BMI The Kings Oak Hospital

Quality Report

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

Ratings

Overall rating for this location	Requires improvement
Are services safe?	Requires improvement
Are services effective?	Requires improvement
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 Kings Oak Hospital is an acute independent hospital in Enfield that provides outpatient, day care and inpatient services. It has 52 registered beds. The hospital is owned and managed by BMI Healthcare Limited.

The hospital provides a range of services including surgical procedures, outpatient consultations and diagnostic imaging services. Services are provided to both insured and self-pay private patients and to NHS patients.

We inspected the hospital on 11-13 October 2016 as part of our independent hospital inspection programme. The inspection was conducted using the CQC's comprehensive inspection methodology. It was a routine planned inspection. We inspected the following three core services at the hospital: medicine, surgery and outpatients and diagnostic imaging.

Prior to the inspection, the hospital's senior management team took the decision to restrict the treatment of children to outpatients only, with the exception of over 16s who were on an adult care pathway.

Facts and Data

The hospital had 42 beds (registered to have a maximum of 52), split across three wards; Hadley ward with 18 beds, Ridgeway ward with 16 beds and six beds on the short stay ward which were not in use. All rooms had ensuite facilities.

There were 5,304 inpatient and day case episodes of care recorded at the hospital from July 2015 to June 2016; of these 44% were NHS funded and 56% were private or self-funded. There were 42,476 outpatient total attendances in the same reporting period; of these 37% were NHS funded and 63% were private or self-funded.

BMI The Kings Oak provided an outpatient service for various specialties. This included, but was not limited to, gynaecology, cardiology, dermatology, oncology, ophthalmology and orthopaedics. Outpatient services were provided from 12 consulting rooms, in addition to a minor procedures room, minor treatment room and phlebotomy room.

There were two operating theatres (one with laminar airflow) and an intervention radiology suite adjacent to the recovery area. There were 4,968 visits to the theatre between July 2015 and June 2016. The five most common surgical procedures performed were:

Image-guided injection(s) into joint(s) (985)

Dorsal root ganglion block (407)

Facet joint injection (263)

Hysterescopy (170)

Multiple arthroscopic op on knee (inc meniscectomy) (166)

Inpatient and day patient endoscopies were undertaken in the theatre department and beds on the wards were used pre and post procedure for recovery. Procedures undertaken included oesophago-gastro duodenoscopy (OGD), colonoscopy, and flexible sigmoidoscopy. There were 379 endoscopy procedures carried out in the twelve months before our inspection.

There were 259 doctors with practising privileges at the hospital and 104.6 whole time equivalent employed staff.

Patients were admitted and treated under the direct care of a consultant and medical care was supported 24 hours a day by an onsite resident medical officer (RMO) Patients were cared by registered nurses, health care assistants and allied health professionals such as physiotherapists and pharmacists who were employed by the hospital.

The hospital Accountable Officer for Controlled Drugs is the Executive Director.

Summary of findings

BMI The Kings Oak was last inspected by the CQC in October 2013.

We inspected and reported on the following three core services:

• Medical care

• Surgery

• Outpatients and diagnostic imaging

We rated the hospital as requires improvement overall.

Our key findings were as follows:

Are services safe at this hospital?

We rated safe as requires improvement overall because:

- The environment did not always meet the requirements of Health Building Notice (HBN) 00-09: Infection control in the built environment. For example, patient rooms and some ward corridors had carpeted floors.
- In the pharmacy, there were no dispensing benches or work surfaces provided for counting or checking items.
- The hospital's target for staff having completed their mandatory training was 90%. Across the hospital 74% of all staff had completed their mandatory training. This was below the hospital's target.
- We identified risks relating to infection prevention and control. There were no signs to encourage hand washing and hand gel dispensers were not clearly marked. In patient rooms some of the carpets had dirty marks and there were marks on the walls, in corners and on skirting boards.
- Suction equipment which required to be stored in sterile packaging was left open in all patient rooms.
- Records were not always completed fully. We saw operation notes that were not dated and did not contain the name of the surgeons or anaesthetist. There were inconsistencies in recording National Early Warning Scores (NEWS) on the observation charts.
- Cleaning products were not stored in locked cupboards as required by the Control of Substances Hazardous to Health Regulations 2002 (COSHH).
- There was no established system for monitoring cleaning within the department including the cleaning of trolleys.

However,

- There was a good incident reporting culture. We saw that incidents were investigated and learning was shared with staff.
- Staff had a good understanding of processes for safeguarding adults and children.
- The RMO provided medical cover 24 hours a day, seven days a week. This meant concerns regarding a patient could be escalated at any time of the day.
- Staffing levels and skills mix were planned using an acuity tool and there were enough staff on duty on every shift to ensure patient received safe care.
- There had been no hospital acquired infection in the reporting period and we saw evidence surgical site infection was closely monitored.
- The diagnostic imaging department complied with policies and procedures based on the Ionising Radiation (Medical Exposure) Regulations (IR(ME)R).
- There was evidence of the WHO checklist being completed and audited in interventional radiography. Patient protocols were in place in radiology.

Are services effective at this hospital?

We rated effective as requires improvement overall because:

Summary of findings

- Although the hospital completed consent form audits, no action had been taken to rectify the findings from previous audits that patients were not receiving written information about their procedure.
- There was no audit of national early warning score (NEWS) systems to identify deteriorating patients which meant the hospital was unable to identify if improvements in practice and outcomes were required.
- It was not clear who was responsible for providing the resident medical officers (RMOs) with clinical supervision.
- The nurses working in the endoscopy room had not been endoscopy trained.
- There was no formal audit programme reviewing the use of guidelines in practice.

However

- The hospital used a combination of professional guidance produced by the National Institute for Health and Care Excellence (NICE) and the Royal Colleges
- Patients' needs were assessed and their care and treatment was delivered following local and national guidance for best practice.
- Pain scores were recorded and patients told us their pain was well managed.
- The hospital measured patient outcomes via a range of measures which included mortality, transfers out, infection rates, readmission rates, referral to treatment times, patient satisfaction scores, incidents, complaints, staff questionnaires, audits, Friends and Family Tests, and mandatory training rates.
- Patient surgery outcomes were within the expected range, although the small number of patients meant it was difficult to compare against national data for specific procedures such as joint replacements.
- Staff were suitably qualified and skilled to carry out their roles effectively and in line with best practice (except for endoscopy, see below).
- Staff obtained written and verbal consent to care and treatment which was in line with legislation and guidance.

Are services caring at this hospital?

We rated caring as good overall because:

- We observed that patients and their families were treated with kindness, dignity and respect
- Friends and Family Test (FFT) scores were consistently high with good response rates.
- Patients we spoke with were consistently positive about the care they received.
- The privacy and dignity of patients was maintained with the use of closed doors and windows and signs on doors to indicate personal care taking place within.
- Patients and their relatives felt involved in their care and were clear on how to contact the hospital if they had any concerns following their discharge.
- Staff offered emotional support to patients and provided encouragement and reassurance to help patients achieve their recovery goals.

However,

- Patients did not have access to information on how to access further emotional support if needed.

Are services responsive at this hospital?

We rated responsive as good overall because:

- Services were planned to meet the needs of patients and to ensure contractual requirements were met. Patients could book a convenient date and time for their appointment.
- Weekend and evening outpatient clinics were regularly being provided to offer flexibility in the service.
- For patients undergoing surgery, the hospital consistently met the referral to treatment target (RTT) of 90% for NHS admitted patients waiting less than 18 weeks from the time of referral to treatment.
- The hospital was meeting national waiting times for diagnostic imaging within six weeks and outpatient appointments within 18 weeks for incomplete pathways for their NHS patients.

Summary of findings

- Complaints were investigated in line with the BMI policy and we saw patient mostly received acknowledgment and response within agreed timescales. Learning from complaints was shared with staff.
- Staff had attended training on dementia and had access to resources to assist them in caring for patients living with dementia.
- Patients had single rooms that provided privacy and comfort with en suite facilities and there was no restricted visiting times for patients.

However,

- The ward environment was not suitable for the care of patients living with dementia.
- We did not see evidence of any actions taken to ensure all patients underwent a pre-operative assessment, despite operations being cancelled due to the lack of pre-assessment.

Are services well led at this hospital?

We rated well led as requires improvement overall because:

- Senior managers were not aware that regular endoscopy procedures were being carried out at the hospital and also showed limited knowledge of how many or what types of medical patients were admitted to the hospital.
- There was a lack of stability in the management team as the physiotherapy manager post was vacant and several members of senior management were quite new in post.
- Some staff felt the recent changes in leadership of the hospital were unclear.
- Not all staff were positive about their local leadership.
- Staff told us of some instances of bullying behaviour by senior staff towards more junior staff.

However

- There was a clear management and operational structure within the hospital that worked across the two hospital sites.
- Most staff were aware of BMI's corporate strategy aiming to deliver best quality care, best practice, and best outcomes for patients.
- There was a clinical governance structure in place and we saw the senior management team understood the key risks and kept an up to date risk register. The hospital risk register included corporate and clinical risks.
- Staff said they felt supported by their colleagues and there was evidence of good team-working.
- Most staff we spoke with told us they received good support from the senior team, who were very visible and approachable
- Patient satisfaction was monitored and reported on monthly through the patient satisfaction dashboard.
- We saw evidence of actions taken to improve findings from the Patient-led Assessment of the Care Environment (PLACE) audit.
- The senior management team and departmental leads were aware of the risks of the hospital and had plans in place to mitigate and eliminate these risks.
- Monthly meetings were in place for all levels of staff.

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

The provider should:

Surgery

Ensure all clinical areas comply with the requirements of Health Building Notice HBN) 00-09: Infection control in the built environment.

Ensure all cleaning products are stored in locked cupboards as required by the Control of Substances Hazardous to Health Regulations 2002 (COSHH).

Summary of findings

Ensure all staff are clear and consistent on the scoring of NEWS to avoid delays in escalating deteriorating patients.

Medical care

Ensure a system for monitoring the cleaning of the endoscopy department is in place including the cleaning of trolleys.

Ensure the endoscopy room is no longer used for storage.

Ensure that signage is place to encourage hand washing and identify hand gel dispensers.

Ensure controlled drugs are disposed of in a timely way.

Should provide dispensing benches or work surfaces provided for counting or checking items.

Improve the environment in patient's rooms and bathrooms.

Ensure staff completed their mandatory training.

Undertake audits of national early warning score (NEWS) systems to identify deteriorating patients.

Ensure that the resident medical officer RMO's has regular clinical supervision.

Outpatients and diagnostic imaging

Ensure the hospital's target for mandatory training is met.

Improve staffing in radiology for sonographers.

Professor Sir Mike Richards

Chief Inspector of Hospitals

Summary of findings

Contents

Requires improvement

BMI The Kings Oak Hospital

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

Summary of this inspection

Background to BMI The Kings Oak Hospital

BMI The Kings Oak Hospital in Enfield, London is part of BMI Healthcare Limited. The hospital has 42 beds and is located in the grounds of Chase Farm Hospital in Enfield. The hospital provides a range of services including surgical procedures, surgical and medical inpatient care, outpatient consultations and diagnostic imaging. There are two operating theatres, an endoscopy room, 12 outpatient consulting rooms, and a minor procedures room, minor treatment room and phlebotomy room.

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

Our inspection team

Our Inspection team was led by: Inspection Manager David Harris

The team included a CQC Inspection Manager and five inspectors supported by specialist professional advisors including, a consultant surgeon, an infection control nurse, a radiographer, and an outpatients manager.

Why we carried out this inspection

This inspection was part of our scheduled comprehensive inspection programme for independent health hospitals.

How we carried out this inspection

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

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

Before visiting, we reviewed a range of information we held and asked other organisations to share what they knew about the service, such as local clinical commissioning groups (CCG). Patients were invited to contact CQC with their feedback.

We carried out this announced comprehensive inspection between 11 and 13 October 2016, as part of inspections of independent health services. The inspection was conducted using the Care Quality Commission's new methodology. We spoke with members of staff, including nurses, doctors, allied health professionals, managers and support staff. We reviewed patients notes, observed treatment and care, examined facilities and equipment. We also spoke with patients and their families and carers.

Requires improvement

Medical care

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

Information about the service

BMI The Kings Oak Hospital is a private hospital in Enfield. The medical services provided were inpatient and endoscopy. Services are provided to insured, self-paying private patients and NHS patients via referrals from GPs and local contract systems.

There were 5,304 inpatient and day case episodes of care recorded at the hospital in the reporting period July 2015 to June 2016. Of these 3% (1207) were inpatient and 9% (4097) were day case patients.

The hospital provided inpatient and day care services and had a total of 42 beds split across three wards; Hadley ward with 18 beds, Ridgeway ward with 16 beds and 6 beds on the short stay ward which were not in use during our inspection. The inpatient medical service was provided by medical consultants with practising privileges, a resident medical officer (RMO), nurses, health care assistants, a pharmacist, allied health professionals and administrative assistants.

Inpatient and day patient endoscopies were undertaken in the theatre department and beds on the wards were used pre and post procedure for recovery. Procedures undertaken include oesophago-gastro duodenoscopy (OGD), colonoscopy, and flexible sigmoidoscopy.

During our inspection we spoke with 14 members of staff: senior managers, nursing staff (including lead nurses and specialist nurses), allied health professionals, consultant physicians, resident medical officer, a pharmacist, housekeepers, catering staff, health care assistants (HCAs), and ward clerk administrators. We also spoke with a number of patients and relatives on Hadley and Ridgeway ward. We observed interactions between patients and staff.

In addition, we considered the environment and looked at records, including 10 patient records. Before and during our inspection we also reviewed performance information about the service.

Requires improvement

Medical care

Summary of findings

We rated medical care overall as requires improvement because:

- In the endoscopy room we found that there was no established system for monitoring cleaning within the department including the cleaning of trolleys.
- We found that the endoscopy room was used for storage.
- We found that there were no signs to encourage hand washing and hand gel dispensers were not clearly marked.
- The pharmacy was located in the outpatient department, in a converted room which was not a suitable environment for the pharmacy.
- In patient rooms we found that some of the carpets had dirty marks and there was some cosmetic wear on wooden shelving (chips to surface and grubby marks) and there were also grubby marks on the walls, in corners and on skirting boards.
- The disposal of controlled drugs was not being carried out in a timely way to reduce the risks of storing medicines not suitable for use.
- The hospital's target for staff having completed their mandatory training was 90%. Across the hospital 74% of all staff completed their mandatory training. This was below the hospital's target.
- There was no audit of national early warning score (NEWS) systems to identify deteriorating patients which meant the hospital was unable to identify if improvements in practice and outcomes were required.
- It was not clear who was responsible for providing the resident medical officers (RMOs) with clinical supervision.
- The nurses working in the endoscopy room had not been endoscopy trained.
- There was no evidence in patients' notes of discussions about the choices of care and treatment available.
- The ward environment was not suitable for the care of patients living with dementia.
- The hospital risk register did not include all corporate and clinical risks.
- Senior managers did not have oversight of what activity was being carried out in terms of endoscopy procedures and medical care.
- There was no leadership for end of life care and the hospital did not have a named lead consultant of end of life care.

However:

- Incidents and safety matters were discussed and reviewed at the daily 'Comms Cell' and at a range of meetings.
- There was an admission policy setting out agreed criteria for admission to the hospital. All patients were admitted to the medical service under the care of a named consultant.
- The hospital used a combination of professional guidance produced by the National Institute for Health and Care Excellence (NICE) and the Royal Colleges.
- Pharmacy staff received and acted on safety alerts relating to medicinal products and medical devices in a timely manner, and provided us with examples of where this happened.
- The hospital measured patient outcomes via a range of measures which included mortality, transfers out, infection rates, readmission rates, referral to treatment times, patient satisfaction scores, incidents, complaints, staff questionnaires, audits, Friends and Family Test, and mandatory training rates.
- Results from the 'Friends and Family Test' showed people would recommend the medical services provided by the hospital. During our inspection patients and their families who we spoke with were consistently positive about the care they received.
- We saw patients had their needs assessed. Patient records contained a range of risk assessments which were correctly completed and reviewed as required.
- Patients referred by their GP could book a convenient date and time for their appointment through NHS 'choose and book' electronic booking system.

Requires improvement

Medical care

- There was a clear management and operational structure within the hospital that also covered the sister hospital nearby. The ward manager was line managed by the director of clinical services.
- Staff were aware of BMI's corporate strategy aiming to deliver best quality care, best practice, and best outcomes for patients.

Are medical care services safe?

Requires improvement

We rated safe as requires improvement because:

- In the endoscopy room we found that there was no established system for monitoring cleaning within the department including the cleaning of trolleys.
- The endoscopy room was used for storage, increasing the risk of infection.
- There were no signs to encourage hand washing and hand gel dispensers were not clearly marked.
- In the pharmacy there were no dispensing benches or work surfaces provided for counting or checking items which staff described meant there was 'room for error'.
- In patient rooms we found that some of the carpets had dirty marks and there was some cosmetic wear on wooden shelving (chips to surface and grubby marks) and there were also grubby marks on the walls, in corners and on skirting boards.
- The disposal of controlled drugs was not carried out in a timely way to reduce the risks of storing medicines not suitable for use.
- The hospital's target for staff having completed their mandatory training was 90%. Across the hospital 74% of all staff completed their mandatory training. This was below the hospital's target.

However:

- Incidents and safety matters were discussed and reviewed at the daily 'Comms Cell' and at a range of meetings.
- The RMO provided medical cover 24 hours a day, seven days a week. This meant concerns regarding a patient could be escalated at any time of the day.
- There was an admission policy setting out agreed criteria for admission to the hospital. All patients were admitted to the medical service under the care of a named consultant.

Incidents

- There were no never events reported in the reporting period July 2015 to June 2016. Never events are serious incidents that are wholly preventable as guidance or

safety recommendations that provide strong systemic protective barriers are available at a national level and should have been implemented by all healthcare providers.
- The hospital reported five patient deaths for the reporting period July 2015 to June 2016 of which there were no unexpected deaths.
- There were 246 clinical incidents reported across the hospital between April 2015 and March 2016.
- No incidents were reported as leading to "severe" harm in the reporting period July 2015 to June 2016.
- The hospital reported that 220 (89%) of the 246 clinical incidents for the same period occurred in surgery or inpatients. It was not possible to identify any inpatient incidents for medical patients in the data provided. 231 (93.9%) were classed as either no harm or low harm. This meant that the incident resulted in low or no harm to the patient.
- Between July 2015 to June 2016 the hospital reported 35 non-clinical incidents were reported across the hospital; 37% (13) of non-clinical incidents were reported by surgery or inpatients via the hospital's incident reporting system.
- The hospital used a paper based document for reporting incidents. All completed incident forms were entered onto a database by quality and risk department staff. Where an investigation was required this was led by the appropriate head of department with 20 days to complete and return the investigation form.
- An incident policy (including serious incidents) was available on the hospital intranet site and staff knew how to access it. Staff members we spoke with told us the reporting of incidents had improved recently, they told us what the process was and gave us examples of incidents that were discussed during team meetings.
- Incidents and safety matters were discussed and reviewed at the daily 'Comms Cell' and at a range of meetings. These included clinical governance, medicines management, the medical advisory committee (MAC).

Duty of Candour

- From November 2014, NHS providers were required to comply with the duty of candour regulation 20 of the Care Quality Commission (Registration) Regulations 2014. The duty of candour is a regulatory duty that rates openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain notifiable safety incidents and provide reasonable support to that person.
- Staff were aware of their responsibilities under duty of candour, which ensured patients and/or their relatives were informed of incidents that affected their care and treatment and they were given an apology.

Safety thermometer

- The hospital used the NHS Safety Thermometer, a national improvement tool for measuring, monitoring and analysing harm. It measured the proportion of patients that experienced 'harm free' days from pressure ulcers, falls, urinary tract infections in patients with a catheter and venous thromboembolism.
- Patients had venous thromboembolism (VTE) assessments completed on admission. VTE assessment audits were undertaken between January 2016 and June 2016 demonstrated that between 93% and 100% of patients had an assessment on admission.
- We saw safety thermometer data displayed in hospital areas which showed information about incidents and patient satisfaction.
- Nursing and pharmacy staff had participated in the 'Safetember' initiative which was a safety awareness campaign in September. This included a falls awareness project.

Cleanliness, infection control and hygiene

- We looked at the results of the patient led assessments of the care environment (PLACE) for the period February to June 2016. The hospital scored 96% for cleanliness. This was below the England average of 98%.
- All the patient rooms we visited were visibly clean. We observed support staff cleaning throughout the day and undertaking this in a methodical and unobtrusive way. Rooms had daily cleaning schedules in place, which staff would tick to indicate when specific areas were cleaned. We saw the daily cleaning schedules were generally up to date and signed. We saw that carpets had been replaced with vinyl flooring in one corridor and six patients' rooms. Staff told us that the replacement programme had started three years ago. The remaining 28 rooms and corridors on Hadley ward and Ridgeway ward had carpet flooring we were advised that since late 2015 there had been plans for their replacement.

- In the endoscopy room we found that there had been no established system for monitoring cleaning within the department. For example we found there was no cleaning checklist in place since the beginning of June 2016. The manager informed us there was not a problem with cleaning but identified that lack of a system for monitoring the cleaning was an issue. They advised they would report an incident if areas were visibly unclean.
- Scopes for decontamination were transported to another BMI hospital close to BMI The Kings Oak with appropriate decontamination facilities. The theatre manager informed us that endoscopy scopes were delivered in a clean trolley and dirty scopes were sent back in the same trolley; however staff were unable to confirm if the trolley was also cleaned.
- The pharmacy department was visibly clean; however there was insufficient storage space. There was no designated area for the reception and unpacking of pharmaceutical supplies, or a segregated holding area for waste disposal.
- Pharmacy staff we spoke with were unable to confirm when the carpet or chairs were last steam cleaned, and told us they felt this meant there was a risk of cross infection. Following our visit we brought this to the attention of the chief pharmacist who told us that the carpets had since been removed.
- Staff told us that the housekeeping staff cleaned the floors daily and that the pharmacy staff were responsible for cleaning the shelving where medicines were stored. We asked to see the cleaning schedules and check lists for the department, and were told none were available.
- There were dedicated clinical hand-washing facilities in the anteroom of the pharmacy. However, the taps were not lever or sensor operated meaning they were not easy to operate without contaminating hands. We saw a risk assessment completed by the hospital in August 2016 which assessed this issue and recommended that the pharmacy should be relocated to an appropriate clinical room.
- Hand hygiene audits were undertaken between February 2016 and May 2016. These demonstrated that on Hadley and Ridgeway ward doctors, nurses, health care assistants and other health professionals scored 100%. The audit also checked if staff adhered to the “bare below the elbows” hospital policy in clinical areas; staff were 100% compliant. However we observed consultants in ward reception area and nurses' station with sleeves rolled down below the elbows and watches on.
- Adequate supplies of personal protective equipment (PPE) were available. However we found that there were no signs to encourage hand washing and hand gel dispensers were not clearly marked. Some of the hand washing gel containers were either empty or had little gel. Which meant that staff did not always have easy access to hand sanitising gel to use when delivering care. We did not observe any staff using the alcohol gel dispensers to clean their hands.
- Between July 2015 and June 2016 there were no hospital acquired cases of Meticillin-resistant Staphylococcus aureus (MRSA), Meticillin-sensitive Staphylococcus aureus (MSSA), Clostridium difficile (C. difficile) and E.coli. We saw that routine screening for MRSA and C. difficile was undertaken pre-admission.
- We observed green ‘I am clean’ labels were in use to indicate when equipment was cleaned. For example patient commodes and seat risers had green labels to indicate that they were clean and ready for use.
- We observed sharps management complied with Health and Safety (Sharp Instruments in Healthcare) Regulations 2013. We saw sharps containers were used appropriately and they were dated and signed when brought into use.
- We saw that the hospital had regular infection control committee meetings attended by senior management and that there were standard agenda items and action points were identified and reviewed.
- Staff we spoke with told us that the environmental risks had been recorded on the hospital risk register. We saw the risk register contained risks associated with facilities, carpets and handwashing facilities throughout the hospital.
- The hospital infection control lead nurse provided support, advice and training to staff. The ward also had a designated lead for infection control that was responsible for the infection control audits.
- Infection prevention and control awareness formed part of the mandatory training programme for staff that did not have physical contact with patients. The hospitals target was 90% of staff having completed the training. Across the hospital only 77% of staff competed the training. This was below the hospital's target.

- Infection prevention and control in healthcare formed part of the mandatory training programme for staff that entered patient's bedrooms. The hospitals target was 90% of staff having completed the training. Across the hospital only 58% of staff competed the training. This was below the hospital's target.

Environment and equipment

- We found that the endoscopy room was used for storage; we observed staff moving equipment from the room into the corridor prior to an endoscopy procedure.
- In the pharmacy there were no dispensing benches or work surfaces provided for counting or checking items which staff described meant there was 'room for error'. Following our visit we brought this to the attention of the BMI Chief Pharmacist, who told us that interim arrangements had been put in place to provide work benches until permanent work benches could be fitted. However we saw that items were counted, checked and documented, and that computers for recording supplies were provided and records maintained in a timely manner.
- The larger room that stored medicines was also used as an office for pharmacy staff to attend to administrative matters. It was carpeted throughout and had fabric chairs that were not wipeable. The floor in the larger room was used as a storage area for non-clinical items such as stationery, which made cleaning difficult. All the medicines storage was raised above the floor level or in a cupboard.
- The risk of unauthorised access to the pharmacy was identified and recorded on the hospital risk register in January 2016. Corrective measures had since been put in place to ensure that the pharmacy met the access and security best practice guidance: Department of Health Health Building Note 14-01: Pharmacy and radiopharmacy facilities. This included installing a steel door, security locks and alarms.
- We observed the corridors on Hadley ward and Ridgeway ward was generally kept clear of equipment.
- In patient rooms we found that some of the carpets had dirty marks and there was some cosmetic wear on wooden shelving (chips to surface and grubby marks) and there were also grubby marks on the walls, in corners and on skirting boards. We saw that one room was being used for storage with medical equipment with a label stating that it was 'out of use', this was dated July 2016. There was also a TV and games console awaiting disposal. Staff advised the carpet was due to be replaced with vinyl since late 2015.
- On the short stay unit we saw that rooms had 'out of use' signs on doors but there was some disagreement between staff about whether or not they were in use as outpatient rooms. In one room we saw there was a desk with computer and physio assessment bed and curtain, in another a computer with some medical equipment and furniture. There was a sign on window says "please do not remove this curtain; this room is being used as a visual field test room". The other rooms appeared to be used for storage and one looked as though it was used as a staff bedroom.
- Resuscitation equipment was stored on a resuscitation trolley, readily available and located in a central position. The equipment was checked daily, fully stocked and ready for use.
- We saw that Electrical Medical Equipment (EME) had a registration label affixed and was maintained and serviced in accordance with manufacturer's recommendations. We also saw safety check labels were attached to electrical systems showing they were inspected and were safe to use.
- Patient led assessments of the care environment (PLACE) 2016 showed that the hospital scored 87% for condition, appearance and maintenance. This was below the England average of 93%
- Health, safety and the environment was part of the statutory training programme, which all staff were required to attend. The hospital's target was 90% of staff having completed the training. Across the hospital 89% staff completed the training.

Medicines

- All clinical staff we spoke with were clear about the arrangements in place for safely managing medicines, including controlled drugs (CDs). CDs are medicines which require additional security. The arrangements were set out in policies and procedures for ordering, recording, storing, dispensing, administering and disposing of medicines.
- An on-site pharmacy service was provided for hospital inpatients and outpatients between 8am and 5pm Monday to Friday. The pharmacy was located in the outpatient department, in a converted room which was not a suitable environment for the pharmacy.

Requires improvement

Medical care

- The service was provided by three whole time equivalent pharmacists, and 2.6 whole time equivalent pharmacy technicians / assistants who worked between the two BMI hospital sites in Enfield.
- Access to the pharmacy during opening hours was by designated pharmacy staff only. There were specific procedures for other named staff to gain emergency access to the pharmacy out of hours, with the resident medical officer (RMO) and senior nurse holding separate keys meaning that single access was not possible.
- Controlled drugs (CDs) were stored in lockable wall units and were checked on at least a daily basis by registered nurses or pharmacists. The CD registers and order books were completed in line with local procedures. A new accountable officer for controlled drugs was appointed in October 2016. Managers told us that BMI required an audit of the controlled drugs should be carried out every three months. We saw that a controlled drugs audits had been completed in April 2016, however further audits had not been completed, and were told that these had not taken place due to management changes. The Chief Pharmacist confirmed the audits had not taken place. However, in June 2016 the hospital had successfully renewed its home office license to supply and possess controlled drugs.
- The controlled drugs cupboard in pharmacy was cramped which meant it was difficult to clearly identify stock. We were told this was due to an ordering error which meant too much stock was held. The disposal of controlled drugs must be carried out by a witness authorised by the controlled drug accountable officer (CDAO). The CDAO should be aware of medicines requiring destruction. We saw no evidence this had happened and brought this to the attention of the CDAO.
- We saw nine items (bags) of controlled drugs clearly labelled for destruction in the CD cupboard in pharmacy. Two items had been there since April 2016 and the most recent of the nine items were identified for destruction in September 2016. The disposal of controlled drugs should be carried out in a timely way to reduce the risks of storing medicines not suitable for use.
- We raised concerns about the untimely destruction of CDs and the pharmacy facilities with the senior management team, the accountable officer for controlled drugs and the BMI Chief Pharmacist. Following our visit the Chief Pharmacist who told us that controlled drugs would no longer be stored in the pharmacy at BMI King's Oak.
- The pharmacy manager had access to specialist advice from the chief pharmacists within the BMI organisation. Staff we spoke with were consistently positive about the pharmacy information and service provided.
- Patients had access to medicines when they needed them. Medicines were supplied to the hospital pharmacy through a centrally managed contract with the BMI procurement department. There was a top-up service for replenishing medicines stock items in all clinical areas and for other medicines issued on an individual basis.
- Staff told us that other pharmacy managers from within the BMI organisation would occasionally visit the hospital to peer review the pharmacy arrangements. However staff could not recall when this last happened and were unable to provide any documentary evidence of such a visit. Individual prescriptions were monitored by pharmacists on a regular basis, who recorded their observations in patient records, and advised staff in the safe administration of medicines.
- All medicines including medical gases were administered only where prescribed by a doctor. Prescriptions were paper and prescription stationery was stored and issued safely using a prescription identifier number for security purposes.
- Emergency medicines used for the treatment of anaphylaxis or cardiopulmonary resuscitation were clearly labelled, available for use, and regularly checked.
- There was an up to date antibiotic protocol which included first and second choice medicines to use, the dosage, and duration of treatment. However, the planned audit to monitor antimicrobial stewardship had not taken place in March 2016 and we saw no evidence that this had been completed since.
- We looked at a random sample of medicines stock in the pharmacy department and treatment areas, and related records, and saw that these had been reconciled correctly.
- Where medicines required cool storage, ambient temperature checks of the storage areas including cupboards and refrigerator temperature checks were carried out and recorded, and were all within the required range. Staff were aware of the process to follow if the temperature should fall out of the safe range.

- On the wards controlled drugs (CDs) were stored in lockable wall units and were checked on at least a daily basis by registered nurses or pharmacists. The CD registers and order books were completed in line with local procedures. Managers told us that BMI required an audit of the controlled drugs should be carried out every three months. We saw that a CD audit had been completed in April 2016 on the wards however we were told that these had not taken place since due to management changes. However, in June 2016 the hospital had successfully renewed its home office licence to supply and possess controlled drugs. For patients being discharged, tablets to take away (TTA) were delivered to the patient. If patients were given medicines as a TTA, they were given specific advice on how the medicines should be stored and handled.

Records

- We reviewed 10 sets of patient records and saw patients care plans included all identified care needs and were completed. Patient records contained a range of risk assessments including pressure ulcer, venous thromboembolism (VTE) checks, nutritional and falls risk assessments which were completed and reviewed as required. Patients' allergies were also recorded in patient records and the medicines administration records.
- The hospital undertook monthly audits of patients' health records, these included monitoring completion of clinical risk assessments for VTE, pressure areas, moving and handling, bed rails, and falls and that all entries by nursing staff and consultants were signed and dated. The audits undertaken between January and July 2016 demonstrated that patient health record compliance was between 88% and 96%.
- Patients' medical notes (hard copies) were stored in lockable cabinets in the nurses' station.
- We observed that when patients had an endoscopy that safety checks undertaken using the World Health Organisation (WHO) 'Five Steps to Safer Surgery'. A copy of the WHO checklist was held within the patient's notes.
- Once records were no longer required after the patient was discharged, they were stored on site in a secure records office prior to being archived.
- A clerk was employed to ensure patient records were available as required, for example to ensure files were available on site for clinic appointments or following a patient re admission.
- Staff were able to access records out of hours and at weekends.
- Information Governance was part of the mandatory training programme which all staff were required to attend. The hospital's target was 90% of staff having completed the training. Across the hospital 89% staff completed the training. This was below the hospital target.

Safeguarding

- The hospital had no reported safeguarding alerts in the reporting period July 2015 to June 2016.
- Staff had access to the hospital's safeguarding policies for children and adults via the hospital intranet and knew the relevant safeguarding leads.
- Staff were able to identify the potential signs of abuse and the process for raising concerns.
- Safeguarding information and contact numbers were displayed as a reminder and easy access for staff on the wards.
- Safeguarding adults and children was part of the mandatory training programme for staff and different levels of training were provided according to the job role. Nursing staff we spoke with on the ward told us they attended safeguarding training. Data provided by the hospital showed that 88% of staff across the hospital completed safeguarding adults level one and two, and that 89% of staff had completed training safeguarding children level one and 81% had completed level 2. The target for training was 90%.
- Safeguarding Adults and Children level three training is part of the mandatory programme for identified staff. 100% of staff had completed safeguarding children level three, however, no staff had completed safeguarding adult's level three.

Mandatory training

- Staff and managers at BMI The Kings Oak followed the BMI healthcare mandatory training matrix requirements. All staff, dependent on their role, had a role specific mandatory training. For example, information security, fire safety and moving and handling was applicable to all staff whereas for example blood transfusion training for health care assistants (HCAs) and porters undertook

different training to phlebotomists. Most training was done by e-learning, in some cases followed by workshops and assessments. Staff completed their training during their work time and most staff we spoke with said they were up to date with their training requirements.

- In addition to e-learning, face-to-face mandatory training was provided in house for example, infection control, moving and handling, safeguarding and fire safety.
- The mandatory training programme included display screen equipment, information governance, documentation and legal aspects, safety, health and the environment, control of substances hazardous to health, equality and diversity, fire safety, moving and handling, adult basic life support, infection prevention and control, safeguarding children level one and two, safeguarding adults level one, dementia awareness, waste management for the disposal of healthcare waste.
- The ward manager demonstrated the system they used locally to monitor their staff attendance at mandatory training to ensure it was completed or refreshed.
- Consultants and clinicians with practising privileges were not required to complete training via the hospital system but assurance of mandatory training was checked by the medical advisory committee.
- The resident medical officers (RMOs) received mandatory training via their RMO agency and had access to the hospital's on-line training systems. The resident medical officers (RMOs) received advanced life support (ALS) and paediatric advanced life support training via the RMO agency.
- The hospitals target for staff having completed their mandatory training was 90%. On the ward 90.9% of staff had completed their mandatory training, however across the hospital 74% of all staff completed their mandatory training. This was below the hospitals target.

Assessing and responding to patient risk

- There was an admission policy setting out agreed criteria for admission to the hospital. All patients were admitted to the medical service under the care of a named consultant.
- We saw evidence in the 10 records we looked at of risk assessments such as skin viability, nutrition and falls being completed. For patients at risk of falling there was a variety of equipment available to mitigate the risk such as mats and 'high/low' beds.
- The hospital used the national early warning score (NEWS) charts for tracking patients' clinical conditions and alerting the clinical team to any deterioration that would trigger timely clinical response. We saw NEWS was completed on all the records we reviewed.
- Staff we spoke with were clear about the processes to follow if a patient deteriorated. Staff and managers told us if the complications were more serious, patients were moved out of the hospital to a neighboring NHS facility by emergency ambulance. However, there was no formal service level agreement between the hospital and any NHS trust although most patients that required transfers were transferred to the local NHS hospital. There were six unplanned transfers of patients from inpatient services to the NHS between July 2015 and June 2016.
- The RMO provided medical cover 24 hours a day, seven days a week. This meant concerns regarding a patient could be escalated at any time of the day. The RMO could contact the relevant consultant as they were required to be available at any time of day when they had patients admitted to the hospital and we were told that staff were able to do so.
- The practicing privileges agreement for each doctor ensured there was 24 hour clinical support from the named consultant when they had patients in the hospital. This included making alternative arrangements for a named consultant to attend to patients in an emergency if they were not available. There was always a resident medical officer (RMO) on site who completed advanced life support training, who was able to provide first line emergency treatment.
- Out of hours patients were able phone the inpatient ward nurses for advice

Nursing staffing

- A senior nurse was in charge as a contact point for staff, consultants and patients 24 hours a day, seven days a week.
- The BMI Healthcare nursing staffing planner tool to determine staffing levels was used, this factored in patient numbers, dependency of patients, skill mix and staff training. For example, a patient undergoing general

anaesthesia was allocated three hours of nursing time and a patient undergoing sedation was allocated two hours. The tool allowed for plus or minus five hours nursing time. The normal staff to patient ratio was 1:6. The ward sister prepared the staff roster two weeks in advance and it was reviewed on a daily basis. Staff we spoke with said there was sufficient staff and the ward sister felt the tool was flexible enough to ensure there was always sufficient staff to meet patients.

- The established staffing levels for qualified nurses was seven whole time equivalents (WTE) and 10 WTE for health care assistance (HCA), However most nursing staff and HCAs worked between the BMI The Kings Oak and another BMI hospital. Staffing levels were monitored daily with a minimum staffing level of two registered nurses within the hospital at all times. Between July 2015 and June 2016 the hospital used an average of 4.3% bank and agency nurses and an average of 16.5% bank and agency HCAs.
- The numbers of staff planned and actually on duty were displayed at ward entrance in line with guidance contained in the Department of Health Document 'Hard Choices'. On the wards we visited we observed staffing levels were in line with planned staffing levels during the day (three qualified nurses plus one HCA) and night (two qualified nurses plus one HCA). Nurses were allocated to patient rooms, during our inspection there were three inpatients and between six and 10 day cases. Nursing staff also had assistance from health care assistants (HCAs). The ward manager was supernumerary to the agreed staffing levels so that if required, they could support ward staff if patient acuity or occupancy increased.
- We observed one handover from night to day staff and found the handover detailed and robust. Staff printed handover notes, which they updated during the handover. All the patients were discussed and actions outstanding for patients were allocated. Staff were allocated to patients who then introduced themselves to the patient.

Medical staffing

- The hospital had 169 doctors with practicing privileges for more than six months. Between July 2015 and June 2016 the number of episodes of care carried out by doctors with practicing privileges were 11% (19) of doctors carried out 100 or more episodes of care, 25% (42) of doctors carried out between 10 and 99 episodes of care, 28% (47) of doctors carried between 1 and 9 episodes of care, 36% (61) of doctors undertook no episodes of care.
- A requirement for all consultants within the BMI practising privileges policy was that they remained available (both by phone and, if required, in person), or arranged appropriate named cover at all times when they had inpatients in the hospital. Part of the consultant's practicing privileges agreement was that they should be located within 30 minutes travel time of the hospital. Since most of the consultants with practising privileges were also employed by neighbouring NHS trusts, staff told us it was easy to contact them when needed.
- The hospital did not have a named palliative care consultant, however, consultants were able to access palliative care consultants at a nearby NHS trust and at a nearby hospice. Only five patients were admitted for palliative care in the 12 months prior to our inspection.
- The day to day medical service was provided by a resident medical officer (RMO) who dealt with any routine and also emergency situations in consultation with the relevant consultant. Out of hours, consultants provided either telephone advice or attended in person.
- The RMO provided a 24 hour 7 day a week service on a two week rotational basis. All RMOs were selected specifically to enable them to manage a varied patient caseload and particular requirements. The hospital had two inpatient RMOs who rotated for at least six months to ensure continuity of care. The RMOs are provided under contract with an external agency that provided training and support.

Major incident awareness and training

- The hospital had a contingency plan in place for staff to use in the event of interruption to essential services. Staff were aware of the escalation process if there was an incident requiring a major response.
- There was a member of the senior management team on duty each day that was responsible operationally for any major incident affecting the hospital. Out of hours there was an on call rota and staff were aware of whom to contact in case of a major incident.

Requires improvement

Medical care

- Fire training was part of the mandatory training programme for some staff to attend, 57% had completed the training. This was below the hospital's target of 90%.

Are medical care services effective?

Requires improvement

We rated effective as requires improvement because:

- The nurses working in the endoscopy room had not been endoscopy trained.
- There was no audit of national early warning score (NEWS) systems to identify deteriorating patients which meant the hospital was unable to identify if improvements in practice and outcomes were required.
- It was not clear who was responsible for providing the resident medical officers (RMOs) with clinical supervision.

However:

- The hospital used a combination of professional guidance produced by the National Institute for Health and Care Excellence (NICE) and the Royal Colleges.
- Pharmacy staff received and acted on safety alerts relating to medicinal products and medical devices in a timely manner, and provided us with examples of where this happened.
- The hospital measured patient outcomes via a range of measures which included mortality, transfers out, infection rates, readmission rates, referral to treatment times, patient satisfaction scores, incidents, complaints, staff questionnaires, audits, Friends and Family Tests, and mandatory training rates.
- We saw that multidisciplinary team (MDT) working was evident in patients' records.

Evidence-based care and treatment

- The hospital used a combination of professional guidance produced by the National Institute for Health and Care Excellence (NICE) and the Royal Colleges. For example, the ward provided care in line with NICE Guideline - CG50 - that covers recognising and responding to deteriorating patients for example.
- The inpatient medical services assessed patients by using the National Early Warning Score (NEWS). The audit calendar did not include an audit of national early warning score (NEWS) systems to identify deteriorating patients. This meant that compliance with evidence based practice and patient outcomes in this area were not measured which meant the hospital was unable to identify if improvements in practice and outcomes were required.
- Clinical policies and procedures were available on the hospital intranet and staff were aware of how to access them.
- The hospital had in place a standard operating procedure for the care of the dying which was issued in June 2016 and was due to be reviewed in September 2019. It incorporated NICE guidelines (2015) Care of the Dying.
- The hospital had an end of life pathway for patients. The personalised end of life care plan guided staff delivery of the priorities of care for patients recognised to be in their last few days or hours of life.
- Pharmacy staff received and acted on safety alerts relating to medicinal products and medical devices in a timely manner, and provided us with examples of where this happened.
- The hospital had an audit calendar which set out the audits to be undertaken across the hospital over the 12 month period for 2016. The audits included for patient health records, hand hygiene, VTE and hand hygiene, controlled drugs and medicines management.

Pain relief

- Patients' pain was recorded on the National Early Warning Scores (NEWS) chart. The NEWS chart is a standardised chart for assessing and responding to acute illness.
- We heard from a patient that pain management was good, and that staff asked about their pain on a regular basis.
- Pain relief was audited via patient satisfaction surveys to monitor the way that staff assessed and explained pain to patients and the pain relief that was then offered.

Nutrition and hydration

- Catering services were outsourced and there had been a change to another private provider. The Patient-led assessments of the care environment (PLACE) for the

period February to June 2015 showed that some food measures scored 89%.This was worse than the national average of 91%. However, ward food scored 96%, which was better than the national average of 92%.

- Patients' nutritional needs were assessed using the Malnutrition Universal Screening Tool (MUST) as recommended by the British Association for Parenteral and Enteral Nutrition. We saw the patients' nutrition and hydration needs were assessed and met. We observed patients always had drinks available within reach.
- Catering staff and HCAs informed nurses if a patient did not eat their meal or if their food and drink intake was low.
- There were three medical patients on the ward during the inspection. They told us that the food was of a good quality and nutritious. They were well provided with hot and cold drinks during their admission. A patient told us they were "Very happy with food, there is a good choice and it is hot when it arrives".

Patient outcomes

- The hospital measured patient outcomes via a range of measures which included mortality, transfers out, infection rates, readmission rates, referral to treatment times, patient satisfaction scores, incidents, complaints, staff questionnaires, audits, Friends and Family Tests, and mandatory training rates.
- Between October 2015 and October 2016 a total of 379 endoscopies were undertaken, of which 78.1% (296) were cystoscopies. The endoscopy service was not JAG accredited. The BMI strategy was to achieve JAG accreditation for all endoscopy services, however during our inspection we were advised that the hospital was proposing to cease providing endoscopy services at the BMI The Kings Oak and move them to their sister hospital.
- Between June 2015 and July 2016 there were four unplanned re-admission of medical inpatients within 28 days. The number of unplanned re-admissions was not high when compared to other independent acute hospitals.
- Between June 2015 and July 2016 there were six unplanned transfers to acute NHS hospitals. The number of unplanned transfers was not high when compared to other independent acute hospitals.
- Between April 2015 and March 2016 five deaths were reported, none were recorded as unexpected. The hospital reported five patient deaths for the reporting period July 2015 to June 2016 of which there were no unexpected deaths in medicine

Competent staff

- Throughout our inspection we observed staff were professional and competent in their interactions with colleagues, patients and their relatives/carers.
- The nurses working in the endoscopy room had not been endoscopy trained. The theatre manager advised all the nursing staff were very experienced.
- Staff told us they participated in the appraisals process and they had access to regular training updates. BMI The Kings Oak appraisal year runs from October to September. On the Ridgeway and Hadley wards 89% of nursing staff and 95% of health care assistants had an appraisal.
- Nurses told us there were opportunities for learning and development. Staff completed their e-learning whilst on duty and were not expected to complete their training in their own time or to come into work on their day off to complete.
- Agency nurses underwent hospital orientation and induction. The use of bank and agency staff between July 2015 and June 2016 was between 3% and 6% each month. This was lower than the average rate for independent hospitals. Senior staff told us they always tried to book the same staff that were familiar with the hospital.
- The rate of bank and agency health care assistants was higher than the average when compared with other independent hospitals for the period June 2015 and June 2016. Between September 2015 and June 2016 the use of agency staff was higher than 10%; however between 20% and 25% agency staff were used in November and December 2015, and February, April, May and June 2016.
- Nursing staff told us they felt supported by the consultants while they were on site and if they needed to contact them out of hours.
- The RMO told us they were able to access consultants if they needed advice and the agency that employed them undertook regular appraisals. However it was not clear who was responsible for providing the RMOs with clinical supervision.

- All consultants working with the hospital had practising privileges which required consultants to have an up to date General Medical Council (GMC) registration, evidence of indemnity insurance and revalidation certificate. These were reviewed and highlighted at Medical Advisory Committee (MAC) meetings.

Multidisciplinary working

- We observed there was effective team working, between all staff groups. This was facilitated by a daily morning 'huddle' meeting, where a representative of each department was present. We observed one meeting which enabled staff to communicate their team's priorities and issues with other departments and share workload if necessary.
- Formal heads of departments meetings took place monthly, where department issues and priorities were raised. Such as audit progress and health and safety matters.
- The resident medical officer (RMO) attended the ward staff handover each evening.
- Consultants and nursing staff that we spoke with all described good working relationships with other hospital services. The nursing staff also worked across site at another BMI hospital.
- In patients records were saw that multidisciplinary team (MDT) working was evident. For example physiotherapists were based on the wards and the hospital had access to a dietician on a practising privileges basis.
- There was pharmacist support on the ward and they provided information to patients on their medications.

Seven-day services

- The arrangements to provide medical and clinical care 24 hours a day, seven days per week was a combination of on-site and on-call arrangements. Two RMOs provided cover on a fortnightly rotational basis. All RMOs received advanced life support training and access to named consultants.
- The RMOs were selected specifically to enable them to manage a varied patient caseload of medical and surgical patients. The management of the RMOs was through liaison with the agency that employed them.
- The hospital had a policy which required all consultants to remain available (both by phone and, if required, in person), and formally arrange appropriate named cover if they were unavailable, at all times when they had inpatients in the hospital.
- There was no pharmacy cover available out of hours or on a Saturday or Sunday. The pharmacy was assessible by the resident medical officer (RMO) and senior nurse when the pharmacy team were not on site.
- Senior managers had an on call rota to cover the hospital.
- A senior nurse in charge was available as a contact point for staff, consultants and patients and was available via bleep or telephone.

Access to information

- Daily 'comm cell' meetings took place where relevant information on matters such as staff numbers, overnight stays, exceptions, and health and safety were communicated with ward staff and senior managers. Staff spoke positively about its purpose and outcomes.
- To ensure continuity of care, staff working on the ward had detailed handover sheets which they could refer to.
- Staff had access to an online learning management system and hospital policies and protocols via the hospital's intranet.
- On the wards there were a variety of information leaflets available.
- Patients' medical notes stayed on the ward until post discharge checks were completed. Once completed, records were archived on-site. If clinical staff needed to access medical records administrative staff could retrieve them.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Mental Capacity Act 2005 (MCA) and Deprivation of Liberties Safeguards (DoLS) training was not part of the mandatory training programme.
- Staff told us formal written consent is taken by the consultant involved when the patient is admitted for the procedure.
- Patients told us staff asked their permission before care or treatment was given and medical staff explained their treatment.
- Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) decision making was set out by a corporate resuscitation policy. Decisions about DNACPR were

communicated during staff handover. We found an example of the DNACPR that was completed in accordance with national guidelines. There was documentation in the patients' medical notes and a record on the DNRCPR of the discussion with the patient's family and reasons why resuscitation would not be successful. The consultant recorded their GMC number on the DNACPR and on the patient's record.
- The personal end of life care plan care documented a patient's DNAR status and whether this had been discussed with the patient and or next of kin.

Are medical care services caring?

Good

We rated caring as good because:

- Results from the 'Friends and Family Test' showed people would recommend the medical services provided by the hospital.
- During our inspection we spoke with patients and their families who were consistently positive about the care they received.
- The privacy and dignity of patients was maintained with the use of closed doors and windows and signs on doors to indicate personal care taking place within.
- Patients felt that they were given relevant information about their diagnosis and treatment and that they were helped to make informed decisions about their care.
- We observed that patients and their families were treated with kindness, dignity and respect.

However:

- There was no evidence in patients' notes of discussions about the choices of care and treatment available.

Compassionate care

- Hospital wide Friends and Family Test (FFT) scores were high. Between January and June 2016 the results were 98-100% with an average response rate of 48% which is above the NHS England average.
- During our inspection we spoke with patients and their families who were consistently positive about the care they received. Patients reported that staff were polite and attentive and families who visited them felt welcomed. We observed clinical and housekeeping staff introduced themselves to patients and patients were treated with kindness and respect.
- The privacy and dignity of patients was maintained with the use of closed doors and windows and signs on doors to indicate personal care taking place within.
- We observed a receptionist arranging for a discharged patient whose family was delayed in collecting them to wait comfortably at the hospital and stay for lunch.
- Patients informed us that staff were attentive and helpful and we observed call bells being answered quickly. Patients were encouraged to tell staff if they required any assistance or pain relief and we saw this being done.
- Relatives visiting patients on Ridgeway ward reported feeling welcomed to the ward and not pressured to leave when visiting hours were over. They felt that staff kept them involved and informed about their relative's care and they had confidence that their relatives were cared for well.
- We saw thank you cards on the notice board in the day room thanking staff for their kindness.

Understanding and involvement of patients and those close to them

- All patients had named consultants which were written on the doors of their rooms. Patients had a good understanding of their care and treatment and many had good relationships with their consultants, having been to them for a number of years.
- Patients felt that they were given relevant information about their diagnosis and treatment and that they were helped to make informed decisions about their care.
- Beyond consent forms, there was no evidence in patients' notes of discussions about the choices of care and treatment available; however patients told us that consultants did discuss a range of treatment options with them.
- Patients we spoke with knew what to do if they felt unwell after they were discharged from the hospital and all patients received a call from a nurse two days after they left to check how they were and provide advice.
- Patients felt that conversations about finances were handled sensitively. We heard from patients and staff that NHS and non NHS patients were not treated differently in any way.

Requires improvement

Medical care

Emotional support

- Staff described compassionate and reassuring ways of giving patients news about their health, for instance taking them into the day room and considering what appropriate specialist staff could also attend and provide support.
- We observed that patients and their families were treated with kindness, dignity and respect. We also heard from every patient we spoke with that this was the standard of care.
- We observed a member of staff offering reassurance to a patient who was concerned about when they would be collected by their family after discharge and arranging for the patient to stay for lunch while they waited.
- We heard examples from patients and staff about how treatment was adapted to maximise the independence of patients. For instance patients were helped to take their own medication.

Are medical care services responsive?

Good

We rated responsive as good because:

- We saw patients had their needs assessed. Patient records contained a range of risk assessments which were correctly completed and reviewed as required.
- Patients had single rooms that provided privacy and comfort with en suite facilities and there was no restricted visiting times for patients.
- Patients told us they saw their consultant at least daily, and the nursing staff were always in attendance to check on their condition.
- Patients referred by their GP could book a convenient date and time for their appointment through NHS 'choose and book' electronic booking system.
- All patients were admitted under the care of a named consultant. The consultants reviewed patients prior to commencement of each treatment and provided a 24 hour on call service as and when required.
- The handling of complaints was monitored to ensure that complaints were dealt within the time frame set out in the BMI complaints policy.

However:

- The ward environment was not suitable for the care of patients living with dementia.

Service planning and delivery to meet the needs of local people

- The endoscopy unit did not have Joint Advisory Group on gastrointestinal endoscopy (JAG) accreditation.
- Inpatient medical care services were provided for both private and NHS patients, there were 5,304 inpatient and day case of which 56% were NHS funded while 44% had another source of funding during July 2015 and June 2016.
- Of the NHS patients 15% of all NHS funded patients and 29% of all other unfunded patients stayed overnight during July 2015 and June 2016.
- The hospital was able to offer an inpatient medical care service and day patient facilities on the Hadley and Ridgeway wards.
- All patients' rooms were single ensuite and there were no restricted visiting times. Relatives were also offered refreshments.

Access and flow

- Between October 2015 and October 2016 a total of 379 endoscopies were undertaken, of which 78.1% (296) were cystoscopies.
- The hospital provided care for some NHS patients undergoing endoscopy. They were referred through NHS e-referral service. Patients referred by their GP could book a convenient date and time for their appointment through NHS 'choose and book' electronic booking system.
- All NHS referral to treatment times (RTT) met the target rate of 90% or better.
- Bed capacity was planned on a weekly basis. The ward manager communicated with the hospital admissions team to manage unscheduled overnight stays. Endoscopy had a planned number of patients due for procedures.
- The hospital had an admissions eligibility policy which ensured suitable patients were admitted to the ward. Consultants told us patients were discussed with their GPs prior to admission to ensure the hospital was the most suitable place for them and they would not admit patients who might need a higher level of care.
- Consultants admitted medical patients by completing a booking form and referring them through the administration team to the appropriate service.

Requires improvement

Medical care

- All patients were admitted under the care of a named consultant. The consultants reviewed patients prior to commencement of each treatment and provided a 24 hour on call service as and when required.
- To take home tablets (TTOs) were available from the pharmacy in a timely way on discharge of a patient.
- Patients told us they saw their consultant at least daily, and the nursing staff were always in attendance to check on their condition.
- Patient who are discharged all receive follow up calls from the nursing team within 48 hours of discharge.

Meeting people's individual needs

- We saw patients had their needs assessed. We reviewed ten sets of patient records and saw their care plans included all identified care needs.
- The ward had open visiting times which meant relatives could visit their loved ones at any time. Staff told us patients families were encouraged to stay to reassure and or assist patients.
- Patients had single rooms that provided privacy and comfort with ensuite facilities. We looked at the results of the patient led assessments of the care environment (PLACE) 2016. The hospital scored 76% for privacy, dignity and wellbeing. This was below the England average of 83%.
- In patients' bedrooms we saw that none of the bathrooms and shower rooms had wheel chair access. We looked at the results of the patient led assessments of the care environment (PLACE) 2016. The hospital scored 75% for disability. This was below the England average of 81%.
- We observed that call bells were answered quickly. Patients told us staff answered bells straight away. The hospital did not audit patient call bell response times.
- In patient rooms the call bells had a designated function for patients to alert catering staff should they need a drink or food between 7am and 8pm. Outside of these hours, patients called a nurse or health care assistant (HCA) to assist with meeting their nutritional needs.
- Patients were offered the choice of cooked or cold meals three times a day, seven days per week. The menus were designed to include a range of special diets and healthy eating options. Patients we spoke with told us they had a choice of food from the menu.
- Dementia awareness was part of the mandatory training programme for staff who worked in a clinical role. Data provided by the hospital showed that 94% of staff across the hospital completed dementia awareness training which was above the hospitals target of 90%.
- The ward environment was not suitable for the care of patients living with dementia. There was no visible signage on toilets; no large clocks displaying the date and time, all the walls on the ward were the same colour. However staff had access to a 'Dementia Box' which had red cups, trays and a dementia flower (blue forget me not) symbol to be used if a patient had dementia. We looked at the results of the patient led assessments of the care environment (PLACE) 2016. The hospital scored 88% dementia. This was above the England average of 80%.
- There was a variety of information leaflets available on the ward though these were only available in English.
- For patients whose first language was not English, staff were able to arrange for interpreters to assist them.
- The hospitals website provided information on the paying for treatment. Patients were able to pay for themselves and fixed price packages were available. Treatment could also be funded through private medical insurance. The hospital also provided services for patient funded through the NHS.

Learning from complaints and concerns

- The hospital executive director oversaw the management of complaints. The handling of complaints was monitored to ensure that complaints were dealt within the time frame set out in the BMI complaints policy. Where there were time extensions in dealing with complaints, the reasons for the extension was recorded. Complaints could be raised in person, by telephone, or in writing.
- Complaints were discussed at the daily comms cell meetings.
- Staff told us they tried to resolve complaints and concerns at the time where ever possible.
- Across the hospital there were 29 complaints raised by patients during the six month period January 2016 to June 2016. We saw evidence that these had been followed up and that learning outcomes had been identified. No complaints had been referred to the Ombudsman or Independent Healthcare Complaints Adjudication Service (ISCAS). There were no consistent trends or themes in the incidents that were reported.

Requires improvement

Medical care

- There was a duty manager at the hospital daily who patients or visitors could speak too if they had any concerns or compliments.
- Information was available on the ward included in the BMI leaflet "please tell me…" to inform patients, relative and visitors on how they could raise any concerns.

Are medical care services well-led?

Requires improvement

We rated well led as requires improvement because:

- The hospital risk register did not include all corporate and clinical risks.
- Senior managers did not have oversight of what activity was being carried out in terms of endoscopy procedures and medical care.
- There was no leadership for end of life care and the hospital did not have a named lead consultant of end of life care

However:

- There was a clear management and operational structure within the hospital that worked across the two hospital sites.
- Staff were aware of BMI's corporate strategy aiming to deliver best quality care, best practice, and best outcomes for patients.
- Medical Advisory Committee (MAC) meetings were held quarterly and attended by consultant representatives and the hospitals executive director.
- All staff we spoke with felt supported by their colleagues. Staff described good team working on the ward.
- Patient satisfaction was monitored and reported on monthly through the patient satisfaction dashboard.

Leadership of Service

- Senior managers were not aware that regular endoscopy procedures were being carried out at the hospital and also showed limited knowledge of how many or what types of medical patients were admitted to the hospital.
- There was no leadership for end of life care and the hospital did not have a named lead consultant of end of life care. However, only five patients were admitted for palliative care in the 12 months prior to our inspection, and the hospital consultants had links to palliative care consultants at a nearby NHS trust.
- There was a clear management and operational structure within the hospital that worked across the two hospital sites. The ward manager was line managed by the director of clinical service.
- Hadley and Ridgeway ward held monthly staff meetings with a standard agenda which for example complaints, incidents, new policies and staff training.
- A cross-site sisters' meeting was held in August 2016, we noted that the head of nursing was not present at this meeting. Staff told us that the head of nursing spent the majority of their time at the other site, the head of nursing advise that only one sister was based on the other site.
- The theatre manager oversaw the endoscopy service.
- Staff told us managers were supportive and approachable, they also felt they had opportunities for personal development and that when they raised concerns they were listen to and their concerns addressed. Staff told us they felt respected and valued.

Vision, strategy innovation and sustainability for this core service

- BMI The Kings Oak was in line with the BMI corporate vision of 'We aspire to deliver the highest quality outcomes, the best patient care and the most convenient choice for our patients and partners as the UK leader in independent healthcare.'
- Senior staff and consultants told us of plans to focus medical services at the sister hospital site nearby; however some staff appeared to have little awareness of these proposals.
- Staff were aware of BMI's corporate strategy aiming to deliver best quality care, best practice, and best outcomes for patients. Staff felt some of the recent changes on the ward contributed to this.
- The six Cs initiative which encouraged staff to embrace the values of Compassion, Competence, Care, Communication, Courage, and Commitment were displayed throughout the hospital.

Governance, risk management and quality measurement for this core service

Requires improvement

Medical care

- The hospital risk register did not include all corporate and clinical risks. The risk of unauthorised access to the pharmacy was identified and recorded on the hospital risk register in January 2016. Corrective measures had since been put in place. The risk register contained risks associated with facilities, carpets and hand washing facilities throughout the hospital these had been added to the risk register in November 2015 and July 2016. The risk register noted that some carpets had been replaced in quarter two. However, we found that the poor environment within the endoscopy unit had not been identified on the risk register.
- The inpatients service was led by a ward manager and they sat on the clinical governance committee. We reviewed the minutes of four meetings and saw there was attendance from the senior management team from across the hospital. Incidents, infection prevention and control, and performance indicators were discussed as part of a standard agenda. Meetings were held monthly.
- Medical Advisory Committee (MAC) meetings were held quarterly and attended by consultant representatives and the hospitals executive director.

Culture within the service

- Between April 2015 and March 2016 staff turnover was below average for nursing and health care assistance. Staff we spoke with were all positive about BMI as an employer.
- Between July 2015 and June 2016 sickness rates for nursing staff and HCAs on the ward was low.
- All staff we spoke with felt supported by their colleagues and said everyone was approachable and friendly. Staff described good team working on the ward.

Public and staff engagement

- Patient satisfaction was monitored and reported monthly through the patient satisfaction dashboard. This information was discussed at monthly management meetings.
- Staff engaged in regular, minuted meetings.
- Staff told us they liked working for the hospital, however the majority of communication was via email and staff did not have time to read them. They also commented that managers spent a lot of time in meetings and that sometimes it was difficult to get hold of people.

Innovation, improvement and sustainability

- The inpatient services were planning to ring fence eight beds for medical admissions at the sister BMI hospital nearby so that patients who were self-funding could be referred by their GPs.

Good

Surgery

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

Information about the service

BMI The Kings Oak offers surgical services to adults for elective surgery, including orthopaedic, gynaecology, ophthalmic and general surgery. Surgical services are provided to insured, self-pay private patients and to NHS patients, through both GP referral and local contract systems. NHS funded patients accounted for 44% of all surgical activity.

The inpatient rooms were situated on the ward. The ward was organised as two units, Ridgeway with 18 beds and Hadley with 16 beds, with a nurses' station situated in the centre. There was a 6 bedded short stay ward which was not in use during our inspection. All single rooms had en suite facilities with most having either a bath or shower. There were two operating theatres (one with laminar flow) and an intervention radiology suite adjacent to recovery.

There were 4968 visits to the theatre between July 15 and June 16. The five most common surgical procedures performed were:

Image-guided injection(s) into joint(s) (985)

Dorsal root ganglion block (407)

Facet joint injection (263)

Hysteroscopy (170)

Multiple arthroscopic op on knee (inc meniscectomy) (166)

Patients were admitted under a named consultant and the Resident Medical Officer (RMO) was available 24 hours a day. Patients were cared for by a team of nurses, physiotherapists and pharmacists supported by dedicated administrative staff.

We carried out an announced inspection over three days and visited the ward and the operating theatres. We spoke with 14 members of staff (medical, nursing, allied health professional and administrative) and eight patients and their relatives. We also reviewed 10 patient records as well as a number of policies and guidelines.

Good

Surgery

Summary of findings

We rated surgery as good overall because:

- There was a good reporting culture and incidents were investigated and lessons learned were shared with staff. We saw evidence of changes being implemented as a result of a serious incident.
- Staff had a good understanding of the principles behind safeguarding adults and children.
- Staffing levels and skills mix were planned using an acuity tool and there were enough staff on duty on every shift to ensure patients received safe care.
- There had been no hospital acquired infection in the reporting period and we saw evidence surgical site infection was closely monitored.
- Staff had access to a range of up to date policies, which were based on National Institute of Health and Care Excellence (NICE) and Royal College guidelines.
- Pain scores were recorded and patients told us their pain was well managed.
- Patient outcomes were within the expected range, although the small number of patients meant it was difficult to compare against national data for specific procedures such as joint replacements.
- The Friend and Family Test (FFT) scores were high. Between January and June 2016 the results were 98-100% with an average response rate of 48% which is above the NHS England average.
- All patients we spoke with were complimentary about the care they received and felt involved in their treatment.
- The hospital consistently met the referral to treatment target (RTT) of 90% for NHS admitted patients waiting less than 18 weeks from the time of referral to treatment.
- Complaints were investigated in line with the BMI policy and we saw patients mostly received acknowledgment and response within agreed timescales. Learning from complaints was shared with staff.
- There was a clear vision for the service and staff understood that vision and the plan in place to achieve it.
- There was a clear clinical governance structure in place and we saw the senior management team understood the risks and kept an up to date risk register.

However,

- Patient rooms and some of the ward corridors had carpeted floors and fabric chairs in use in the clinical environment. This did not meet the requirements of Health Building Notice (HBN) 00-09: Infection control in the built environment.
- Suction equipment which required being stored in sterile packaging was left open in all patient rooms. This posed an infection control risk.
- Records were not always completed fully. We saw two operation notes that were undated and did not contain the name of the surgeons or anaesthetist. We also noted some inconsistencies in recording NEWS scores on the observation charts.
- There were inconsistencies amongst staff in the scoring of NEWS which could lead to delays in escalating deteriorating patients.
- Cleaning products were not stored in locked cupboards as required by the Control of Substances Hazardous to Health Regulations 2002 (COSHH).
- Although the hospital completed consent form audits, no action had been taken to rectify the findings that patients were not receiving written information about their procedure.

Good

Surgery

Are surgery services safe?

Requires improvement

We rated safe as requires improvement because:

- Patient rooms and some of the ward corridors had carpeted floors and fabric chairs were in use in the ward environment. This did not meet the requirements of Health Building Notice (HBN) 00-09: Infection control in the built environment.
- Suction equipment which required being stored in sterile packaging was left open in all patient rooms. This posed an infection control risk.
- Records were not always completed fully. We saw two operation notes that were undated and did not contain the name of the surgeons or anaesthetist. We also noted some inconsistencies in recording NEWS scores on the observation charts.
- There were inconsistencies amongst staff in the scoring of NEWS which could lead to delays in escalating deteriorating patients.
- Cleaning products were not stored in locked cupboards as required by the Control of Substances Hazardous to Health Regulations 2002 (COSHH).

However,

- There was a good reporting culture and we saw that incidents were fully investigated and lessons learned were shared with staff.
- Staff had a good understanding of the principles behind safeguarding adults and children.
- Staffing levels and skills mix were planned using an acuity tool and there were enough staff on duty on every shift to ensure patients received safe care.
- There had been no hospital acquired infection in the reporting period and we saw evidence surgical site infection was closely monitored.

Incidents

- The provider did not report any never events in surgical services in the reporting period of July 2015 to June 2016 (Never Events are serious incidents that are wholly preventable as guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and should have been implemented by all healthcare providers).
- There was one serious incident (SI) reported for the period of July 2015 to June 2016, relating to an intra-operative complication (a piece of an instrument broke off) during spinal surgery. Staff we spoke with were clear of the investigation process required for a SI, in line with NHS England Serious Incident Framework. We saw evidence this incident was fully investigated and actions were taken to minimise the risk of a similar incident recurring.
- 118 other incidents were reported between July 2015 and June 2016, with a large majority of these being low harm incidents. The two most common incidents reported was cancelled surgery (79) and patients booked for day case procedures staying overnight (55).
- All staff we spoke with told us they knew how to report an incident and were encouraged to do so by senior staff. Staff reported incidents using a paper based incident report and the information was then transferred onto an electronic system by senior staff. A new electronic incident reporting system was due to be introduced a few weeks after our visit and staff training was being rolled out to allow all staff to report incidents electronically. There was a transparent and proactive culture that empowered all staff to report incidents in a 'no blame' environment. Staff we spoke with were aware of the types of situations where incident forms should be completed and were able to give examples of incidents they had reported. Staff told us learning from incidents took place during daily handover and monthly ward meetings but not all staff received individual feedback when they reported incidents.
- Incidents review meeting took place regularly, where the senior management team discussed all reported incidents, agreed lead investigator and monitored the progress of each investigation. Incidents were also a standard agenda item for the daily 'comm cell meeting' attended by all heads of department.
- Staff we spoke with had a good understanding of the duty of candour requirement and were able to explain how it applied to their specific roles. We saw evidence the Duty of Candour requirement was adhered to when we reviewed the SI report.

Safety thermometer

- NHS Safety Thermometer scheme is used to collect local data on specific measures related to patient harm and

'harm free' care. Data was collected on a single day each month to indicate performance in key safety areas. This data was collected by the ward electronically and a report produced for each area.

- Safety thermometer data we saw for the reporting period showed patients had received harm free care with no cases of urinary infection, falls, pressure ulcers or venous thromboembolism (VTE) every month except for the month of April 2016 when two patients had sustained a fall.
- Display boards were visible at the entrance to the ward displaying patient survey results and staffing levels. However during our visit, we observed safety thermometer data was not displayed.

Cleanliness, infection control and hygiene

- We observed there were dedicated staff for cleaning ward areas and theatres. Staff had received training and were therefore able to follow best practice with respect to minimising cross-contamination. The surgical wards we visited were clean and all the patients we spoke with were satisfied with the cleanliness. We looked at the equipment used on wards and found them to be clean. Labels indicated when they had been cleaned.
- There was easy access to personal protective equipment (PPE) in all areas we inspected and staff used PPE during their activities as required.
- We observed staff complying with infection control policy; being bare below the elbow and washing their hands. Hand wash basins and alcohol hand sanitising gel were available in each patient's room. Alcohol hand sanitising gel was also available in ward corridors and at the entrance; however hand washing facilities were not available in these areas.
- The patient rooms and some of the ward corridors had carpeted floors and fabric chairs were in use in the clinical environment. This did not meet the requirements of Health Building Notice (HBN) 00-09: Infection control in the built environment. The provider recognised this risk and had included it on their risk register. Staff informed us a refurbishment programme was planned and the plan was to replace all the carpeted floorings. However, there were no significant concerns identified with infection rates.
- There was a dedicated infection prevention and control (IPC) nurse who worked closely with link nurses on the ward and in theatres. The IPC nurse carried out regular audits and reported to the director of clinical services.
- Handwashing audits were carried out by the infection control and prevention nurse and link nurses on a regular basis in both the ward and theatre areas. Data we reviewed for the period of January to July 2016 showed compliance with hand washing in theatres was 100% except for the month of March and June where the rate was 90%. However during our inspection, we observed poor handwashing by one member of staff dealing with patients in the anaesthetic room. Data for the ward was only available for January to April 2016 and showed 100% compliance.
- All patients were swabbed for methicillin-resistant staphylococcus aureus (MRSA) during their preoperative assessment. Staff told us patients colonised with an infection such as MRSA would be taken for surgery at the end of the theatre list to allow a thorough deep clean of the theatre prior to the next patient accessing the operating room the next day.
- There had been no incidents of hospital acquired infections such as MRSA or C Difficile during the reporting period. Staff had access to policies to manage infection prevention and control.
- Surgical equipment decontamination was completed off-site at a BMI facility. Staff told us they had a good relationship with the decontamination staff and the arrangement worked well.
- Servicing of the theatre ventilation systems was undertaken by the service engineer at appropriate intervals and we saw evidence the operating theatres were compliant with HTM 03-01: Specialised ventilation for healthcare premises.
- Surgical sites infection data was collected and reviewed by the management team to identify trends. Data submitted showed there were eight surgical site infections between July 2015 and June 2016. The rate of infection during primary hip arthroplasty, other orthopaedic and upper gastro-intestinal and colorectal procedures was slightly above the rate of other independent hospitals we hold this type of data for. The rate of infection for primary knee arthroplasty and breast procedures was however below the rate of other independent hospitals we hold this type of data for.
- The patient led assessment of the care environment (PLACE) results for the period of February to June 2016 regarding cleanliness showed a satisfaction level of 96% compared to an England average of 98%.

- Suction equipment which required being stored in sterile packaging was left open in all patient rooms. This posed an infection control risk and we highlighted this issue to the senior nurse who took remedial actions immediately.
- Disposable curtains were used in recovery and we observed these were all dated to indicate they had been recently replaced.
- We observed two stools in theatres, which despite having a clean sticker attached, had torn coverings. This meant staff could not ensure this equipment were being appropriately cleaned to prevent infection.
- Cleaning audits were carried out by the IPC nurse and we saw the results for the July audit for the ward areas showed an overall compliance of 95%.

Environment and equipment

- We saw resuscitation equipment readily available on the ward and in theatre, with security tabs present on each. Staff carried out daily checks of equipment stored on the resuscitation trolley and broke the seal weekly to inspect the contents of the trolley. We saw evidence these checks were consistently carried out for both theatre and the ward.
- All the equipment we inspected had the necessary portable appliance testing and had been serviced in the last year. Staff were aware of how to report equipment faults and told us repairs generally took place promptly.
- All patients were accommodated in ensuite private rooms, which were located off of the main ward corridors. All rooms were equipped with a nurse call bell and emergency buzzers within the main bedroom area and the ensuite bathroom. The call bell system allowed nursing staff to indicate when they were in the room and therefore reduced interruptions and maintained patient's privacy and dignity.
- Theatres were located on the same level as the ward and there was controlled access via keypad lock. One of the operating theatres had laminar flow, which is considered best practice for ventilation within operating theatres.
- Equipment stores on the ward were tidy and all equipment stored safely. We saw a range of mobility and orthotic equipment available to physiotherapy staff. Staff told us storage was an issue and we saw they used an out of use patient room as additional storage space for larger items such as seated weighing scale and ECG machine.
- Sharps bins were located appropriately throughout theatres, recovery and the surgical wards. All bins inspected had been labelled correctly and we observed one of the sharps bins in theatres to be overfull.
- There was adequate storage for consumables in recovery and on the ward; items were stored in labelled drawers to allow efficient access for staff.
- The theatre environment was small and staff told us storage of instruments was sometimes an issue. There was also limited facilities for staff and the changing area did not have facilities for staff to shower.
- We noted there had been 10 cases of cancelled surgery due to lack of appropriate equipment during the reporting period. However staff did not feel availability of equipment was an issue as they could often borrow equipment from the nearby BMI sister hospital, if required.
- We saw specialist bariatric equipment was available in theatres and staff on the ward were able loan bariatric equipment when required.
- Staff told us the heating system for the hospital was dated and there had been a few instances when the supply of hot water and heating had been interrupted. Staff told us the recovery area often felt cold and we saw two portable electric heaters in use during our visit. One of the electric heaters did not have an up to date Portable Appliance Test (PAT) sticker.
- We were also able to gain access to the domestic area on the ward as the door was left open. We noted cleaning products were not stored in locked cupboard as required by the Control of Substances Hazardous to Health Regulations 2002 (COSHH). This posed a health and safety risk.

Medicines

- All clinical staff we spoke with were clear about the arrangements in place for safely managing medicines, including controlled drugs (CDs). CDs are medicines which require additional security. The arrangements were set out in policies and procedures for ordering, recording, storing, dispensing, administering and disposing of medicines.
- An on-site pharmacy service was provided for hospital inpatients and outpatients between 8am and 5pm Monday to Friday. The pharmacy was located in the outpatient department, in a converted patient bedroom with an ante room in a converted ensuite bathroom.

- The service was provided by three whole time equivalent pharmacists, and 2.6 whole time equivalent pharmacy technicians / assistants who worked between the two BMI hospital sites in Enfield.
- Access to the pharmacy during opening hours was by designated pharmacy staff only. There were specific procedures for other named staff to gain emergency access to the pharmacy out of hours, with the resident medical officer (RMO) and senior nurse holding separate keys meaning that single access was not possible.
- Controlled drugs (CDs) were stored in lockable wall units and were checked on at least a daily basis by registered nurses or pharmacists. The CD registers and order books were completed in line with local procedures.
- The risk of unauthorised access to the pharmacy was identified and recorded on the hospital risk register in January 2016. Corrective measures had since been put in place to ensure that the pharmacy met the access and security best practice guidance: Department of Health Health Building Note 14-01: Pharmacy and radiopharmacy facilities. This included installing a steel door, security locks and alarms.
- Patients had access to medicines when they needed them. Medicines were supplied to the hospital pharmacy through a centrally managed contract with the BMI procurement department. There was a top-up service for replenishing medicines stock items in all clinical areas and for other medicines issued on an individual basis.
- There was an up to date antibiotic protocol which included first and second choice medicines to use, the dosage, and duration of treatment. However, the planned audit to monitor antimicrobial stewardship had not taken place in March 2016 and we saw no evidence that this had been completed since.
- Where medicines required cool storage, ambient temperature checks of the storage areas including cupboards and refrigerator temperature checks were carried out and recorded, and were all within the required range. Staff were aware of the process to follow if the temperature should fall out of the safe range.
- A recent snapshot audit of medicine administration records showed 32% had a missed dose with no reasons recorded on the chart. The audit also identified that patients own medication and CD were not being recorded correctly and the correct signatures were not obtained when returning these medicines to patients. In the six medicine administration records we reviewed, we saw evidence the reasons for omissions were being recorded but the recommendation of the audit in relation to the recording of patient own medication had not been implemented.

Records

- There were care pathways in place for specific procedures such as joint replacement and generic surgical pathways for various other surgical procedures. These pathways covered the patient journey from pre-assessment to discharge and contained all the relevant risk assessments such as VTE, pressure ulcer, manual handling and nutrition. In the 10 records we reviewed, we saw these risk assessments were completed for most patients.
- Records were paper based and included documentation from all members of the multidisciplinary team in a chronological order. The records were in good condition and we saw patients were reviewed daily by their consultant during their stay. The Resident Medical Officer (RMO) also documented a daily review of patients and this included results of blood tests. Test results were available electronically and were often printed and included in the records.
- In the records we reviewed, we saw two operation notes that were undated and did not contain the name of the surgeons or anaesthetist. We also noted some inconsistencies in recording NEWS scores on the observation charts and brought this to the attention of the nurse in charge.
- We saw evidence the World Health Organisational (WHO) surgical checklist was completed correctly and at appropriate times. The WHO Surgical Safety Audit was completed on a regular basis and ten sets of patient records were sampled each time. Audit data for January to July 2016 showed compliance ranged between 99 to 100%.
- Records audit were carried out regularly as part of the corporate audit calendar and we saw compliance ranged from 88% to 95% between January and July 2016.
- Once records were no longer required after the patient had been discharged, they were stored on site in a secure records office.

Safeguarding

- Staff we spoke to were able to explain their understanding of safeguarding and the principles

behind safeguarding adults and children. They were clear about the escalation process and were able to access the safeguarding lead for advice and guidance. This understanding was better for more senior staff we spoke to and some junior staff said they would ask senior staff for advice.

- Staff completed safeguarding training and we saw training rates for adult safeguarding level 2 was 88%. All clinical staff were required to undertake level 2 training. However staff were starting to attend Level 3 training in preparation for the development of paediatric services.

Mandatory training

- Staff completed their mandatory training though the BMI online system and also attended face to face training. Staff told us they were allocated time to complete online learning and face to face training was usually booked in consultation with the ward manager to ensure this was reflected in the rota. We looked at the training portfolio and if the training staff attended was appropriate for their roles.
- Overall mandatory training rates were 95 % for theatres and 91% for ward staff.

Assessing and responding to patient risk

- The surgery team used the five steps to safer surgery, which was in line with best practice guidance from the National Patient Safety Agency, and the WHO checklist to ensure that patients received safe surgical care.
- The majority of patients underwent either a face to face or telephone pre-assessment screening. All pre-assessment took place at another nearby BMI hospital. We saw evidence in patient records to show the pre-assessment process was thorough and various risk assessments were carried out. The pre-assessment nurses would highlight any concerns to the consultant, who would then inform the anaesthetist as appropriate. In specific cases, patients had an anaesthetic review pre-operatively. However in data supplied by the hospital, we saw 10 operations were cancelled on the day due to clinical reasons, such as not stopping certain medication pre-operatively, as patients had not been through a pre-assessment. Staff we spoke with explained that sometimes patients were booked in for surgery days after their initial consultation and therefore they were unable to attend the pre-assessment screening.
- Ward staff used the National Early Warning Score (NEWS) to identify deteriorations in a patient's condition. In eight of the ten records we reviewed, we saw the NEWS score was recorded and there was a clear escalation process. However, in one set of records, we saw that although observations were recorded at regular intervals, staff did not always calculate the NEWS score. In another set of records, we saw that staff were not scoring the NEWS score accurately. Specific parameters relating to oxygen usage was not being taken into account when calculating the score. We spoke to the senior nurses on the ward and it became apparent the scoring was not consistent for patients requiring supplementary oxygen. This could lead to delays in escalating deteriorating patients.
- The RMO was available on site 24 hours a day and reviewed any deteriorating patients immediately. Nursing staff were clear about how they would contact the RMO and felt they were very responsive.
- The practising privileges agreement required the designated consultant to be contactable at all times when they had inpatients within the hospital. They needed to be available to attend within an appropriate timescale according to the level of risk of medical or surgical emergency. This included making suitable arrangements with another approved practitioner to provide cover in the event they were not available, for example whilst on holiday.
- There was a theatre on call rota but currently this did not include an anaesthetist. There was an agreement in place whereby the anaesthetist in charge of the list was responsible for the patients for 24 hours post-operatively and could be contacted to attend to deteriorating patients or for returns to theatre.
- The theatre briefing took place prior to the start of every list and provided an opportunity for the team to ensure all staff understood their responsibilities, check all equipment was available and discuss the order of the list. However we observed not all nursing staff involved in the case attended the briefing. We observed the WHO checklist being carried out appropriately in theatre.
- Staff used the 'Waterlow' Pressure Ulcer Prevention Score to assess the patients' risk of developing a pressure sore and air mattresses were available from an external company for patients with a high score. However there was no access to a specialist tissue viability professional.

- Nursing staff contacted every patient by phone within 48 hours of discharge to ensure they were recovering well at home and discuss any concerns or questions patients might have. Staff told us that if they had concerns about the patients' recovery, such as increased pain or wound healing, they would ask the patient to attend the ward for a review with the RMO or inform the consultant.
- Data provided by the hospital showed the VTE assessment target of 95% was not met for January 2016 but achieved 99% for February 2016 and 100% from March to June 2016.
- Between July 2015 and June 2016, there were six incidents of unplanned transfers of inpatients to another hospital. There were no trends, with regards to types of surgery, or concerns with individual surgeons, identified. This number was not high when compared to a group of independent acute hospitals which submitted performance data to CQC.

Nursing staffing

- At the time of our inspection, there were no nursing vacancies on the ward and five vacancies in theatre. Senior staff told us it was harder to recruit theatre staff as often applicants did not have the right level of experience.
- A corporate acuity tool was used to determine staffing levels to meet the needs of each patient. The acuity tool in use was fairly new and staff told us they felt it was better than the previous tool. Managers always supported staff when requests for additional staffing were made to meet the needs of individual patients or during busy times.
- Since the large majority of patients were elective admissions, staffing levels were planned in advance and staff we spoke with felt staffing was adequate on the ward and in theatres.
- The senior nurses completed duty rotas in advance and any change on the day was clearly documented. Staff worked flexible hours to cover the rota and shifts included day, night and twilight. Gaps in the rota were generally covered by bank staff or staff from the nearby sister BMI hospital. Agency use was rare and the rota we looked at confirmed this.
- Ward nurses met for a handover at the start of their shift, where all patients on the ward were discussed. We observed thorough and patient-centred handovers which took place in the patient's room. The RMO also joined the morning and evening handover when their workload allowed.

Surgical staffing

- Patient care was consultant led and the hospital practising privilege agreement required that the consultant visit inpatients admitted under their care at least daily or more frequently according to clinical needs. We saw evidence of daily consultant review in the records we looked at.
- RMOs were provided to the hospital by an external agency and each RMO usually worked 24 hours a day for two weeks while on duty. They would then have two weeks off prior to returning for another week.
- The RMO we spoke with during the inspection felt they were adequately supported by the consultant and nursing staff. They were encouraged to contact the consultant for advice and felt the consultants were supportive when they were contacted.
- Consultants were required to be within 30 minutes journey of the hospital if they had patients under their care at the hospital. If, on occasions, this was not possible, they were required to nominate another named consultant (with practicing privileges) to provide cover. Up to date contact numbers for consultants were available to nursing staff in wards and operating theatres.

Physiotherapy staffing

- There were two part time physiotherapists employed to work on the ward. The physiotherapist reviewed patients twice a day and also made onward referral for outpatient physiotherapy on discharge. The physiotherapy staff we spoke with told us their caseload was manageable and they were able to provide the input required to each patient. They also worked closely with their colleagues at the nearby BMI hospital and were therefore able to cross cover if required.

Major incident awareness and training

- All staff received fire training as part of their mandatory training programme; staff told us they had the opportunity to rehearse scenarios and we saw evacuation equipment was available on the ward.
- The hospital had a business continuity plan detailing what to do in various situations that may affect the day

to day running of the ward and theatres. Copies of the business continuity plan were available on the ward and in theatres and senior staff we spoke with were able to describe what actions they would take in specific situations.

Are surgery services effective?

Good

We rated effective for surgery as good because:

- Staff had access to a range of up to date policies, which were based on National Institute of Health and Care Excellence (NICE) and Royal College guidelines.
- Pain scores were recorded and patients told us their pain was well managed.
- Fasting times were in line with the Royal College of Anaesthetists (RCOA) guidelines and we saw these were revised if there was any delay in the list.
- Patient outcomes were within the expected range, although the small number of patients meant it was difficult to compare against national data for specific procedures such as joint replacements.
- We saw evidence staff received training and their competencies were assessed prior to them working independently.

However

- Although the hospital completed consent form audits, no action had been taken to rectify the findings from previous audits that patients were not receiving written information about their procedure.

Evidence-based care and treatment

- BMI corporate guidelines and policies were available on the intranet and in folders on the ward. Staff we spoke with were aware of how to access these policies. We saw these guidelines were up to date and referenced to current best practice from a combination of national and professional guidance such as the National Institute of Health and Care Excellence (NICE) and Royal College guidelines.
- The service was compliant with NICE guidance CG 74: Surgical site infections: prevention and treatment in the preoperative, intraoperative and postoperative phases of care.
- The Enhanced Recovery Programme was well embedded for orthopaedic and general surgery, in line with NICE and best practice guidance.

Pain relief

- Post-operative pain relief was prescribed by the anaesthetist and included regular and as required painkillers. Nursing staff told us they would get the RMO to review patients whose pain was not controlled.
- Patients we spoke with all told us they received analgesia regularly and felt their pain was well managed.
- Most patients received oral painkillers although some patients had intravenous (IV) patient controlled analgesia (PCA). Staff underwent additional training to care for patients on a PCA.
- Pain was assessed regularly using a patient reported scoring system of 0-3, where 0 was no pain and 3 was severe pain. We saw evidence of pain scores in all the records we reviewed.
- We observed a nursing handover and saw that pain control was discussed for each patient.

Nutrition and hydration

- Nursing staff assessed nutrition on admission using the Malnutrition Universal Screening Tool (MUST) and we saw the MUST was completed in all the records we reviewed.
- The hospital did not have a dietician but staff told us they were able to access a dietician, through an external organisation when required.
- Pre-assessment and ward nurses advised patients of fasting times before surgery and we observed this was in line with the Royal College of Anaesthetists (RCOA) guidelines. When lists were delayed, anaesthetists rang the ward and advised nursing staff about revised fasting times to ensure patients were not kept fasted for longer than necessary.

Patient outcomes

- The hospital submitted data to the National Joint Registry for all orthopaedic joint replacement and patient related outcome measures (PROMs) was collected for all NHS funded knee and hip replacement

and groin hernia surgery, although due to the small number of surgeries being performed, adjusted health gain could not be calculated to compare against national scores.

- EQ-VAS or EQ-5D indexes, both of which are additional measures of patient health outcomes and pain relief post-operatively, showed health gains and reduced pain following knee and hip replacement.
- Hospital staff told us the organisation was working with the 'Private Healthcare Information Network' to improve reporting of patient outcomes across the independent healthcare sector. They hoped this would make patient outcome data more easily comparable with NHS providers.
- There had been four cases of unplanned readmission between July 2015 and June 2016 and five cases of returns to theatre following a surgical procedure. We reviewed the data provided by the hospital and no trends were identified.

Competent staff

- All new staff including agency staff were inducted into their area of work. We were shown completed induction checklists which outlined department orientation and familiarisation with specific policies.
- There were 169 consultants with practicing privileges at the hospital, of which 61 did not carry out any surgery at the hospital during the reporting period. The large majority of surgery was carried out by 19 consultants.
- Practising privileges were reviewed regularly and consultants were required to show evidence of their annual appraisal/revalidation. Data submitted by the hospital showed one consultant had their practice privilege removed during the reporting period.
- There was a process for checking General Medical Council and Nursing and Midwifery Council registration, as well as other professional registrations.
- Surgical staff, both in theatres and the ward, had specific competency documents and we saw evidence staff underwent training and competency based assessments prior to working independently. A matrix was available in theatres to indicate which staff were competent to use specific equipment.
- The hospital had a competency based training programme for nurses and HCAs. We saw each staff member had a personal competency and mandatory training folder where they stored their certificates and recorded evidence of learning and development. This was also used as evidence towards revalidation.
- RMO was provided via an agency and we saw evidence the hospital held up to date training records for the RMOs currently working at the hospital. Consultants we spoke with did not express concerns about RMO competencies, although they were not involved in the selection process.
- Staff appraisal rates were 90% for nurses and healthcare assistant working on the ward. Most of the staff we spoke with during the inspection confirmed they had an appraisal recently and they found the process was helpful in identifying their learning needs.

Multidisciplinary working

- Nursing, physiotherapy and medical staff we spoke with during the inspection told us there was good multidisciplinary team work on the wards. The physiotherapist received a daily handover from the nurse in charge which included discussions about discharge plans. The physiotherapist told us nursing staff assisted with therapy sessions when more than one person was required to support patients' rehabilitation.
- Patients who required adaptive equipment or assistance with activities of daily living on discharge were referred to an occupational therapist. The occupational therapy service was provided by an external provider and staff reported patients were assessed promptly, once referred.
- Pre-operative assessment nurses worked closely with individual consultants to ensure any issue identified was clearly communicated and necessary actions, such as an anaesthetic assessments or additional tests, were taken promptly.
- During the inspection, we observed good team working between nurses, the physiotherapist, pharmacist and RMO.

Seven-day services

- Patients received physiotherapy seven days a week. The physiotherapy input at weekends was usually provided by bank physiotherapy staff or staff from the nearby BMI hospital, on a rota basis.
- RMOs were available on site 24 hour per day, seven days per week.

- Consultants reviewed their patients daily and we saw evidence of this when looking at patient records. When consultants were on leave, they arranged for another consultant (also with practicing privileges at the hospital) to review their patients and the ward nurses were informed of this arrangement in advance.
- An on-call theatre team were available for emergency returns to surgery out of hours. The team comprised of a theatre scrub practitioner, a health care assistant and recovery staff. The anaesthetist was generally the person completing the theatre list that day.
- Diagnostic imaging was available 24 hours per day, seven days per week by an on call radiographer who was available via a bleep system within a 30 minute response time.
- There was no pharmacist out of hours and at weekends, but there were specified arrangements for staff to gain emergency access to the pharmacy out of hours, with the RMO and senior nurse holding separate keys.

Access to information

- Medical records were situated on site and staff were therefore able to access records at any time. Staff we spoke with told us they would access the medical records to retrieve notes in cases such as a re-admission or if the patient contacted the ward with concerns.
- Patient records on the ward were comprehensive and included consultation letters and pre-assessment documentation. This ensured staff were aware of all the necessary information such as medical history and advice already provided to the patients.
- Staff had access to electronic and paper copies of hospital policies and guidelines on the ward and in theatres.
- Communication from senior management was usually cascaded to staff via team meetings, emails or through the hospital and BMI newsletters.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- We saw consent forms were competed in all the records we reviewed. Consent forms fully described the procedure completed as well as risks associated with it and full signatures from the consenting clinician and patient. Consenting generally took place on the morning of the surgery.
- We saw staff confirmed consent with patients in theatres prior to them being anaesthetised.
- Consent audit was part of the regular audits carried out by the hospital and we saw consent audit was carried out in March and June 2016, with scores of 93% for both. The audit showed there was no record of patients being provided with information leaflets for both months. There were no actions taken as a result of these audit findings.
- Staff received training on the Mental Capacity Act (MCA). Capacity assessments were generally carried out by consultants but staff told us they would inform senior nurses and the safeguarding lead if they had concerns.
- Staff we spoke with had received training and were aware of Deprivation of Liberty Safeguards (DoLS) principles. However staff explained they rarely cared for patients with cognitive impairment so DLOS application was not something they have experience of. They were however able to describe the process and told us they would seek senior advice.

Are surgery services caring?

Good

We rated caring for as good because;

- Friends and Family Test (FFT) scores were consistently high with good response rates.
- All patients we spoke with were complementary about the care they received and told us staff treated them with respect.
- Patients and their relatives felt involved in their care and were clear on how to contact the hospital if they had any concerns following their discharge.
- Staff offered emotional support to patients and provided encouragement and reassurance to help patients achieve their recovery goals.

However

- Patients did not have access to information on how to access further emotional support if needed.

Compassionate care

Good

Surgery

- Hospital wide Friends and Family Test (FFT) scores were high. Between January and June 2016 the results were 98-100% with an average response rate of 48% which was above the NHS England average.
- We observed patients were treated with dignity, respect and kindness during all interactions with staff. Staff addressed patients by their preferred name and understood patient's specific needs.
- A patient told us 'everyone was kind and helpful' and they were encouraged to tell staff if they required any assistance or were in pain.
- Patient's privacy was maintained by ensuring the doors were closed during personal care or whenever the patient needed some privacy with their relatives.
- The named consultant was indicated on the door of the patients' rooms. Patients also knew the name of the nurse looking after them for the shift.
- All patients we spoke with were complimentary about the care they were receiving by all members of the MDT and they had confidence in the team caring for them.

Understanding and involvement of patients and those close to them

- Patients told us they felt well supported and were given appropriate and timely information to participate in their care and treatment right from their first meeting with the consultant to discharge.
- All the patients spoken with told us they understood all the information given to them about their operation/ procedure, anaesthetic, discharge information and their follow-up clinic.
- Relatives were actively encouraged to be involved in the treatment and discharge plans where appropriate and were able to speak to a doctor when needed.
- We observed one patient in the anaesthetic room, who was not involved in the anaesthetic plan despite attempts by the patients to inform staff about a particular medication he would like to avoid.
- Patients felt that conversations about finances were handled sensitively. We heard from patients and staff that NHS and non NHS patients were not treated differently in any way.
- All the patients we spoke with were aware of what to do if they felt unwell during admission and when discharged home.

Emotional support

- We saw staff provided emotional support to patients and always reassured and encouraged patients to achieve their goals. However, patients did not have access to information on how to access further emotional support if needed.
- Patients were able to call the ward after discharge if they were concerned about their recovery and progress.
- We observed a member of staff offering reassurance to a patient who was concerned about when they would be collected by their family after discharge and arranging for the patient to stay for lunch while they waited.

Are surgery services responsive?

Good

We rated responsive as good because:

- Staff had attended training on dementia and had access to resources to assist them in caring for patients living with dementia.
- Services were planned to meet the needs of patients and to ensure contractual requirements were met.
- The hospital consistently met the referral to treatment target (RTT) of 90% for NHS admitted patients waiting less than 18 weeks from the time of referral to treatment.
- Complaints were investigated in line with the BMI policy and we saw patients mostly received acknowledgment and response within agreed timescales. Learning from complaints was shared with staff.

However,

- We did not see evidence of any actions taken to ensure all patients underwent a pre-operative assessment, despite operations being cancelled due to the lack of pre-assessment.

Service planning and delivery to meet the needs of local people

- Service planning at the hospital was generally straightforward due to the elective nature of all surgical interventions. Surgical patients were a mixture of NHS patients referred through the Choose and Book system or through local contracts and private patients, referred by their GP. A small number of patients self-referred.

- Operating theatre lists for elective surgery were planned in advance and patients were offered a choice of when they could have their surgical procedures, allowing this to be at a time that suits their family and work commitments.
- All surgical patients discharged from the hospital, including those who had day case procedures, received a follow-up telephone call 48 hours later to ensure they were managing at home. Any issues would be addressed during the phone call, if possible, or patients would be booked in for an outpatient review with the consultant or nurse. These calls were completed by an allocated member of staff on the ward.

Access and flow

- Data provided by the hospital for the period of July 2015 to June 2016 showed a total of 79 operations were cancelled. Of these 79, 22 operations were cancelled for non-clinical reasons. The two main reasons for non-clinical cancellations were equipment not available (10). Clinical cancellations were mainly due to patients being unfit for surgery due to blood pressure or other infections. However we saw that 10 patients were cancelled as they did not undergo pre-operative assessment, where certain issues would have been picked up. We did not see evidence of any actions taken to ensure all patients underwent a pre-operative assessment. The majority of the hospital's inpatient activity was surgical cases. There were 5304 inpatient and day case activities during the reporting period; of those 44% were NHS funded. There were 4968 visits to theatre.
- Once a decision to operate was made in clinic, the bookings team worked closely with the consultant, ward staff and the patient to agree a suitable date for surgery. Staff told us this system worked well and patients were admitted for surgery at the earliest opportunity.
- The referral to treatment time (RTT) target of admitting 90% of patients within 18 weeks of referral was consistently met for the reporting period.
- All patients were admitted to the ward and allocated a room prior to theatre. This meant there were no delays in discharging patients from the recovery area back to their room on the ward. Staff told us theatre and ward nurses worked closely and theatre staff would transfer patients back to the ward, if the ward nurses were busy and unable to collect patients.
- Discharge planning was started during the pre-assessment stage of the pathway and patients' needs post discharge were identified. Staff told us referrals to occupational therapist took place at pre-admission for patients undergoing hip and knee replacement.
- Discharge summaries and a list of take home medication were sent to each patient's GP on discharge.
- All patients were reviewed by their consultants before being discharged and a discharge letter was sent to the patient's GP.

Meeting people's individual needs

- Staff had access to language line to assist communication with non-English speaking patients. Staff we spoke with were aware of this and we saw information on how to access the language line was available both on the ward and in theatres.
- Patients did not have access to information on how to access emotional support from external sources such as local charities or voluntary organisations.
- The hospital did not often admit patients with learning disabilities. However staff told us their needs would be identified at the pre-assessment appointment and they would ensure family members and carers were involved from the start. Carers were welcome to stay overnight and staff would make special arrangements for the carer to accompany the patient to the anaesthetic room and be present when they woke up from the operation.
- All patients had individual rooms with ensuite facilities. There was wheelchair access to the hospital and the ward; however the showers in the ensuite bathrooms were not wheelchair accessible.
- Intentional rounding by care staff was completed throughout the patients stay. These meant patients were visited in their rooms hourly to check for example, if call bells and a drink were in reach, if the patient had pain or had any other requests.
- During our inspections, we observed nursing staff answered call bells immediately and understood individual patient needs.
- Information on special cultural, religious or dietary needs was gathered at the pre-assessment stage and this information was passed onto the ward and theatre teams. This meant that patients were offered a choice of food to meet their needs during their stay.

- There were a few corporate BMI leaflets available on the ward. There was information about how to leave feedback and encouraged patients to name individual staff who had provided exceptional care.

Learning from complaints and concerns

- The hospital received 29 complaints between July 2015 and June 2016; of which 8 were still open at the time of our inspection. All complaints were escalated to the clinical director and director of clinical services and discussed at the complaints response meetings. Complaints were investigated in line with the BMI complaints policy.
- Staff told us in cases when patients were unhappy with aspects of their care, they would escalate to the on-site management team and aim to resolve any issues verbally.
- Learning from complaints was shared with all staff at clinical governance meetings, departmental meetings and via email.

Are surgery services well-led?

Good

We rated well led as good because:

- There was a clear vision for the service and staff understood that vision and the plan in place to achieve it.
- There was a clear clinical governance structure in place and we saw the senior management team understood the key risks and kept an up to date risk register.
- Staff we spoke with told us they received good support from the senior team, who were very visible and approachable.

However

- There was a lack of stability in the management team as the physiotherapy manager post was currently vacant and several members of senior management were fairy new in post.

Vision and strategy for this core service

- Staff knew the vision for the hospital and plans to develop it. They told us the hospital was actively working on developing a paediatric unit and to re-introduce surgical services to children. Staff told us good progress was being made in achieving this as two part time paediatric nurses had been employed and all staff were in the process of undergoing the relevant additional training required to care for children post-operatively.
- Surgical staff understood the hospital's aim to continuously improve quality and enhance patient experience. Staff felt the planned refurbishment plan would improve patient experience.

Governance, risk management and quality measurement for this core service

- There was evidence of a robust clinical governance structure in place at the hospital and senior staff from surgery were fully involved. We saw senior staff attended various meeting such as incident review, complaints review, infection prevention and control and clinical governance.
- There was a corporate audit calendar in place and we saw that staff at the hospital carried out the relevant audits. Audit results were discussed at the clinical governance, Medical Advisory Committee (MAC) and team meeting and actions plans were implemented when poor compliance was noted.
- Clinical governance meetings were held monthly and the minutes we saw showed these meetings were structured and well attended. Discussions at these meetings were focused on quality and risks and we saw areas such as incidents, complaints, risk register and the audit calendar was discussed. The surgical department was represented by a consultant anaesthetist and consultant surgeon as well as the ward and theatre manager. Feedback from the Medical Advisory Committee (MAC) was a standing agenda.
- The MAC meetings took place quarterly and practicing privileges, quality assurance and new national guidelines were discussed.
- Feedback from hospital wide meetings was disseminated to staff at local team meetings, via email or newsletter. Team meeting minutes were shared with staff unable to attend and they were asked to sign to indicate they had read the minutes. We saw evidence of this on the ward.
- Senior staff we spoke with told us they regularly reviewed performance in their areas and were able to benchmark themselves against other similar BMI hospitals.

- The risk register for the surgical wards and theatres was held and maintained by the risk and quality manager within the hospital and was reviewed at 'comm cell' and clinical governance meetings. We saw the risk register included the risk we identified during the inspection such as infection control risks due to the environment.
- There was no formal service level agreement (SLA) in place with local hospitals to facilitate transfer of any deteriorating patients. The senior management team explained they had been unable to obtain this SLA with the local NHS facility.

Leadership / culture of service

- All staff told us they enjoyed their work at the hospital and felt part of a 'family'. Some staff we spoke with had worked at the hospital for a long time and they told us the reason they had stayed was the friendly and supportive atmosphere.
- Staff on the ward and in theatre told us their manager was approachable and supportive and there was a 'no blame culture'. Generally staff spoke positively about recent changes introduced by the new management team.
- The senior management team was very visible and staff told us a member of the executive team came to the ward and theatre area daily as part of the executive rounding. Staff felt this was helpful as they could feedback any issues straightaway.
- The Executive Director (ED) was due to leave the hospital immediately after our inspection and staff were sad to see him go. They told us he had taken the time to get to know individual members of staff and they therefore felt able to approach him with any concerns. Some staff were nervous of the leadership change as they felt the majority of the management team were relatively new in post.
- The sickness rate was less than 10% for all nurses during the reporting period of July 2015 to June 2016. There was variable sickness rate for health care assistants and operating department practitioners during that same period.
- There was a high level of staff stability for nurses in theatre and on the ward.
- The anaesthetic representative on the MAC did not fully understand the current situation with regards to SLA for patient transfer and told us there was an agreement in place with the local NHS Hospital. This could therefore lead to some anaesthetic staff being given the wrong information.
- The physiotherapy manager post was currently vacant and some staff mentioned there had been a lack of stability in the senior management posts.

Public and staff engagement

- The senior management team told us they held regular staff forums, where representatives of staff groups from all clinical areas were invited to share their concerns and ideas for improvement. The forum also provided the senior management team with the opportunity to inform staff of upcoming development within the hospital and the BMI group. However some staff we spoke with told us they had never attended this forum and some did not know these took place.
- The hospital had implemented a staff recognition scheme based on the 6 C's (care, compassion, communication, courage, competence and commitment). Staff were awarded certificates to recognise situations where they had displayed these qualities.
- All patients were actively encouraged to provide feedback but there were plans to introduce a patient forum. The senior management team told us they had identified a former patient, who was also a local resident, to assist them in implementing the patient forum.

Innovation, improvement and sustainability

- The hospital had recently introduced 'joint school', a pre-operative education class for patients undergoing joint replacement. The purpose of the sessions is to provide patients with information about their surgery, manage their expectations and start discharge planning earlier.
- The evidence based Enhanced Recovery Programme was in place for all patients undergoing joint replacement.
- Hospital staff told us the organisation was working with the 'Private Healthcare Information Network' to improve reporting of patient outcomes across the independent healthcare sector. They hoped this would make patient outcome data more easily comparable with NHS providers and drive improvement in quality.

Good

Surgery

- The hospital was in the process of developing a dedicated paediatric unit and staff with specialist paediatric training were being recruited.

Good

Outpatients and diagnostic imaging

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

Information about the service

BMI Kings Oak Hospital is a private hospital in Enfield. The hospital provides a range of services including outpatient consultations and diagnostic imaging services. Services are provided to insured, self-paying private patients and NHS patients via referrals from GPs and local contract systems.

The outpatient and diagnostic imaging services at BMI Kings Oak hospital were located on the first and ground floor of the hospital. There were 12 general consulting rooms, a minor procedures room, minor treatment room and phlebotomy room. Pre-assessment clinics were now held at the BMI Cavell sister site. There were a total of 42,476 outpatient appointments at this site between July 2015 and June 2016 for first and follow up appointments. This included 2,006 appointments for children aged between 0-17 years. These were a combination of both NHS and private patients.

The hospital ran a wide range of outpatient clinics including cardiology, gastroenterology, orthopaedics, general surgery, pain management and rheumatology. There were surgical clinics for ear, nose and throat, dental, breast and plastics. The outpatient department was managed by the outpatient manager who had responsibility across both BMI Kings Oak and Cavell outpatient departments. Diagnostic imaging also had its' own cross site clinical lead with a deputy manager on site.

The diagnostic imaging department performed scans and x-rays using a variety of equipment including ultrasound, x-ray, mammography and interventional radiography.

During our inspection, a team of inspectors and specialist advisors visited the main outpatients and diagnostic imaging department.

We spoke with nine patients, carers and relatives. We also spoke with 14 members of staff including managers, reception and booking staff, nurses of all grades, radiographers, healthcare assistants, doctors, consultants and domestic staff. We observed care in outpatient clinics and three radiology procedures. We received comments from staff focus group events and from patients directly.

We also reviewed the systems and management of the departments including the quality and performance information and reviewed 12 sets of patient records.

Good

Outpatients and diagnostic imaging

Summary of findings

We rated the outpatients and diagnostic imaging service as good overall because:

- The services had processes which staff followed to report serious and other incidents and concerns. The system was a mixture of paper based and electronic. Several staff told us it would shortly be changing to a full electronic system which would improve the process.
- The provider met the Referral to Treatment (RTT) targets and the diagnostic waiting times target within the 18 week patient pathway, for NHS patients.
- The systems in place for the prevention of healthcare associated infections with specific regard to hand hygiene, were followed throughout the outpatient and diagnostic imaging department. The department was clean and tidy.
- Equipment was maintained and patient records were stored securely. Records were available for clinics and diagnostic images were obtained prior to any consultation.
- Nurses, radiographers, healthcare assistants, phlebotomist and others all had appropriate qualifications, skills, knowledge and experience to carry out their respective roles.
- All staff we spoke with had completed mandatory training. Staff were aware of their responsibilities within adult and children safeguarding practices and support was available within the hospital. Staff followed correct consent procedures.
- Staff were committed to delivering good care but some staff felt unsupported by senior management.
- We observed and were told that the staff were caring and involved patients, their carers and family members in decisions about their care.
- Staff were aware of the complaints policy and told us how most complaints and concerns were resolved locally.
- There was an effective governance and management framework to support the delivery of good quality care at a local, regional and corporate level within the organisation.
- The staff we spoke with were very proud of the work they did and their team approach.

However:

- The environment did not fully comply with national infection prevention and control guidelines.
- There was no audit of patient waiting times for outpatient clinics and several of the clinics we observed over-ran.
- We saw family members were relied on for translation services. This could lead to situations where patient needs and wishes were not properly known.
- There was limited understanding of the Mental Capacity Act 2005.

Good

Outpatients and diagnostic imaging

Are outpatients and diagnostic imaging services safe?

Good

We rated safe as good because:

- A system was in place for staff to report serious and other incidents that were unexpected or untoward. Lessons learnt were shared with team members and staff told us of some actions they had taken to improve services.
- Cleaning and routine checks on rooms and equipment were in place and complete.
- We observed staff adhering to infection control procedures. Hand gel dispensers were available throughout the departments and staff used them. We also saw an adequate supply of personal protective equipment (PPE) such as aprons and gloves.
- There were sufficient staff in outpatients and diagnostic imaging to manage the service. Some of the staff rotated across both hospital sites.
- The diagnostic imaging department were complying with all the policies and procedures based on the Ionising Radiation (Medical Exposure) Regulations (IR(ME)R). The IR(ME)R regulations are to protect patients, staff and the public.
- Records were available for outpatient appointments and a new system was in place to reconcile outpatient notes with medical notes once patients had been discharged. The allergy section in the notes was not routinely completed and some of the carbon copy written notes were difficult to read.
- There was evidence of the WHO checklist being completed and audited in interventional radiography. Patient protocols were in place in radiology.
- There was a refurbishment plan in place to improve parts of environment across outpatients and diagnostic imaging.

Incidents

- There was a hospital-wide incident reporting policy in place.
- There were no 'never events' reported for outpatients and diagnostic imaging between July 2015 and June 2016. (never events are serious, largely preventable patient safety incidents, which should not occur if the available preventable measures have been implemented.)
- The hospital provided the incident log covering outpatients and diagnostic imaging from July 2015 to June 2016. There were 22 reported clinical incidents and 2 non-clinical incidents.
- We saw that incidents had been investigated and root cause analysis had been completed to identify the causes of the incidents.
- Incidents were reported using the hospital's incident reporting system. Actions and learning were disseminated to staff in various formats including the departmental meetings and email updates. Staff were aware of the reporting system and felt it was easy to use. They were aware of their responsibilities to record safety incidents and near misses, although they were not always clear on what to report. For example, there had been an incident where specimens had been put in the wrong specimen pot. These pots were now stored in different areas and clearly labelled.
- We saw the minutes of outpatient staff meetings where incidents were discussed and learning applied.
- Staff demonstrated their understanding of the principles related to Duty of Candour and their obligations. They were less sure of the systems in place to ensure patients were fully informed of the circumstances which led to any incident resulting in severe/moderate harm. However, all staff we spoke with confirmed they apologised to patients when care was not as it should have been.
- The hospital had processes in place to report any radiation incidents to the Care Quality Commission (CQC) under Ionising Radiation (Medical Exposure) Regulations (IR (ME) R). At the time of the inspection, there were no open cases with the CQC. One incident was reported to the Radiology Protection Advisor (RPA) who advised it was a non-reportable incident.

Cleanliness, infection control and hygiene

- On visual inspection, all areas we visited in outpatients and diagnostics appeared clean and tidy, including the toilets and changing rooms. Posters prompting hand hygiene were clearly displayed and hand gel pumps were available across the areas. We observed staff but not many patients using them during our observation in the main outpatient waiting area.

Good

Outpatients and diagnostic imaging

- We observed the majority of staff adhered to the 'bare below the elbow' guidance and staff wore personal protective equipment (PPE) where necessary. This reduced the risk of infections to staff and patients and was in line with good practice.
- Infection prevention and control policies were available for staff to access on the intranet. There was an infection control link nurse in outpatients who attended relevant meetings and fed back to the team.
- The majority of sinks were not fully compliant with HBN 0009 Infection Control in the Built Environment (March 2013), which is department of health best practice guidance.
- The majority of consulting rooms were carpeted and did not meet infection control guidelines. A refurbishment programme is in place. Two rooms used for gynaecology and ENT consultations met the required guidelines.
- All soft furnishings were wipeable and in good condition.
- The vinyl floor in the departments needed replacing in some areas such as diagnostic imaging. Staff told us of a planned replacement of the floor areas in the dental room and the toilets.
- Mandatory training compliance records for outpatient staff showed 100% compliance. This training included infection prevention and control. Staff in both diagnostic imaging and outpatients confirmed they had attended this training and were able to show us their own personal training records.
- Outpatients and diagnostic imaging used an established wipe system for decontaminating scopes. Full records were kept to demonstrate the process had been followed correctly. There was a separate clean and dirty utility space.
- We observed good waste streaming with the use of hazardous waste bins and recycling bins. We found the temporary closure on sharps bins was in use.
- We saw departmental cleaning schedules in diagnostic that was completed and up to date. We also saw the use of 'I am clean' stickers on equipment throughout outpatients and diagnostic imaging.
- A quarterly infection control committee was in place.Information and minutes from these meetings were shared with the outpatients staff.

Environment and equipment

- There was resuscitation equipment available across outpatients and diagnostics. We looked at resuscitation trolley checklists and found them to be checked and signed on a daily basis.
- There was adequate seating and space in outpatients. Work was planned to reconfigure the space in diagnostic imaging to improve patient flow through the department and allow space for expansion of services.
- Bariatric chairs and high rise chairs suitable for orthopaedic patients were available in the outpatient area.
- The hospital's Patient Led Assessment of the Care Environment (PLACE) scores relating to outpatients and diagnostic imaging were lower than the England average. These included scores for cleanliness, condition, appearance and maintenance, privacy, dignity and wellbeing and disability. This indicated improvements needed to be made. We looked at the PLACE action plan and noted actions had been taken to make improvements such as replacing net curtains with blinds in diagnostic imaging.
- X-ray equipment had regular servicing carried out by manufacturer engineers. We saw evidence of the manufacturers completed service reports. We also saw evidence of routine surveys of all X-ray equipment.
- The imaging service had arrangements in place to control and restrict access to ionising and non-ionising radiation areas.
- The diagnostic imaging department's risk register included replacing ageing imaging. A full risk assessment had been done to mitigate the risks.
- We saw up to date Quality Assurance (QA) records for the equipment in the breast-imaging department.
- We observed radiology staff wearing specialised personal protective aprons. These were available for use within all radiation areas and on mobile equipment. Staff were also seen wearing personal radiation dose monitors which were monitored in accordance with the relevant legislation.

Medicines

- The medicines cupboards we inspected were locked and secure, all stock was within expiry date and there was evidence of stock rotation. Cupboards containing substances hazardous to health were also locked.

- Fridge temperatures were checked and recorded daily and were within the required range to store medicines safely.The ambient temperature of the room was also checked daily.
- Prescription pads were stored securely in locked cupboards and drawers. There was a system in place to record and log the usage of the prescription pads by clinicians. This meant there was information available to identify the serial numbers of the prescription sheet used, the patient prescribed to and the doctor prescribing. This met best practice guidelines for the use of controlled drug stationary.
- Outpatients and diagnostic imaging were compliant with the Home Office Controlled Drugs audit done in June 2016.
- Staff were aware of the policies involving medicines management and knew where they were located in the department and on the staff intranet.
- The layout and design of the pharmacy meant it was difficult to find a confidential area to discuss prescriptions with patients.

Records

- Records were stored across the hospital in various locations. These locations were safe and secure and could only be accessed by authorised staff.
- Electronic records could only be accessed by authorised personnel. Computer access was password protected and staff used individual log-ins.
- We looked at 12 patient records. Overall they were completed correctly. However, some allergy information was missing and the carbon copy notes were difficult to read.
- The hospital used a radiology information system (RIS) and picture archiving and communication system (PACS). This meant patients radiological images and records were stored securely and access was password protected.
- The hospital used an image exchange system and were able to access imaging from other hospitals in preparation for a patient's consultation.
- Medical records generated by staff with practising privileges were overall kept on site in the medical secretaries' office. Notes were copied and filed at the end of clinic consultations. Consultants had to comply with data protection regulations if notes were to be taken off site. The hospital had a comprehensive process in place to ensure staff complied with this requirement.
- We reviewed patient records on the imaging system and saw that the radiographers had completed them accurately, including the documentation of who checked patient identification and the recording of patient dose information. We also saw evidence that the radiographers had checked and documented patient pregnancy status in line with departmental protocol.

Safeguarding

- Safeguarding has three levels of training; level one for non-clinical staff, level two for all clinical staff and level three for staff working directly with children and young people. Level 2 and 3 training was on-line and staff were responsible for accessing this. Records demonstrated that 100% of staff had completed training in children and adults safeguarding across outpatients and diagnostic imaging to the required level for their role.
- The adult and paediatric phlebotomist was up to date with level 3 training for children.
- New arrangements were in place to ensure compliance with the Royal College of Nursing 'Safeguarding children and young adults: roles and competences for health care staff' Intercollegiate Document to ensure the relevant staff received the correct level of training.
- We saw policies in place and in date for both safeguarding children and adults.
- The majority of staff we spoke with demonstrated they understood safeguarding processes and how to raise an alert. They could access support from senior staff if needed. There were flow charts within each department detailing the actions to be taken and who to contact in the event of an adult or child safeguarding concern.

Mandatory training

- Mandatory training included infection control, health and safety, fire safety, conflict resolution and safeguarding.
- Mandatory training included e-learning and face to face meetings. Staff told us the quality of the training was good.

Good

Outpatients and diagnostic imaging

- Radiology management told us that all radiographers were up to date with their mandatory training and all staff we spoke to confirmed this. Records showed 95% compliance rates for diagnostic imaging staff across all mandatory training requirements.

Assessing and responding to patient risk

- Arrangements were in place to respond to emergencies. Emergency equipment and drugs were available and easily accessible.
- There was always a resident medical officer (RMO) on site who had completed advanced life support training, who was able to provide first line emergency treatment.
- Staff told us clinical observations such as temperature and blood pressure were monitored and recorded prior to, during and after any interventional procedure. This meant the patient was monitored to detect any deterioration in their condition. We were told of an incident in which a patient deteriorated within the interventional imaging room. Emergency procedures were correctly followed.
- Local rules in diagnostic imaging were evidenced as required under Ionising Radiations Regulations 1999 (IRR99) and were within review dates. IRR99 are a statutory instrument, which form the main legal requirements for the use and control of ionising radiation in the United Kingdom.
- The Ionising Radiation (Medical Exposure) Regulations 2000 (IR(ME)R) procedures were in place and all documentation was available on a shared drive. The radiology manager and staff in their team ensured that x-rays and other diagnostic tests were only made in accordance with the IRMER regulations.
- There were warning and information signs displayed in the diagnostic imaging department informing people about areas and rooms where radiation exposure took place.
- Kings Oak hospital was supported by an external radiation protection service. They provided the radiation protection advisor (RPA) and medical physics expert (MPE), for diagnostic imaging.
- There were radiation protection supervisors (RPS) in diagnostic imaging. Their role met the Ionising Radiation Regulations 1999. Dose reference levels were evident for X-ray rooms.
- An adapted version of the World Health Organisation (WHO) checklist was used for all interventional procedures. We saw copies of these scanned into the patient electronic record.
- We reviewed the BMI wide risk register and saw the risk for replacing the interventional radiology equipment was of high priority. We were assured, following discussions with the radiology manager that suitable interim measures have been put in place to reduce the risk to patients.

Nursing, diagnostic imaging and administrative staff staffing

- There were dedicated nursing and healthcare assistant staff across the outpatients department.
- The staffing in outpatients consisted of the senior lead, a deputy lead nurse, three registered nurses, four healthcare assistants, a bank nurse and a phlebotomist. Senior staff felt the staffing levels were adequate to meet the demand of the scheduled and extra evening and weekend clinics. There were currently no vacant posts. Long term bank staff were used as part of the staffing in the outpatients department. Induction was thorough and no agency staff were used.
- The outpatient receptionist's team were short staffed and currently had three posts out to advert. Staff told us it had been busy and difficult to cover the clinics.
- Staffing in the diagnostic imaging department consisted of a departmental lead covering both Kings Oak and Cavell hospitals, a senior deputy radiographer, registered radiographers, assistant practitioners, reception and administrative staff.
- Arrangements for handovers and shift changes in outpatients and diagnostic imaging ensured patients were safe by ensuring enough staff were available.

Medical staffing

- Consultants who held clinics were responsible for the care of their patients. Secretaries organised the clinic lists around consultant availability.
- There were 259 consultants recorded as having practicing privileges at the hospital. Of this number, 11% worked regularly at the hospital undertaking a 100 or more consultations from July 2015 to June 2016. A further 25% of consultants undertook between 10 and 99 consultations in the same time period.

Good

Outpatients and diagnostic imaging

- Consultant radiologists were not always on site but there was a process for cover in order to access support and advice. A radiologist would always attend at least once in the day to view and report imaging and scan results.

Major incident awareness and training

- The hospital had a major incident plan in place and there was evidence of business continuity plans for both outpatients and diagnostic imaging.
- Staff understood what actions to take in response to a major incident.
- Staff told us there was regular testing of fire alarms and they knew where the fire assembly point was and how to evacuate the patients and staff within their immediate areas.

Are outpatients and diagnostic imaging services effective?

Not sufficient evidence to rate

- Patients' needs were assessed and their care and treatment was delivered following local and national guidance for best practice. However, there was no formal audit programme reviewing the use of these guidelines in practice.
- Staff obtained written and verbal consent to care and treatment which was in line with legislation and guidance.
- We saw evidence of the World Health Organisation and other checklists were carried out in the imaging department.
- Staff were suitably qualified and skilled to carry out their roles effectively and in line with best practice. Staff felt supported to deliver care and treatment to an appropriate standard.
- 100% of staff had received appraisals in outpatients and diagnostic imaging.

Evidence-based care and treatment

- Staff had access to evidence based protocols and pathways based on National Institute for Health and Care Excellence NICE and Royal Colleges' guidelines. A central BMI team supported all hospitals within the organisation to remain updated and informed the hospital of any changes to guidance. Staff told us these would be discussed at the governance and risk meetings for sharing further information with staff.
- Policies and procedures were available for staff to view on the intranet.
- The interventional radiology checklist adopted from the World Health Organization (WHO) surgical checklist was used within interventional radiography. We saw evidence from audits of 100% compliance with the use of the checklist.
- The diagnostic imaging department referred to national diagnostic reference levels (DRLs) within their service. We saw DRLs displayed in all areas visited. DRLs are typical doses for examinations commonly performed in radiology departments. They are set at a level so that roughly 75% of examinations will be lower than the relevant DRL. They are not designed to be directly compared to individual doses however, they can be used as a signpost to indicate to staff when equipment is not operating correctly. We saw the annual dose audit which had been checked by the Radiation Protection Advisor within the department.
- We observed staff confirming the correct identification of patients before proceeding with the x-rays.

Patient outcomes

- Outpatients and diagnostic imaging followed the hospital Did Not Attend policy.
- Outcome forms following a patient consultation were uploaded onto the computer system on the same day as the consultation.
- There was a lack of local and national audits and initiatives within the outpatient department generally to monitor and report on patient outcomes.
- We looked at the audit schedule for 2016 which covered audits such as resuscitation equipment and medicines management.

Competent staff

- There was a medical advisory committee (MAC) responsible for consultant engagement. For a consultant to maintain their practising privileges at the hospital there were minimum data requirements with which a consultant must comply. These included

registration with the General Medical Council (GMC), evidence of insurance and a current performance appraisal or revalidation certificate. In speaking with staff we were assured this process was followed.

- Practicing privileges and competences of consultants were monitored and they would be suspended from practising in the hospital if the standards were not met. Staff told us of this process and how there were five consultants currently suspended until they could demonstrate compliance with the standards required.
- Staff told us they were able to identify specific learning through the appraisal process and were able to access training to support the identified need.
- We saw evidence that nurses, radiographers and others had appropriate skills, knowledge and experience to carry out their roles effectively. This included suitably qualified children's nurses who had recently been appointed.
- We saw evidence of competency assessments for when staff took on new responsibilities.
- Staff administering radiation were appropriately trained to do so. We spoke with the radiology manager who showed us records demonstrating staff compliance with the IRMER regulations.
- Records showed that outpatients staff were 100% compliant and diagnostic imaging staff 96.7% compliant with their mandatory training requirements.

Multidisciplinary working

- Breast one stop clinics were held in the diagnostic imaging department throughout the week and on a Saturday morning. We spoke to some patients attending the clinic and they told us it had been a good experience and they felt well looked after by the team.
- A radiologist told us of the close working relationship with pathology services at a nearby hospital to support the one-stop clinics.
- Many meetings were multidisciplinary in the hospital. This allowed multi-disciplinary input from nursing, medical and diagnostic staff.
- We saw good communication between the interventional team during a procedure.

Seven-day services

- The outpatients department was open Monday to Friday 7.30am- 9pm and Saturday from 7.30am- 2pm.
- The radiology service provided emergency cover 24/7 across the modalities. Radiologists were on-call each day for phone consultations. Workstations were available at home to report urgent images.

Access to information

- Staff told us and we saw that they had access to hospital policies and procedures on the intranet.
- No patients were seen in outpatients without a paper or electronic record being available.
- The consultant's secretaries provided the consultant's own notes prior to any outpatient appointment. We looked at the clinic lists and saw 100% of notes were available on the day of the inspection.
- We were told a few consultants took the notes off site. It is a requirement of their practicing privileges that they register as a data controller with the Information Commissioner's Office. This information was held on the consultant's file and checked regularly to ensure compliance with this requirement.
- Any previous diagnostic images were available to view as part of an image sharing system.
- The hospital used a radiology information system and picture archiving and communication system (PACS). This meant patient's radiological images and records were stored securely and access was password protected.
- Staff in the breast-imaging service told us that they always tried to obtain previous images for women attending for mammograms with suspicious findings, as the previous images may assist with making a more accurate diagnosis.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff demonstrated confidence and competence in seeking verbal and written consent from patients. Verbal consent was observed in the X-ray room and the urology outpatient clinic. The consent process included a discussion of the risks to the patient and an opportunity for the patient to ask questions.
- Four patients we spoke with told us they had been asked for their consent before they received treatment.
- Staff received training on the Mental Capacity Act (MCA). Capacity assessments were generally carried out by consultants but staff told us they would inform senior nurses and the safeguarding lead if they had concerns.

Good

Outpatients and diagnostic imaging

Are outpatients and diagnostic imaging services caring?

Good

We rated caring as good because:

- Throughout the inspection we witnessed good care being given. Patients clearly appreciated the staff and the care they were given. Some patients had mobility issues and staff ensured they were assisted where appropriate and not rushed.
- All of the patients we spoke with were positive about their experience of care.
- Oncology trained nurses were available for patients who were to be given bad news.
- We observed staff being respectful at all times and with particular regard to patient's privacy and dignity.

Compassionate care

- We observed good interactions between nurses, radiographers, medical staff, healthcare assistants and administration staff and the patients. Interactions were considerate and respectful in manner.
- We observed patients asking questions at both the outpatients and the diagnostic imaging reception. The reception staff responded in a friendly and helpful manner.
- Patient's privacy and dignity was always respected in the care we observed. We noted diagnostic imaging had made changes to the changing rooms to improve on this aspect.
- The services provided a chaperone when required.
- Several patients described the care in the hospital as 'excellent.'
- We observed patients being greeted in a friendly manner by staff but they were not often told of the wait time for the clinic.

Understanding and involvement of patients and those close to them

- Most patients we spoke with felt well informed about their care including any investigations that were planned. Patients we spoke to in the breast imaging clinic told us that staff were good at explaining procedures and providing opportunities for them to ask questions. One person told us she had recommended the service to her friends.
- We spent time in the main outpatient reception area and observed patients being greeted and booked into the clinics. They were given clear instructions as to the paperwork that needed completing and were able to ask any questions.

Emotional support

- We observed staff acting in a professional way. Patients told us staff were caring and professional.
- Staff told us a quiet clinic room would be made available for breaking bad news.
- Patients who were receiving treatment and support through the breast care service were offered follow-up emotional and social support. We saw evidence that treatment options were discussed and that patients were encouraged to be part of the decision making process.

Are outpatients and diagnostic imaging services responsive?

Good

We rated responsive as good because:

- People were able to access services for assessment, diagnosis or treatment when they needed to. The hospital was meeting national waiting times for diagnostic imaging within six weeks and outpatient appointments within 18 weeks for the incomplete pathways for their NHS patients.
- The service closely monitored any complaints and staff were confident in dealing with them locally where possible.
- Patients had good access to refreshment areas in the main outpatient department and water dispensers were available in diagnostic imaging.
- Weekend and evening clinics were regularly being provided to offer flexibility in the service.
- Staff were aware of patients with dementia but told us they did not see them on a regular basis.

However,

Good

Outpatients and diagnostic imaging

- There was access to an interpreter service for patients whose first language might not be English but we observed and were told that relatives were used instead.
- We saw evidence that sometimes appointments were delayed due to consultations overrunning. We spoke with one patient whose appointment had been delayed by over thirty minutes but they did not know why.

Service planning and delivery to meet the needs of local people

- 'From 1st May 2016, the hospital offered a restricted service to children. This meant they only saw children above three years of age in outpatients for consultations only.
- A consultant paediatrician represented the children and young people on the Medical Advisory Committee to offer support and advise on paediatric matters. Staff told us that if patients require a paediatric consultant, their appointment was booked with the appropriate person through the national enquiry and bookings centre.
- We were told and staff confirmed they were not undertaking any invasive surgery on anyone 16 years or below. Any 16-18 year olds were pre-assessed on an adult pathway prior to any planned surgical intervention.
- NHS patients were able to use the 'choose and book' system to enable them to choose a suitable appointment.
- The environment was appropriate and patient-centred with comfortable seating, refreshments and suitable toilets.
- The hospital offered outpatient consultation only for oncology patients. No other intravenous chemotherapy or other cancer treatments were provided.

Access and flow

- There were 47,602 outpatient total attendances in the period July 15 to June16. Of these 37% were NHS funded and 63% were other funded.
- Patients we spoke with told us the appointment system was easy to use and they had no problems arranging a suitable appointment.
- Some clinics overran during our inspection. No formal audit was undertaken of clinic wait times although some staff acknowledged this was an ongoing problem.
- Diagnostic imaging had dedicated porters so that patients could be transported efficiently to and from the ward.

Meeting people's individual needs

- We noted that water dispensers, a hot drinks and a vending machine were available in the outpatient's area. Patients were also told they could use a small café on the first floor of the hospital.
- There was a small play area for children in the outpatients waiting room. We spoke with the new children's lead nurse. She told us work was underway to do risk assessments on children's needs such as a separate waiting space. This was work in progress at the time of the inspection.
- Staff told us interpreting services could be booked for patients attending outpatient or diagnostic imaging appointments. However, we saw a relative being used to interpret before a diagnostic imaging procedure took place.
- The staff we spoke with demonstrated a good understanding of the needs of patients with dementia. We were assured the patient who may be distressed or confused would be treated appropriately.
- Overall patients we spoke with were very positive about the outpatient and diagnostic imaging services and told us they received good treatment and were happy to attend these departments.
- We saw the outpatient department kept a wide choice of patient information leaflets which meant that patients were supported to make informed choices about their care.
- During our inspection, we visited the phlebotomy room. This was a walk-in service meaning patients did not need to make an appointment.
- Reasonable adjustments were made so that disabled patients could access and use the outpatient and diagnostic services. Reception desks had sections that were at wheelchair height.
- Patients with bariatric needs were not referred to the outpatients or diagnostic imaging departments.

Learning from complaints and concerns

Good

Outpatients and diagnostic imaging

- Complaints were handled in line with the hospital policy.
- The hospital received 29 complaints between July 2015 and June 2016; of which 8 were open at the time of our inspection.
- Complaints were discussed at the Complaints Response Bureau as well as reviewed by the Clinical Governance Committee, and department meetings. We saw evidence of these discussions in the various meeting minutes.
- The Director of Clinical Services was responsible for ensuring a comprehensive investigation was undertaken on the clinical aspects of complaints and ensuring the recommendations made from any complaints were implemented across clinical services.
- Staff told us learning from complaints was shared via various forums such as the team meeting. We saw evidence of changes made following a complaint. New screens were in place to protect a patients privacy and dignity whilst undergoing investigations in outpatients such as an Echocardiogram (ECG).
- We saw the results from the patient satisfaction survey were similar to the England average of NHS patients across the period January 16 to June 16.
- Response rates ranged from 34%-61% during the same time period and were above the England average for NHS patients apart from in January 16.
- We did not see any recent patient satisfaction survey results displayed in outpatients or diagnostic imaging.

Are outpatients and diagnostic imaging services well-led?

Good

We rated well-led as good because:

- We saw evidence of actions taken to improve findings from the PLACE audit.
- Most staff were aware of the corporate vision.
- The senior management team and departmental leads were aware of the risks of the hospital and had plans in place to mitigate and eliminate these risks.
- Monthly meetings were in place for all levels of staff

However,

- Staff felt the changes in leadership of the hospital were unclear.
- Not all staff were positive about their local leadership.

Vision and strategy for this service

- Most of the staff we spoke with were aware of the BMI vision and values.
- The vision for outpatients was informed by the corporate vision. For example, changes had recently been made to offer pre-assessment clinics at Cavell hospital only.
- An improvement and refurbishment plan was in place for both outpatients and diagnostic imaging to improve the patient flow and environmental concerns such as carpets in the clinical areas.
- The recent change to the paediatric service was in its infancy. We saw evidence of revised hospital policy being followed in diagnostic imaging on the day of the inspection. However, we were told this was new in place and had not been in operation before our visit.
- Senior managers were able to identify strengths in their service provision such as the breast imaging and the interventional service.

Governance, risk management and quality measurement

- Governance arrangements were in place and the framework supported the delivery of good quality care. For example, complaints and incidents were discussed at the CRB, heads of department meetings, the Medical Advisory Committee and the Quality and Safety board.
- Vacancies for staff were all advertised. The reduced staffing impacted on the reception team.
- There was a corporate audit calendar in place. Audit results were discussed at the clinical governance, MAC and team meetings and actions plans were implemented when poor compliance was noted.
- We saw the departments had updated risk registers in place and the ones that had been identified in our discussions were reflected on these registers. For example, the departmental lead in diagnostic imaging described the risks associated with the ageing interventional equipment. We saw this on the corporate risk register as a priority.
- MAC meetings took place quarterly and practicing privileges, quality assurance and new national

guidelines were discussed. We saw evidence of this in the minutes including discussion of practising privileges being removed as there was non-compliance with the requirements.
- There was a contract in place with an external service to offer Radiation Protection advice and support.

Leadership and culture of the service

- The outpatient senior team told us they were confident for the future of the service. They felt a focus on outpatients with the improvement plan was in progress.
- The majority of staff described a positive working environment and good team work amongst colleagues. However, we heard several accounts where staff had been treated unprofessionally and some staff wanted to leave.
- Assistant practitioners in diagnostic imaging were pleased they had the opportunity to undertake the role and be supported to progress on a professional radiography course.
- Outstanding work by staff was rewarded in the form of a 'Guardian Angel' award. This had been given to a member of the diagnostic imaging service for their exceptional contribution.

Public and staff engagement

- The departments sought feedback from patients using the Friends and Family survey.
- Staff engaged in regular and minuted meetings.
- Although several staff told us they were proud to work for the hospital, they did not always feel involved or listened to as regards service improvement.

Innovation, improvement and sustainability

- Staff skills were maximised by the training of assistant practitioners to support radiology staff.
- Both departments had plans in place to improve the services.
- The breast imaging clinics offered a comprehensive and responsive service for patients with breast concerns.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider SHOULD take to improve

Surgery

- Ensure all clinical areas comply with the requirements of Health Building Notice (HBN) 00-09: Infection control in the built environment.
- Ensure all cleaning products are stored in locked cupboards as required by the Control of Substances Hazardous to Health Regulations 2002 (COSHH).
- Ensure all staff are clear and consistent on the scoring of NEWS to avoid delays in escalating deteriorating patients.

Medical care

- Ensure a system for monitoring the cleaning of the endoscopy department is in place including the cleaning of trolleys.
- Ensure the endoscopy room is no longer used for storage.
- Ensure that signage is place to encourage hand washing and identify hand gel dispensers.
- Ensure controlled drugs are disposed of in a timely way.
- Should provide dispensing benches or work surfaces provided for counting or checking items.
- Improve the environment in patient's rooms and bathrooms.
- Ensure staff completed their mandatory training.
- Undertake audits of national early warning score (NEWS) systems to identify deteriorating patients.
- Ensure that the resident medical officer RMO's has regular clinical supervision.

Outpatients and diagnostic imaging

- Ensure the hospital's target for mandatory training is met
- Improve staffing in radiology for sonographers.