investigation and ensured they were well informed and knew what to expect at all times.

Understanding and involvement of patients and those close to them

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

- The service allowed for a parent or family member or carer to remain with the patient for their scan if this was necessary.
- In line with NICE QS15 Statement four, patients had the opportunity to discuss any concerns and preferences prior to their investigation.

Are diagnostic imaging services responsive?

Good

We rated responsive as **good.**

Service delivery to meet the needs of local people

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

- The department planned services around the needs and demands of patients. Appointments were available Monday to Thursday 8:30 to 20:00 and Friday 8:30-17:30.
- The hospital was well signposted and had ample parking for all patients. The diagnostics area was well signposted and reception staff were available at main reception.
- The environment was appropriate and patient centred for adults. The waiting areas were fresh and bright, visibly clean and welcoming. There was an adequate number of seating and a drinks machine was available in the main x-ray waiting room.

Meeting people's individual needs

The service took account of patients' individual needs.

- For those patients who had learning disabilities staff told us they would be alerted on the referral forms and would encourage carers or relatives to attend appointments.
- Staff working on the unit were unclear about the access to translation services and we were told that patients who needed this would bring a relative with them. However, the hospital told us that specialist communication services were provided, for example interpreters where English was not a first language. Therefore, we were not assured that arrangements were in place to access translation services if needed.

Access and flow

People could access the service when they needed it.

- Patients could access NHS services by the national Choose and Book portal which the service told us gave patients a greater choice of appointment time. Private patients could book appointments through the centralised team or the BMI website, which included a 'live chat' support function.
- The service met the six-week diagnostic test national standard and told us waiting times were up to two weeks. The service told us they actively managed their clinic capacity to ensure they could maintain short wait times. We reviewed an audit where 20 examinations (MRI, CT and Ultrasound) were randomly chosen and audited in November and December 2018.

Requires improvement

Diagnostic imaging

This information incorporated both the Shelburne and the Chiltern Hospitals; in the audit cases 55% the waiting time was between 1-3 working days. In 35% the waiting time was 3-6 working days and for 10% the waiting time was more than 6 working days.

- Images were usually reported on within four days and all reports were sent to the referring clinician. A reporting time audit taken over the first 6 months of 2018 showed that reporting time 0-2 days averaged at 88.7%.

  Any urgent requests such as cancer referrals were given an urgent appointment. If an appointment was not available at short notice then the radiographer in charge of the modality would be consulted to secure an appointment for the patient as soon as possible. This patient would then be highlighted for urgent reporting on the clinical record interactive system (CRIS) and given to the next radiologist to report. If a certain radiologist was requested they would be called by the radiographer and made aware of the need for an urgent report.

- The service monitored 'did not attend (DNA) rates for the Chiltern and the Shelburne Hospitals. From July to December 2018 there were 2,834 appointments of which only nine were DNA. The service told us that they contacted the patient within 30 minutes of failure to attend. A standard operating procedure had been written the month of our inspection which outlined the actions staff should take when this happened.

- Waiting times in the department were short and this was corroborated by what the patient told us and what we witnessed during our inspection. However, the service did not monitor waiting times.

Learning from complaints and concerns

- Complaints were analysed during the quality and risk report across all location. Complaints were discussed at local level during the imaging departmental meeting held at the Chiltern Hospital and across the whole of the hospital at the Shelburne. There were no reported complaints from the diagnostics department for the period of March 2018 to August 2018.

Are diagnostic imaging services well-led?

Requires improvement

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

Leadership

Managers were developing the right skills and abilities to run a service providing high-quality sustainable care, however the management team was still in its infancy.

- The radiology manager worked with the senior lead for both hospitals to understand challenges the department faced and identify the actions required to overcome them. We saw how an action plan had been developed along with timescales, which included priorities such as recruitment and retention, and updating all radiation protection paperwork (local rules) due the end of January 2019.

- Team meetings for radiology staff took place at the Chiltern Hospital and had been re-started since the new manager had taken over and were aiming for monthly. We reviewed minutes for September through to January 2019 and saw how the meetings had a standard agenda which included incidents, complaints and clinical information and updates.

- The lead for radiology and the associate director of nursing who was based at the Shelburne Hospital met regularly during meetings such as the heads of departments monthly meeting. Alongside other departments from both hospitals incidents, updates and feedback would be shared. Further ad-hoc meetings would be arranged as and when required.

Vision and strategy

The provider had a vision for what it wanted to achieve and was working towards turning it into action.

- The BMI corporate vision was to deliver the highest quality outcomes, the best patient care and the most convenient choice for patients. The senior management had implemented a local vision for the

hospital based on a care, compassion, competence, communication, courage and commitment. The local BMI vision was displayed throughout the department and staff knew what this was.

- The radiology department had sufficient plans for the replacement of high cost equipment through managed services.

Culture

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

- Staff told us they had monthly team meetings which were based at the Chiltern Hospital. We saw many staff attended these and minutes were available to all staff on notice boards and on line.
- All staff spoke proudly about their work in their individual speciality and as a part of the diagnostic imaging service. Staff felt supported in their work and said there were opportunities to develop their skills and competencies, which senior staff encouraged. Staff told us they felt valued and supported by colleagues and senior managers. Some staff had been supported through study at masters' level
- All staff placed the patient at the centre of their service and described the care they delivered was based around the patient's needs.
- Staff spoke positively about working for BMI and told us their managers and the executive team acknowledged their wellbeing needs.
- Staff undertook annual staff satisfaction surveys for BMI, results for the 2017 were available. The most positive results included staff were committed to doing their very best for BMI Healthcare, could rely on others in their team and found their jobs interesting and fulfilling. Some of the least positive results included ineffective introduction to change, pay rates and the recognition of achievement. However, these results were from 2017 as the 2018 results were not yet published and there had been significant changes to leadership within the hospital and also across the diagnostic department. From what staff told us within the diagnostic department they were happy to work for BMI and felt valued by their senior teams.

Governance

The service needed to improve its governance processes and systems to deliver good quality, sustainable services.

- There was no cohesive system or oversight of what equipment had been subjected to quality assurance checks. In some of the records where actions had been identified these were not always completed or actions followed through immediately. Staff, had identified that the process for receiving handovers from machine engineers was not working as often there was no staff member in the unit during the engineers visit. However, this had not been added into the action plan and there was no assurance the handover procedure had improved. This meant that oversight of governance processes was not fully embedded into the day to day management of the unit.
- There was no process in place to make sure aprons were systematically checked to ensure the safety of staff.
- The hospital used assurance systems and service performance measures, which were reported on and monitored. The hospital had an audit dashboard and the ability to compare their performance to other hospitals across BMI. Audit, results and action plans were discussed at the monthly clinical governance and heads of department meetings. However local audit programmes were still in their infancy and had yet to be embedded into practice.
- The radiation protection committee (RPC) had yearly meetings, unfortunately there were no previous recorded minutes available as these had not been stored on the shared drive for the hospital. Therefore, any documented issues and action plans from previous meetings could not be reviewed. In future, all recorded minutes were to be stored on the shared drive to reduce the risk of this happening again, this was a documented action from the meeting.
- We reviewed the minutes of the first meeting held by the new management team. During the RPC the terms of reference were re-established and those staff integral to the meeting were to be invited, such as the director of clinical services, theatre and consultant

representation. Moving forward all minutes would be shared with committee members to ensure all areas had oversight of any actions required or issues identified.

- The RPC had a standard agenda which included the annual radiological protection report, management arrangements for radiation protection and summary of actions. Both hospitals were included in the meeting. We saw quality assurance programmes for the equipment at the Shelburne Hospital radiology department were arranged and discussed. Discussions were also documented that radiation doses must be aggregated for those staff who worked across both sites.
- The hospital had a governance and risk management structure to support their delivery of care. We saw how the flow of information from the senior management team cascaded through the departments. Hospital sub-committees reported to the clinical governance committee, which fed into the medical advisory committee (MAC). Senior leaders then reported to the corporate BMI Healthcare regional and national clinical governance structure. Outcomes from the clinical governance meetings were shared at the heads of department (HODs) meetings.
- We reviewed meeting minutes from the Clinical Governance Committee, Medical Advisory Committee, Radiation Protection Committee (RPC) and Head of Departments meeting. All followed a standard agenda and were laid out in a clear and easy to follow format with incidents and risk featuring as standing agenda items across all meetings. It was clear how information flowed from senior level through to all departments.
- Staff in the radiology department had access to important information and updates and these were displayed in the processing room/ office at the Chiltern Hospital. Staff meeting minutes were displayed alongside. A communications book was used to share messages across the team and daily communication cell emails were added into this.
- The clinical governance team were involved in ensuring all policies and procedures were up to date and in line with current national guidance.New policy and standard operating procedures (SOPs) were disseminated thorough the weekly news bulletin, for example a new sickness policy was due for launch in October 201. The clinical governance meeting minutes were shared across all departments.

Managing risks, issues and performance

The provider had systems to identify risks, plan to eliminate or reduce them, and cope with both the expected and unexpected, however, registers on display did not always include the most up to date information.

- Local risk registers fed into the hospitals risk register. Risk registers were displayed in staff areas and all staff were aware of what the top risks were for their area. For the radiology department at the Shelburne Hospital the main risks were the age of the equipment.
- The mobile image intensifier which was used in theatres was 15 years old and it had been identified that it was becoming increasingly difficult to calibrate and find parts. The risk register showed that this was being managed and the service had oversight of potential issues should a complete breakdown occur. There were no plans to replace this unit at the time of our inspection.
- The mammography machine, which was not being used as a diagnostic tool but for checking the placing of guide wires was 14 years old and needed to be replaced. Staff told us this was being discussed and had been added onto the risk register.
- Risk registers had current risk scores and acceptable risk score. However, the information we reviewed did not have dates when the risk was added or reviewed. Whilst all risks were marked as open we could not be sure when they were last reviewed. The provider told us that all dates were recorded in their electronic reporting system, however for those risks displayed this information was not evident.

Managing information

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

- There was sufficient information technology equipment for staff to work with across the

diagnostics service. The service had access to hospital's computer systems. They could access policies and resource material from the BMI's hospital's intranet.

- Staff could access electronic patient records easily, when screens were not in use we observed staff had locked them.

Engagement

- Staff could attend local departmental meetings, and the daily communications meeting. Committees such as the Health and Safety Committee held monthly meetings and then had subcommittee meetings for example, the Water Safety Sub Committee.
- The 2017 BMI staff survey (BMiSay) was carried out by an external agency. Overall measures were lower than the 2016 survey. The hospital analysed the results showing key strengths and areas for improvement, and shared plans for improvements with the staff.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider SHOULD take to improve

- Outpatient nursing rosters should meet the needs of patients and have sufficient numbers of staff on duty to facilitate safe, effective care and treatment to be delivered..
- Consider planning the off-duty rota for nursing staff at least one month in advance.
- Address all aspects of the standard agenda at outpatient team meetings and include audit results, action plans and specific learning from incidents and complaints
- Provide patient information leaflets in a variety of languages, that reflect the demographics of patients using the service and in large print.
- Implement a process that identifies the need for an interpreter before the patient attends their first appointment.
- All leaflets should include review dates and references to ensure they reflect current best practice.
- Consider the implementation of a formal arrangement to access to tissue viability advice.
- Increase staff awareness of the availability of the portable hearing loop.
- Maintain accurate, up to date quality assurance records for all equipment including records of when actions are resolved.
- Review the storage of all documents relating to the servicing of equipment to facilitate easy access should these be requested to demonstrate assurance that the equipment is fit for purpose.
- The provider should ensure all staff are aware of how to take handover of equipment after an engineer had finished repairing/servicing it to facilitate a safe handover.
- Consider the introduction of a monitoring system, to assist track the condition of lead aprons.
- Maintain accurate records of radiation dosage administered by all staff
- The provider should consider taking action to improve mandatory training rates for staff.
- Consideration should be given to promoting the role of the Freedom to Speak Up champions to give staff the confidence to utilise their expertise should they wish to do so.