BMI Healthcare Limited

BMI The Chiltern Hospital

Inspection report

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This report describes our judgement of the quality of care at this service. It is based on a combination of what we found when we inspected, information from our ongoing monitoring of data about services and information given to us from the provider, patients, the public and other organisations.

Ratings

Overall rating for this location	Good
Are services safe?	Good
Are services effective?	Good
Are services caring?	Good
Are services responsive to people's needs?	Good
Are services well-led?	Good

Summary of findings

Overall summary

Our rating of this location improved. We rated it as good because:

- The service had enough staff to care for patients and keep them safe. Staff had training in key skills, understood how to protect patients from abuse, and managed safety well. The service controlled infection risk well. Staff assessed risks to patients, acted on them and kept good care records. They managed medicines well. The service managed safety incidents well and learned lessons from them. Staff collected safety information and used it to improve the service.
- Staff provided good care and treatment, gave patients enough to eat and drink, and gave them pain relief when they needed it. Managers monitored the effectiveness of the service and made sure staff were competent. Staff worked well together for the benefit of patients, advised them on how to lead healthier lives, supported them to make decisions about their care, and had access to good information. Key services were available seven days a week.
- Staff treated patients with compassion and kindness, respected their privacy and dignity, took account of their individual needs, and helped them understand their conditions. They provided emotional support to patients, families and carers.
- The service planned care to meet the needs of local people, took account of patients' individual needs, and made it easy for people to give feedback. People could access the service when they needed it and did not have to wait too long for treatment.
- Leaders ran services well using reliable information systems and supported staff to develop their skills. Staff understood the service's vision and values, and how to apply them in their work. Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. Staff were clear about their roles and accountabilities. The service engaged well with patients and the community to plan and manage services and all staff were committed to improving services continually.

However:

- The medical records department was cluttered and did not maintain a safe working environment for staff working in the department.
- Not all staff who were required to complete the Care and Communication of the Deteriorating Patient mandatory training had completed it.
- The theatre trolley in endoscopy had a tear which did not allow for effective cleaning. This could pose infection control risks and cross infection.
- The endoscopy service did not always have an appropriately trained staff member to support patients when breaking bad news.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Outpatients	Good 	Our rating of this service improved. We rated it as good because: • The service had enough staff to care for patients and keep them safe. Staff had training in key skills, understood how to protect patients from abuse, and managed safety well. The service-controlled infection risk well. Staff assessed risks to patients, acted on them and kept good care records. The service managed safety incidents well and learnt lessons from them. Staff collected safety information and used it to improve the service. • Staff supplied good care to patients. Managers checked the effectiveness of the service and made sure staff were competent. Staff worked well together for the benefit of patients and had access to good information. Services were available three days a week. • Staff treated patients with compassion and kindness, respected their privacy and dignity, took account of their individual needs and helped them understand their conditions. They gave emotional support to patients, families and carers. • The service planned care to meet the needs of local people, took account of patients' individual needs, and made it easy for people to give feedback. People could access the service when they needed it and did not have to wait too long for a diagnostic procedure. • Leaders ran services well using reliable information systems and supported staff to develop their skills. Staff understood the service's vision and values, and how to apply them in their work. Staff felt respected, supported and valued. Leaders focused on the needs of patients receiving care. Staff were clear about their roles and accountabilities. The service engaged well with patients. Outpatients is a small proportion of hospital activity. The main service was surgery. Where arrangements were the same, we have reported findings in the surgery section.

Summary of findings

We rated this service as good because it was safe, effective, caring, responsive and well led.

Services for children & young people

Good 

Our rating of this service improved. We rated it as good because:

- The service had enough staff to care for children and young people and keep them safe. Staff had training in key skills, understood how to protect children and young people from abuse, and managed safety well. The service controlled infection risk well. Staff assessed risks to children and young people, acted on them and kept good care records. The service managed safety incidents well and learned lessons from them.
- Staff provided good care and treatment. The Children's lead monitored the effectiveness of the service and made sure staff were competent. Staff worked well together for the benefit of children and young people, supported them to make decisions about their care, and had access to good information.
- Staff treated children and young people with compassion and kindness, took account of their individual needs, and helped them understand their conditions. They provided emotional support to children and young people, families and carers.
- The service planned care to meet the needs of local people, took account of children and young people's individual needs, and made it easy for people to give feedback. People could access the service when they needed it and did not have to wait too long for treatment.
- Leaders ran services well using reliable information systems and supported staff to develop their skills. Staff understood the service's vision and values, and how to apply them in their work. Staff felt respected, supported and valued. They were focused on the needs of children and young people receiving care. Staff were clear about their roles and accountabilities. The service engaged well with children, young people and the community to plan and manage services and all staff were committed to improving services continually.

However,

- Staff should consider weighing patients in a private area.

Summary of findings

The Children and young people's service is a small proportion of hospital activity. The main service was surgery. Where arrangements were the same, we have reported findings in the surgery section.
We rated this service as good because it was safe, effective, caring, responsive and well led.

Diagnostic imaging

Good

Our rating of this service improved. We rated it as good because:

- The service had enough staff to care for patients and keep them safe. Staff had training in key skills, understood how to protect patients from abuse, and managed safety well. The service controlled infection risk well. Staff assessed risks to patients, acted on them and kept good care records. They managed medicines well. The service managed safety incidents well and learned lessons from them. Staff collected safety information and used it to improve the service.
- Staff provided good care to patients, and monitored their pain. Managers monitored the effectiveness of the service and made sure staff were competent. Staff worked well together for the benefit of patients, advised them on how to lead healthier lives, supported them to make decisions about their care, and had access to good information. Key services were available seven days a week.
- Staff treated patients with compassion and kindness, respected their privacy and dignity, took account of their individual needs, and helped them understand their conditions. They provided emotional support to patients, families and carers.
- The service planned care to meet the needs of local people, took account of patients' individual needs, and made it easy for people to give feedback. People could access the service when they needed it and did not have to wait too long for a diagnostic procedure.
- Leaders ran services well using reliable information systems and supported staff to develop their skills. Staff understood the service's vision and values, and how to apply them in their work. Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. Staff were clear about their roles and

Summary of findings

accountabilities. The service engaged well with patients and the community to plan and manage services and all staff were committed to improving services continually.

Diagnostic imaging is a small proportion of hospital activity. The main service was surgery. Where arrangements were the same, we have reported findings in the surgery section.
We rated this service as good because it was safe, effective, caring, responsive and well led.

Medical care (Including older people's care)

Good

Our rating of this service stayed the same. We rated it as good because:

- The service had enough nursing and support staff with the right qualifications, skills, training and experience to keep patients safe and to provide the right care and treatment.
- Infection prevention and control processes had been reviewed and developed further to support staff practices during the pandemic.
- Equipment in endoscopy and oncology units was managed effectively with evidence of regular checks and clear records were maintained. This included the emergency equipment such as the resuscitation trolleys which were tagged and easily accessible.
- The service provided mandatory training in key skills to all staff and monitored training compliance.
- The service managed medicines safely and followed good practice guidance. Staff followed their procedures for access to the pharmacy out of hours.
- Managers ensured that these staff received training, supervision and appraisal. The staff worked well together and as a multidisciplinary team.
- Staff understood and discharged their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005.
- Staff understood how to protect patients from abuse and had training on how to recognise and report abuse and they knew how to apply it.
- Managers used reliable information systems and supported staff to develop their skills. Staff understood the service's vision and values, and how to apply them in their work.

Summary of findings

- Staff were focused on the needs of patients and delivering individualised care. Staff were clear about their roles and accountabilities.
- The service engaged well with patients and the community to plan and manage services and all staff were committed to improving services continually.
- Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service promoted equality and diversity in their daily work and provided opportunities for career development. The service had an open culture where patients, their families and staff could raise concerns without fear.
- Leaders operated effective governance processes, throughout the service and with partner organisations. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.
- Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events.

However:

- The theatre trolley in endoscopy had a tear which did not allow for effective cleaning. This could pose infection control risks and cross infection.
- The endoscopy service did not always have an appropriately trained staff member to support patients when breaking bad news.

Medical Care is a small proportion of hospital activity. Where arrangements were the same, we have reported findings in the surgery section.
We rated this service as good because it was safe, effective, caring, responsive and well-led.

Surgery

Good 

Our rating of this service stayed the same. We rated it as good because:

- The service had enough staff to care for patients and keep them safe. Staff had training in key skills, understood how to protect patients from abuse, and managed safety well. The service controlled infection risk well. Staff assessed risks to patients,

Summary of findings

acted on them and kept good care records. They managed medicines well. The service managed safety incidents well and learned lessons from them. Staff collected safety information and used it to improve the service.

- Staff provided good care and treatment, gave patients enough to eat and drink, and gave them pain relief when they needed it. Managers monitored the effectiveness of the service and made sure staff were competent. Staff worked well together for the benefit of patients, advised them on how to lead healthier lives, supported them to make decisions about their care, and had access to good information. Key services were available seven days a week.
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However:

- The medical records department was cluttered and did not maintain a safe working environment for staff working in the department.
- Not all staff who were required to complete the Care and Communication of the Deteriorating Patient (CCDP) mandatory training had completed it.

Summary of findings

We rated this service as good because it was safe, effective, caring, responsive and well led.

Summary of findings

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Summary of this inspection

Background to BMI The Chiltern Hospital

BMI The Chiltern Hospital is operated by BMI Healthcare Limited. BMI Healthcare Limited has been owned by Circle Health Group since December 2019.

The hospital opened in March 1982 and is a private hospital in Great Missenden, Buckinghamshire. The hospital primarily serves the communities of South Buckinghamshire. It also accepts patient referrals from outside the area. The hospital leadership team including directors and heads of department work at both the BMI Chiltern Hospital and the nearby BMI Shelburne Hospital.

BMI The Chiltern Hospital provides surgery, endoscopy, oncology, outpatients and diagnostic imaging services for adults. The hospital is a non-interventional site for children and young people seeing 0-18 year olds in outpatients and diagnostic services. The hospital provides inpatient/day case facilities for surgery and interventional care in outpatients for 16/17 year olds on an adult pathway. No interventional procedures are performed for children under the age of 16.

The hospital provides care and treatment to adults and children and young people who have private medical insurance, pay for themselves and NHS funded patients.

In the reporting period from September 2020 to August 2021:

- There were 5,448 surgery day cases and 1,134 inpatient episodes of care recorded at the hospital; of these 71% were privately/insured funded patients and 29% NHS funded
- There were 1,274 oncology treatment. All patients were either self -funded or insured.
- There were 1,196 endoscopy patients treated as ambulatory or day cases; of these 65% were privately/insured funded patients and 35% NHS funded.
- There were 4,209 children and young people's appointments which included, outpatient, imagining and physiotherapy appointments and paediatric blood test.
- There were 60,609 episodes of care in the outpatient department.
- There were 22,143 episodes of care in the diagnostic imaging department.

The hospital has two wards, Chalfont and Shardeloes, with 56 bedrooms in total. Shardeloes is a day case ward and Chalfont an inpatient and day case ward. The majority of rooms have ensuite facilities. The hospital has three theatres (two with laminar flow) and a separate JAG accredited endoscopy theatre. The Oncology suite has four individual pods and four en-suite bedrooms. The outpatient department consists of 12 consulting rooms, minor procedures room, colposcopy room and treatment room. The diagnostic imaging service includes computerised tomography (CT), magnetic resonance imaging (MRI), DEXA (bone density scanning), digital mammography, ultrasound and plain film X-ray. There are no emergency facilities at this hospital.

There were 135 surgeons, anaesthetists and physicians working at the hospital under practising privileges.

The hospital is registered to provide the following regulated activities:

- Diagnostic and Screening Procedures
- Surgical Procedures
- Treatment of Disease, Disorder or Injury

Summary of this inspection

The hospital has a registered manager who has been in post since July 2016. A registered manager is a person who has registered with the Care Quality Commission (CQC) to manage a service. Registered persons have a legal responsibility for meeting the requirements of the Health and Social Care Act 2008 and associated regulations about how a service is managed.

The hospital was previously inspected in 2019 and rated as requires improvement.

We inspected BMI The Chiltern Hospital using our comprehensive inspection methodology. We carried out a short-announced inspection on 20-21 September 2021.

Where our findings also apply to other services, for example management arrangements, we do not repeat the information but cross-refer to the surgery service level.

How we carried out this inspection

During the inspection, we assessed the surgical, medical care which included endoscopy and oncology units, outpatients, diagnostics imaging and children and young people services. We also reviewed the overall governance processes for the hospital and reported on this as part of the well-led domain. We spoke with approximately 45 members of staff and 20 patients, observed patient care and procedures with their consent, looked at patient waiting areas and clinical environments and attended staff huddles. We looked at 10 patients' care and treatment records, and at hospital policies, procedures and other documents relating to the running of the services.

You can find information about how we carry out our inspections on our website: https://www.cqc.org.uk/what-we-do/how-we-do-our-job/what-we-do-inspection.

Outstanding practice

We found the following outstanding practice:

- The oncology service had received the Macmillan Quality Environment Mark (MQEM) award in 2020 which identifies and recognises cancer environments that provide high levels of support and care for people affected by cancer. This has been developed in partnership with the Department of Health in England, as it is a core component of the English Cancer Reform Strategy.

Areas for improvement

Action the service MUST take is necessary to comply with its legal obligations. Action a trust SHOULD take is because it was not doing something required by a regulation but it would be disproportionate to find a breach of the regulation overall, to prevent it failing to comply with legal requirements in future, or to improve services.

Action the service SHOULD take to improve:

- The hospital should ensure emergency exits and pathways remain clear and unobstructed in the medical records department at all times to maintain a safe working environment for staff (Regulation 15: Premises and equipment).

Summary of this inspection

- The hospital should ensure staff who are required to complete the Care and Communication of the Deteriorating Patient (CCDP) mandatory training have completed it (Regulation 12: Safe care and treatment).
- The endoscopy service should ensure the patient's trolley maintained in good state of repair to minimise risk of cross infection. (Regulation 12: Safe care and treatment).
- The endoscopy service should ensure there is appropriately trained staff to support and provide information to endoscopy patients when breaking bad news. (Regulation 18: Staffing).
- The children and young people service should consider weighing patients in a private area.
- The diagnostic imaging service should consider displaying the names of the radiation protection supervisors and the radiation protection advisor in the imaging department.

Our findings

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Outpatients	Good	Inspected but not rated	Good	Good	Good	Good
Services for children & young people	Good	Good	Good	Good	Good	Good
Diagnostic imaging	Good	Inspected but not rated	Good	Good	Good	Good
Medical care (Including older people's care)	Good	Good	Good	Good	Good	Good
Surgery	Good	Good	Good	Good	Good	Good
Overall	Good	Good	Good	Good	Good	Good

Good

Outpatients

Safe	Good
Effective	Inspected but not rated
Caring	Good
Responsive	Good
Well-led	Good

Are Outpatients safe?

Good

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

Mandatory training

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

All staff received and kept up to date with their mandatory training. The most recent figures showed 97% of staff had completed their mandatory training. This was better than the corporate target of 95%.

The mandatory training was comprehensive and met the needs of patients and staff. Staff had time to complete training but sometimes did this outside of normal working hours. When this happened, staff were paid for the extra time taken to complete this.

Managers checked mandatory training and alerted staff when they needed to update this. Managers individually reminded staff to complete upcoming mandatory training. Managers followed up and supported staff who had not completed training on time. Managers paid staff for time outside of their working hours to complete training if required.

Clinical staff also completed training on recognising and responding to patients with dementia.

Safeguarding

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

At our last inspection in 2019, we raised concerns about the level of safeguarding training for staff. The provider acted on these concerns and all staff now had training specific for their role. A safeguarding lead for both adults and children supported staff and held additional training at level four. The hospital trained non-clinical staff at level one and clinical staff received training at level two or three which was dependent on their level of clinical responsibility.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. Staff we spoke with showed a good knowledge of what actions they would take if they had concerns.

Staff knew how to recognise adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. Staff could access contact details of the local safeguarding teams and find the safeguarding policy of the hospital. Between September 2020 and August 2021, there were two reported safeguarding incidents by the outpatient department which had been appropriately managed.

Cleanliness, infection control and hygiene

The service-controlled infection risk well. Staff used equipment and control measures to protect patients, themselves and others from infection. They kept equipment and the premises visibly clean.

Clinical areas were clean and had suitable furnishings which were well-maintained. The provider installed a sluice in 2019 following recommendations from our previous inspection in 2019. The hospital also installed new sinks in all consultation rooms. We saw staff demonstrating cleaning processes for equipment before and after use.

The service scored 100% on its most recent Infection Prevention and Control (IPC) audit (August 2021) and 100% over the past three months. It scored 99% on a July 2021 IPC audit of patient equipment and 100% on August 2021 hand hygiene audits. All staff completed IPC training.

Cleaning records were up-to-date and showed staff cleaned all areas regularly. Managers audited cleaning checklists conducted by staff at the department. Deep cleaning of the outpatient department occurred once a week and we saw records to support this.

Staff followed infection control principles including the use of personal protective equipment (PPE). PPE was readily available, and staff followed guidelines around the safe application and removal of PPE.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment kept people safe. Leaders ensured staff were trained to use equipment and managed clinical waste well.

The design of the environment followed national guidance. The outpatient department was accessed via the main reception. The outpatient department had an open entrance with an infection control station setup. Staff occupied this station and asked for the purpose of patients' visits. After completing the COVID-19 IPC station, patients checked in at the reception desk

The waiting area was open with a TV operating advertising material for the provider. The provider had a designated children's play area, but this was not being used due to COVID 19 guidance. Leaders said they wanted to implement announcements for appointments on the TV in the future to improve the experience for patients hard of hearing.

Leaders conducted risk assessments for the health and safety of the building and staff. Managers completed the last assessment in September 2021 for the outpatient department and concluded it was suitable for its purpose.

The hospital conducted electrical safety checks of equipment. An external company conducted checks for all equipment in the department. We saw equipment being tested by an external contractor in the department when we inspected. The hospital also provided records that confirmed suitable arrangements for this.

The service had enough suitable equipment to help them to safely care for patients. Staff stored stock in a suitable manner. We checked stock at random; it was in date and there was evidence of stock rotation. Staff told us there were no barriers to getting the right equipment and necessary consumables needed to provide safe and effective care to patients.

Consumables were stored neatly in trolleys in the consulting and treatment rooms. Consumables we checked in the outpatient department were in date and there was evidence of stock rotation.

Staff disposed of clinical waste safely after each clinic. Sharps bins were correctly labelled and not overfilled. Staff emptied waste bins after each clinic, and they were stored securely until collected by an external supplier whom the hospital contracted to dispose of clinical waste.

Assessing and responding to patient risk

Staff completed and updated risk assessments for each patient and removed or minimised risks. Staff showed and quickly acted upon patients at risk of deterioration.

At our last inspection in 2019, we raised concerns that a local action plan was not available for staff when a patient became aggressive. Managers now had a system requiring staff to escalate concerns to their line manager when they felt unsafe and for the line manager to de-escalate the situation. Staff we spoke with knew the new procedure. Staff would log any incident involving violence as a significant incident. Leaders and managers from the outpatient department had not logged any significant incidents relating to aggressive behaviour between September 2020 and August 2021.

Staff knew in advance which patients were attending clinics. Patients requiring additional assistance or support were highlighted on the daily list of attendance. For example, if a mobility aid was required by the patient, this would be noted.

Staff responded promptly to any sudden deterioration in a patient's health. There were pathways for identifying and managing deteriorating patients. Alarms were operational in each consultation room. We tested these alarms and saw staff responded promptly to them. Staff could also call a specific number to summon emergency support from the wider hospital when required. Staff we spoke with knew what actions to take and who to escalate their concerns to. Staff had training in immediate life support which included basic life support (BLS) training to ensure they had the skills to identify a deteriorating patient.

The department had resuscitation trolleys for adults and children. The adult trolley held a defibrillator which staff tested for us and worked correctly. The defibrillator had defibrillator pads for adults and children that were in date.

Staffing

The service had enough staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix, and gave bank, agency and locum staff a full induction.

Good

Outpatients

There are no agreed national guidelines as to what constitutes 'safe' nurse staffing levels in outpatient departments. However, at our last inspection in 2019, we raised concerns that rosters did not show enough clinical staff to ensure patients were looked after safely. In addition, rotas were issued short notice due to lack of staff.

At this inspection, the service had enough staff to keep patients safe and addressed the concerns previously raised. Leaders now held a daily communication call each day where hospital departments reported the number of staff on duty and reported risks associated with this. Managers now have rosters arranged for the department in advance. Staff we spoke with were positive about the changes in how the department was now staffed and there was always enough staff with the right skill mix to cover clinics so that patients could see a suitable clinical member of staff.

Managers accurately calculated and reviewed the number and grade of nurses and healthcare assistants needed for each shift. Managers showed a spreadsheet system for each week. Two senior staff members checked and managed the spreadsheet, and this was password protected to ensure managers could track changes. Managers could add clinics further in advance if asked.

The service had low sickness rates. The department sickness rate was 3%. The department had a turnover rate of 31.6% over the past year. This did not appear to affect the staffing capacity at the department in a negative way.

Managers made sure all bank and agency staff had a full induction and understood the service. The outpatient department used a total of 2,349 agency and bank staffing hours in the past year. Managers completed an induction checklist relevant to the location with locum staff. This included making staff aware of any location specific information. We saw a copy of the locum induction to confirm this.

The service offered practising privileges to consultants. Practising privileges is a well-established process within independent healthcare whereby a medical practitioner is granted permission to work in an independent hospital or clinic, in independent private practice, or within the provision of community services.

There were suitable staff numbers in the physiotherapy department to cover both the outpatient and inpatient aspect of their service.

Records

Staff kept detailed records of patients' care and treatment. Records were stored securely and available to all staff providing care.

Records were stored securely when not being used in the department. Staff stored patient notes in a separate locked room to the outpatient clinic area. Staff working in the outpatient department only had access to patients' records for the clinics running that day. Administrative staff kept the storage room locked, and access was given to outpatient staff when a doorbell alerted the administrative staff.

Administrative staff entered paper-based records into an electronic tracking system when they arrived at the hospital. These would then be filed away until their allocated clinic date.

When records were transferred to the outpatient department they were stored in a designated place in the nurse's office where they would be collected and returned by the consultant leading the clinic. Staff locked this office when there weren't staff present.

Good

Outpatients

There were failsafe systems that ensured staff did not lose patient records. The electronic system could show where staff stored a record in the storage room and when it was needed for use in a clinic.

We did not review patient records on the day of inspection; however, we did see five consent forms retrospectively filled out correctly for procedures proposed at the hospital. We also saw a health documentation audit which showed an improvement from 91% to 96% between November 2020 and July 2021. This audit looked at accuracy, safety and security of individual records audited.

Medicines

The service used systems and processes to safely prescribe, administer, record and store medicines.

Staff managed medicines and prescribing documents in line with the hospital policy. Medicines were not routinely stored in the outpatient department. Emergency medicines were stored in cardiac arrest packs and two drug bags. Staff checked emergency medicines once a week and filled out checklists to confirm this. We checked medicines at random on the day and all medications were in date. All emergency medicines had security tags to prevent tampering.

Oxygen was stored correctly. The hospital also had an oxygen pipeline system in areas where staff conducted clinical procedures.

Consultants could prescribe medicines during clinics, and these were electronically sent to the pharmacy for collection. A record of any medication prescribed would be put in the patient's notes. Paper based prescriptions could also be used to prescribe medication. Medication audits monitored the safe storage and tracking of paper-based prescriptions.

Pharmacy arrangements ensured the safe storage of medicines. This included suitable security precautions for locking controlled and emergency drugs. The department had a pharmacist responsible for medication. This included the processing of any controlled drug requests. Pharmacists checked medications that needed monitoring when they stored, and we saw checklists to support this.

Medicine audits were conducted at the department. Results were above 98% for audits conducted in October 2020, January 2021, and July 2021. The audits looked at safe storage, security, labelling of medicines, and emergency medicines.

Incidents

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

Staff knew what incidents to report and how to report them. All staff members had access to the incident reporting system. All staff we spoke with could give an example of a significant event that would require reporting. There was a clear policy and pathway to guide staff on how to report incidents. The service had not recorded any never events. There had been no serious incidents reported in the past twelve months.

Staff understood the duty of candour. The hospital had not had any incidents in the last 12 months where duty of candour had been applied. Leaders spoke about being open and honest with patients, apologising if something went wrong and learning lessons through the process.

Good

Outpatients

The service had systems to ensure staff knew about safety alerts and incidents, so patients received their medicines safely. Staff interviewed understood the concept of, and where to look for safety alert updates. Leaders had a system that included distribution and acknowledgement of receipt from staff. Managers supplied action plans if the safety alert affected them directly. A log of safety alerts for the department was seen retrospectively by our inspection team. Leaders had updated the safety alerts policy in July 2021.

Are Outpatients effective?

Inspected but not rated

At present we do not rate effectiveness for outpatient departments in acute independent hospitals but during our inspection we noted the following.

Evidence-based care and treatment

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

Staff followed up-to-date policies to plan and deliver high quality care according to best practice and national guidance. Leaders would check new guidance during monthly clinical governance meetings and send emails to staff to review guidance relevant to their role. We saw meeting minutes to support this at department and hospital level.

Clinical leaders reviewed and approved clinical policies for supporting up to date evidence-based practice and national guidance at a national committee which is part of the hospital's governance assurance framework which was reviewed in May 2021. The outpatient team would not attend these meetings but did have access to meeting minutes if they needed this information.

Nutrition and hydration

The outpatient department had coffee and water stations available for patients who required it.

Pain relief

Staff monitored patients to see if they were in pain.

Consultants managed pain relief while running their clinic. Outpatient managers had access to pain medication if this was needed through a pharmacy in the hospital where a dedicated pharmacist managed all medication associated with the outpatient department.

Patients were not routinely assessed for pain in the outpatient department as this was not a clinical risk typically encountered. However, if needed, pain would be discussed by the consultant as part of the presenting condition and captured in the patient notes accordingly.

Physiotherapy services managed pain as part of their service, but we did not explore the methods they use to achieve this when we spoke with the department.

Good

Outpatients

Patient outcomes

Staff checked the effectiveness of care and treatment where possible.

Clinical managers carried out patient outcome audits at the hospital site, however data for the outpatient department performance was limited.

Please see the surgery core report for more details.

Competent staff

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

Staff were experienced, qualified, and had the right skills and knowledge to meet the needs of patients. The provider checked professional memberships required for staff to carry out their roles. Healthcare assistants completed an external care certificate for their professional development.

Managers gave all staff a full induction tailored to their role before they started work. In our last inspection in 2019, we had concerns regarding induction arrangements. The hospital addressed these concerns and managers provided new starters with an induction pack which covered their first 90 days with the organisation. Outpatient managers also supplied a specific pack to their department.

The outpatient department had a well-planned induction programme for newly appointed staff. This was a set programme for staff to orientate themselves with the hospital, their department, the expected behaviours and training in procedures and policies. This was tailored to the individual's role at the hospital. Staff were allocated a mentor to support them when they first joined the team.

Managers supported staff and ensured they had yearly appraisals of their work. We reviewed three appraisals after the inspection. Managers discussed staff development during appraisals and included extending staff skills to different clinical areas, for example minor operations.

Managers made sure staff attended team meetings or had access to full notes when they could not attend. Staff could access the minutes of these meetings through a shared drive on a computer if they could not attend. Managers and staff said that face to face meetings were disrupted at the department due to COVID 19. Managers scheduled meetings monthly, but staff told us that this did not always happen due to restrictions on the number of staff in one room. Managers conducted virtual meetings as an alternative and minutes of these meetings were available on the hospital computer system to review.

Multidisciplinary working

Doctors, nurses, and other healthcare professionals worked together as a team to help patients. They supported each other to supply good care.

Staff we spoke with were seen working well together. They described a positive working environment where they felt respected and were able to raise concerns with their colleagues if they needed to.

Good

Outpatients

The department manager was present at head of department meetings and the daily communications call each morning. The physiotherapy team were in a separate area of the department and were available to assist when required by the outpatient team. The pharmacy team also contributed to the running of the department from a medicine management standpoint.

Seven-day services

Key services were available five days a week to support prompt patient care. Wider hospital services were available seven days a week.

The provider operated outpatient clinics five days a week. Consultants ran their clinics at different times in the morning, afternoon and evening and managers arranged this ahead of time with the consultants. Outpatient clinics did not run at the weekends, however the wider hospital remained open for patient enquiries and inpatient services.

Health promotion

The service had relevant information promoting healthy lifestyles and support in patient areas. Managers removed information leaflets from the outpatient department in line with COVID 19 guidance. The information was available if requested by patients.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients' consent.

Staff gained consent from patients for their care and treatment in line with legislation and guidance. We saw evidence that consent for surgical processes was obtained during outpatient appointments and prior to an operation. This gave patients time to have a thorough discussion with their consultant and time to think about their treatment options.

Written consent was required for some minor operations conducted at the outpatient department, for example, skin procedures. We reviewed five consent records post inspection and saw they were fully completed. The department had arrangements to support communication needs of patients when indicating their consent including interpretation services. This would be arranged with the hospital booking team ahead of time.

Staff could describe and knew how to access the policy on the Mental Capacity Act (2005) and Deprivation of Liberty Safeguards. Staff we interviewed could explain where policies were found for reference if they required this.

Are Outpatients caring?

Good

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

Compassionate care

Good

Outpatients

Staff treated patients with compassion and kindness. Staff did not always respect their privacy and dignity but did take account of their individual needs.

Patients said staff treated them with kindness. We spoke with seven patients during our visit. All patients spoken with praised their care.

Comments included:

“Two thumbs up”,

“Brilliant care”,

“Consultants explain things well and allow you time for questions”.

Patients gave positive feedback about the service. Leaders provided us with results and analysis from the postcard scheme run at the hospital. Between January 2020 and November 2020, excluding February, March and September, positive feedback accounted for 95% of responses. Leaders produced a monthly report that divided the data up in two ways, this was the funding type and the service that the respondent saw during their visit.

Patients and their families could give feedback on the service and their treatment. When needed, staff supported them to do this. Feedback postcards were the main source of feedback at the department. Managers clearly displayed the cards for patients and signs were available in the main corridor promoting the scheme.

All staff had dementia awareness training as part of their roles so that patients and their carers could be supported fully, in a compassionate way during their visit.

Emotional support

Staff provided emotional support to patients, families and carers to minimise their distress. They understood patients' personal, cultural and religious needs.

Staff gave patients and those close to them help, emotional support and advice when they needed it. Staff took time to interact with patients and those close to them in a respectful and considerate way. Staff and managers cared for patients and were attentive to their needs during interactions. For example, we saw staff opening doors and providing help for patients with mobility needs. If privacy was indicated, staff chaperones were available during consultations.

Staff supported patients and helped them keep their privacy and dignity. At our previous inspection, we highlighted the need for a designated room for distressed relatives in the outpatient department. The department had created a designated room in the department for this purpose and staff had awareness of this new arrangement.

Understanding and involvement of patients and those close to them

Staff supported patients, families and carers to understand their condition and make decisions about their care and treatment.

Good

Outpatients

Staff made sure patients and those close to them understood their care and treatment. Staff explained how they would help patients as part of their role.

Patients said consultants were thorough, spent time explaining procedures to them and they felt comfortable and assured. Patients told us they did not feel rushed during their appointments and that they had the opportunity to ask questions. They felt they were given clear and adequate information.

Patients and their families could give feedback on the service and their treatment and staff supported them to do this. The department had a patient survey which was visible through advertising and staff were proactive in directing patients to this. The survey was then analysed monthly.

Patients gave positive feedback about the service. We spoke with seven patients who all gave positive feedback. We also reviewed patient survey data which was on average 95% positive in 2020.

Are Outpatients responsive?

Good

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

Service delivery to meet the needs of local people

The service planned and provided care in a way that met the needs of local people and the communities served. It also worked with others in the wider system and local organisations to plan care.

The hospital worked with the clinical commissioning groups to ensure services reflected local plans and demand. The provider had diverted and postponed work, and made their services available, where needed to aid the NHS with the COVID 19 pandemic. The provider had now stopped this support and the hospital and department have returned to their original remit of care.

Facilities and premises were appropriate for the services being delivered. There was free parking on site for patients. The building signage was clear, and the waiting room layout promoted social distancing. Consultation rooms and clinical areas were accessible for all patients and were on one floor only. Patients could assess appointments both face to face and virtually. Clinics ran in the morning, afternoon, and evening.

Managers monitored and minimised missed appointments. Managers required consultants to give two weeks' notice and a valid reason for any clinic cancellation. Consultants filled out an authorisation form and this needed management signatures for approval. Patients received a confirmation letter or email to confirm their appointment. Patients would also receive a text message 48 hours before their appointment. Patients were asked to contact the hospital by telephone if they wanted to cancel their appointment.

Managers ensured that patients who did not attend appointments were contacted. Managers input cancelled appointments onto their appointment system. Administrators rebooked the appointments by telephone for the next available slot, this included evening clinics. Patients we spoke with confirmed that they had been contacted when they missed an appointment.

Good

Outpatients

The hospital's website listed the treatments and services available to patients and gave details on how to contact the hospital to discuss services offered.

Meeting people's individual needs

The service took account of patients' individual needs and preferences. Staff made reasonable adjustments to help patients access services.

Patient's individual needs were discussed during the booking of an appointment. Staff used the information to provide care and treatment in a safe way and mitigate any possible risk to the patient. If staff found that the service could not meet the patient's needs, staff would not treat them at the hospital, but refer them to an alternative health care provider who could better support the patient.

Staff working in the outpatient department knew in advance which patients were attending clinics that day. Patients requiring extra assistance or support were highlighted on the daily list of attendance and measures were organised accordingly.

Staff's lack of awareness of the hearing loop was raised at our last inspection in 2019. Staff we spoke with at this inspection could tell us about the hospital's policy on meeting the information and communication needs of patients with a disability or sensory loss. Staff told us about the hearing loop. We saw signs in the outpatient department to let patients know hearing loops were available in the hospital. Staff supplied accessible information standard (AIS) leaflets for patients if they needed information on the facilities provided at the hospital. The outpatient department had an information accessible folder that also supplied details on translations services. The hospital had an AIS champion that staff could contact for further advice. Information leaflets were available on demand in a wide variety of languages and font sizes for patients to ask.

Managers made sure staff, and patients, loved ones and carers could get help from interpreters or signers when needed. The provider acted on our concerns at the last inspection about interpreter services for patients attending their first appointment. Staff booking an appointment added translation needs on the booking system so that outpatient staff could act ahead of time. During COVID 19, staff did restrict translator visiting but they managed this through alternative measures such as video conferencing and telephone.

The outpatient department was suitable for patients who required physical support. The department was based on one level with wide corridors for wheelchair access and disabled toilet facilities. The environment was designed with access in mind. For example, the waiting area had suitable areas to manoeuvre wheelchairs.

Access and flow

People could access the service when they needed it and received the right care promptly.

Managers made sure patients could access services when needed. The provider did not check all waiting list times in their department but did have monitoring tools in place for supporting the NHS 18 week waiting target. Managers kept a spreadsheet which checked these waiting times and prioritised referrals based on need. We saw an example of this tool from August 2021 where 454 patients were checked. When the provider received a referral, staff uploaded it onto their computer system, and an appointment was given for the first available clinic or consultant if the referral asked for this. During the COVID 19 pandemic, the provider had supported a local NHS trust with two week wait (2WW) referrals on a short-term basis.

Good

Outpatients

Managers and staff worked to make sure patients did not stay longer than they needed to in the outpatient department. Signage was visible, asking patients to approach the reception desk if they had been waiting more than 15 minutes for their appointment. The waiting area was enclosed away from the reception desk and the manager acknowledged that it could be difficult for staff to monitor patients who have been waiting for a long time. The manager also acknowledged that there have been complaints around waiting times previously, but staff had started making verbal announcements to check who had been waiting. There was no formal monitoring of wait times in the outpatient department following this trend being identified. However, we did not see patients waiting a long time to be seen by a consultant and feedback did not suggest this was a problem at the department.

Learning from complaints and concerns

It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learnt with all staff. The service included patients in the investigation of their complaint.

The outpatient department received 67 complaints between September 2020 to August 2021. The highest number of complaints received in one month was 11.

Managers investigated complaints and identified themes. Managers raised new complaints with senior managers during a daily communications call. This ensured senior managers had a recording of the complaint as early as possible. Complaints were followed up further at governance meetings as they were answered by the hospital. Managers at the department said pricing of services was the most common complaint that was made.

Patients knew how to complain or raise concerns. We spoke with patients during our visit and one patient confirmed that they knew how to make a complaint.

Managers shared feedback from complaints with staff and learning was used to improve the service. Complaints and positive feedback were a standing agenda item for outpatient team meetings.

Are Outpatients well-led?

Good

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

Leadership

Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff. They supported staff to develop their skills and take on more senior roles.

There were clear lines of leadership and accountability. The manager had clinical responsibility and managed the registered nurses and healthcare assistants. The physiotherapy team worked closely with the ward and outpatient department and was line managed by a separate manager to the outpatient department.

Good

Outpatients

When we spoke to the managers, they had a good understanding of the challenges to quality and sustainability in the department and were able to tell us the actions needed to address them. They told us they felt supported by other members of the senior management team and the medical director. They were able to discuss any issues with them, were listened to and their views respected.

Staff working in the outpatient department spoke highly about their managers and felt supported and valued. Managers were highly visible and approachable, and we saw evidence of this on the inspection.

The department had a management structure with clear lines of responsibility and accountability which staff understood. The head of the outpatient department had responsibility for the running of the clinics and took part in the wider governance and meeting structure of the hospital. This meant they understood the priorities of the hospital and how their department was involved in delivering this. Staff working in the outpatient department understood their job role and their responsibilities. Staff could name who their line manager was and who to speak to for specific situations such as safeguarding.

Managers supported staff to undertake training to develop their leadership skills. Managers discussed career development of staff at their appraisals. Staff from the department said they felt managers provided opportunities to develop, but more importantly they were given a choice in this and pressure wasn't applied if staff were content with their current positions.

Vision and strategy

The vision and strategy are focused on sustainability of services and is aligned to local health plans.

The hospital had a clear vision for its services. Their purpose was to "provide high quality, safe and compassionate care their patients need and expect". The hospital created four key principles which underlined four further values. The hospital's vision was "Prioritising our patients and staff ensuring a safe environment, whilst preserving an effective and responsive service being well led by professional and trustworthy culture".

Outpatient staff understood the provider's values and the direction the organisation intended to develop. A newsletter produced by the provider allowed staff from the department to keep up to date with developments in the hospital.

Culture

Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service promoted equality and diversity in daily work. The service had an open culture where staff could raise concerns without fear.

At our last inspection in 2019, some members of staff told us of a negative culture in the department. This had been resolved and during this inspection, staff were positive about teamwork and staff relationships. Staff spoke about a positive, supportive culture where they looked forward to coming to work. The hospital supplied a staff wellbeing handbook to enhance the mental health of staff.

Managers promoted equality and diversity. Staff spoke of a friendly, inclusive environment. All staff from the department completed equality and diversity training and could give examples of care that promoted this.

Good

Outpatients

The hospital and department reviewed the most recent staff survey results and created an action plan to address concerns raised by staff. For example, positive themes from the staff survey included confidence in the leadership team of the hospital and that staff felt they were paid fairly for the job role they had. Negative themes identified were addressed through actions taken by the hospital. For example, staff felt that there was difficulty in career progression within the hospital at times. The hospital responded by putting more efforts into their employee development programme.

Staff said they felt comfortable raising concerns with their line manager. Staff expressed having a good relationship with their manager. The hospital also had a named Freedom to Speak Up Guardian. Additionally, open staff forums were held more widely, and leaders were visible conducting walk arounds of the department.

Governance

Leaders ran effective governance processes throughout the service. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.

Systems to effectively ensure the improvement of quality were in development at our last inspection. During this inspection we saw evidence that the systems were now embedded.

The outpatient department had their own meeting to disseminate information but also used handover and emails. We reviewed minutes and saw information was discussed, shared and acted upon to improve patient safety, care and outcomes. The provider had a sequence of meetings at both departmental, location, and provider level. Managers scheduled department meetings monthly, however staff told us that these had been disrupted due to the limitations of meeting face to face as part of IPC guidance. We saw meeting minutes which had a structure that covered important agenda items for the department and hospital. These minutes were available following the meeting and staff knew where to find them.

The senior managers ran clinical governance and head of department meetings monthly and the head of the outpatient department attended these meetings. A governance structure ran across the hospital and managers at senior and departmental level could explain how it ran. The hospital launched a new governance assurance framework in May 2021 which involved several committees that focused on the individual needs of the hospital. The management of the outpatient department were aware of these committees and shared important information with the outpatient team.

There was a quality and effectiveness audit schedule. The hospital had a wider audit schedule in place which covered a range of areas including medicine management, infection prevention and control, resuscitation and health documentation. Senior managers included the outpatient department in this audit schedule.

Managing risks, issues and performance

Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues.

Senior managers recorded risks in a risk register for all departments. The outpatient department had one risk rated as “very low”. This was a privacy risk associated with patients or staff opening a procedure door unintentionally while a clinic or treatment was in progress. The quality and risk manager checked the risk register at a location level and a committee met to review the register in further detail. Please see the surgery core service report for more detail.

Leaders examined risk trends in health and safety, infection control and medicines management meetings. The outpatient department manager attended these meetings and observations from these meetings were fed up to an audit and risk committee.

At a department level, the manager implemented new processes for staff. These included a process for responding to a sudden deterioration of patients and new action plans for when a patient could become aggressive.

Managing information

The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats. The information systems were integrated and secure.

The hospital used computer toolkits and dashboards to collect and monitor data throughout the hospital including the outpatient department. Data on staffing, quality and safety was collected and reviewed at a senior management level.

The location had an information governance committee and corporate digital team to manage queries from staff. The site had a dedicated Information Security Officer and a named Caldicott guardian for information handling queries.

Staff did not leave computers unattended and areas holding information were locked when left unattended.

Staff received mandatory training for information governance. Information governance training for the organisation was 90%. The outpatient department training completion rate was 100%

Engagement

Leaders and staff actively and openly engaged with patients and staff.

The hospital and outpatient service actively encouraged patients to give feedback about their experience to help improve services. For example, through patient feedback cards, and promoting reviews on search engine websites.

Patient experience surveys were positive, accounting for 95% of responses. Leaders produced a monthly report that divided the data up in two ways, this was the funding type and the service that the respondent saw during their visit. An annual report was also available for the outpatient department and showed an analysis of the responses in further depth. The location also promoted the use of google reviews to obtain feedback from patients. They have a current rating of four out of five stars based on 64 reviews.

The head of the outpatient department understood the importance of staff feedback. The staff were happy in their roles and felt listened to. A staff survey was in operation and followed a framework from a staff rating organisation to enhance worker morale and opinion. The results suggested that improvements in staff morale were happening.

Staff were previously unhappy with induction training and the consideration of shift patterns at the department at our last inspection. During this inspection, we saw evidence of both induction training and managers planning rotas six months in advance.

Staff received updates from senior managers using newsletters. Senior managers also made department visits to speak with staff. Managers updated staff through team meetings and fed back from huddles attended daily.

Good

Outpatients

Learning, continuous improvement and innovation

The outpatient department prioritised learning and improvement among their staff. Staff we spoke with were interested in developing the service and themselves to give the best experience for patients. When problems were identified, the department worked with the leadership of the hospital to come up with solutions. For example, staff we spoke with were being developed in new skills associated with minor operations at the hospital.

The physiotherapy service of the site had expanded to include a hydro pool for rehabilitation and a full gym for physiotherapy services which was in development when we last inspected the service.

Good

Services for children & young people

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

Are Services for children & young people safe?

Good

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

Mandatory training

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

Nursing staff received and kept up-to-date with their mandatory training. Mandatory training for the Children's nursing team including the bank nurses had an overall compliance of 98.8%, with the lead children's nurse at 92% and the two bank nurses at 92% and 83% respectively.

The service had a target of 90% for their mandatory training which was met by two out of the three children's nurses. The lead told us that the nurse who wasn't meeting this was off work and would compete this on her return to work.The mandatory training was comprehensive and met the needs of children, young people and staff. Some of the mandatory courses relating to the care of children and young people included paediatric immediate life support and resuscitation and safeguarding training at various levels depending on specific job role.

The Children's lead nurse monitored mandatory training and alerted staff when they needed to update their training. Training and competency levels were monitored for bank staff as well as permanent staff.

Staff we spoke with said they felt the training they received was suitable and supported them to carry out their role.

Safeguarding

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

The service had a safeguarding lead. The safeguarding lead for children was the director of clinical services. Staff knew the named safeguarding leads.

Good

Services for children & young people

Staff knew how to make a safeguarding referral and who to inform if they had concerns. They told us who the named safeguarding lead was and the process for escalating concerns. Staff had access to flowcharts and resource folders which showed how to contact the local authority's children's safeguarding board if a concern was identified.

The hospital had a Safeguarding Children and Young people policy which was in date. Staff were aware where to find the policies should they need them.

Nursing staff received training specific for their role on how to recognise and report abuse. The Director of Clinical Services and the Children and Young People Lead nurse were trained to level 4 in Safeguarding for Children and Adults. The bank registered children's nurses were trained to level 3 in Safeguarding for Children and Adults.

Safeguarding children training included all forms of abuse including female genital mutilation and PREVENT, protecting people at risk of radicalisation. Training figures showed that the outpatient's staff were 100% compliance with their Safeguarding Children Level 2 and 3 training.

Non-clinical staff received training specific for their role on how to recognise and report abuse. They completed level two for safeguarding children and young people. Which was in line with national guidance.

Staff followed safe procedures for children visiting the hospital. The service had a chaperoning for Children and Young People in Outpatients policy in place and this was in date.

BMI recruitment policies were in place to ensure staff with the right skills and competencies were recruited and Disclosure and Barring (DSB) clearance processes were undertaken.

Staff said that there was ample scope for learning and development.

A National Clinical Lead for Children and Young people was in post and easily accessible for safeguarding advice and concerns. The service also had access to a Multi-Agency Safeguarding Hub and the Children's Social Care Emergency Team.

There had been two safeguarding incidents in the last 12 months, both relating to the child missing their appointment. Actions were taken for both incidents with no concerns or follow up required, leading to the matters being closed.

Cleanliness, infection control and hygiene

The service controlled infection risk well. Staff used equipment and control measures to protect patients, themselves and others from infection. They kept equipment and the premises visibly clean.

All areas were clean and had suitable furnishings which were clean and well-maintained. We observed the hospital to be clean, chairs were wipeable and the sinks were Health Building Note compliant (HBN).

Staff followed infection control principles including the use of personal protective equipment (PPE). All staff in clinical areas were "bare below the elbows", had their hair tied back and wore clinically appropriate clothing. The service provided appropriate and adequate quantities of PPE for staff including gloves and aprons in a range of sizes. Staff were able to access PPE at the point of use. There was easy and constant access to hand washing facilities throughout the hospital which were used by staff.

Cleaning records were up-to-date and demonstrated that all areas were cleaned regularly. Children and young people staff were responsible for cleaning the designated children's waiting area within the hospital's outpatient department. We saw all cleaning records were up-to-date.

The hospital had an Infection Prevention and Control Lead in place and held IPC meetings where Children and Young People was a standing agenda. Outbreak, incidents, IPC training, audits and risk assessments were some of the topics of discussion which took place during these meetings.

Staff cleaned equipment after patient contact and labelled equipment to show when it was last cleaned. We found equipment to be clean. Staff used "I am clean" stickers to indicate they had cleaned the equipment recently and it was ready for use by another patient.

The hospital carried out bi-monthly hand hygiene audits in all the areas children and young people were treated. Observational hand hygiene audits for April, June and August 2021 demonstrated a compliance of 100%.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment generally kept people safe. Staff managed clinical waste well.

The service had enough suitable equipment to help them to safely care for children and young people. Resuscitation equipment specific for children of all age ranges was available within the outpatient areas. Records showed these were checked daily with more detailed checks completed weekly.

We observed a number of pieces of equipment including weighing scales, resuscitation and breathing apparatus which was marked as available for use. This equipment had stickers clearly indicating they had been serviced and subjected to the required testing to remain appropriate for use.

Staff carried out daily safety checks of specialist equipment. They carried out daily and weekly checks on emergency equipment to check for the availability and safety of equipment. Records showed that staff had completed the required checks.

The hospital completed a risk assessment for Children and Young People attending waiting room/main outpatient area which outlined the main hazards and current controls.

Staff disposed of clinical waste safely. During the inspection we saw the correct management of waste and the use of coloured bags to correctly segregate off hazardous and non-hazardous waste. This was in line with the Health Technical Memorandum 07-01: Safe management of healthcare waste.

The service had an effective system to manage waste disposal. There was a BMI healthcare corporate waste management policy which the hospital staff followed. Across the service sharps bins were correctly assembled and labelled to ensure traceability. This was in accordance with the Health and Safety (Sharp Instruments in Healthcare) Regulations 2013 (the Sharps Regulations).

Assessing and responding to patient risk

Good

Services for children & young people

Staff completed and updated risk assessments for each child and young person and removed or minimised risks.

The service had a Standard Operating Procedure with outlined the process to safely and effectively manage children and young people that may require transfer to another healthcare facility due to deterioration in their condition. All staff were aware of this and were able to detail how they would transfer a critically ill patient, via ambulance to the nearest NHS emergency department. This risk was reduced by only allowing children and young people under the age of 16 to have consultations, not procedures, in the hospital and screening children and young people aged 16 and 17 to check suitability to enter the adult pathway for minor procedures.

The service held an agreement with the Children's Acute Transport Service (CATS) which offered telephone advice and triaging facilities with easy access to all Paediatric Intensive Care Units in case of emergencies.

The hospital no longer had an SLA for paediatrics with the local Trust as they did not undertake paediatric surgery. Outside of normal working hours, staff could access advice from the CYP nursing team at BMI The Saxon Clinic as outlined in their corporate CYP Policy.

Staff completed risk assessments for each child and young person on admission / arrival, using a recognised tool, and reviewed this regularly, including after any incident. All 16 & 17 year olds who required a surgical procedure or an interventional procedure in imaging had a risk assessment carried out by a children's nurse prior to the procedure to ensure they were suitable to follow the adult pathway.

The hospital had a flow chart detailing the process for the adult pathway risk assessment. The criteria included that minor procedures could be carried out on 16 & 17 year olds providing they were assessed as suitable to follow the adult pathway within the current imaging and outpatient patient pathway.

Information provided by the hospital showed a total of fifty-four 16-17 years olds were seen on the adult pathway in the last 12 months.

Children and young people under the age of 16 were not permitted to have any invasive procedures.

The pre-assessment team assessed and approved a young person for the adult pathway. During this process the young person and their parent/guardian were informed a paediatric specialist was not part of the adult pathway so this could be considered as part of their decision before consenting to surgery.

The risk assessment shown to us was thorough and screened patients for other illnesses and potential care issues that could lead to complications. The flow chart provided instructions for where to book children and young people if they were unsuitable for treatment at the hospital

Resuscitation simulations were practiced within the hospital three times a year. These scenarios were followed up with an action plan detailing any areas for improvement. A delay in the team responding after the emergency call went out was identified as one of the areas which needed improvement on during a recent simulations.

All clinics were consultant led. All outpatients staff were trained to Paediatric Life Support: Basic or Intermediate Level. The RMO was available on site.

Good

Services for children & young people

Staff weighed and measured the height of children and young people attending the service and checked they were within expected norms.

Nurse staffing

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

Children were seen in outpatients, imaging and physiotherapy for consultation only.

The lead children & young person (CYP) nurse covered the consultant paediatrician clinics as a priority either by herself or with two bank registered children's nurses.

Paediatric clinics were available throughout the week including Saturdays. The service also provided consultation only appointments for children and young people for specialists such as dermatology.

The service had adequate number of staff and had an advert out for a bank registered children's nurse for additional support.

Medical staffing

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

All clinics were consultant led and worked flexibly.

The service had paediatricians available on Saturdays to run their clinics. In the week children and young people were seen by specialists such as dermatologists on a consultation only basis.

All consultants completed a Paediatric Practice form as part of their practising privileges application.

Records

Staff kept detailed records of children and young people's care and treatment. Records were clear, up-to-date, stored securely and easily available to all staff providing care.

Patient notes were comprehensive and all staff could access them easily. All six records we reviewed were complete. They included pre-assessment checks, appropriately completed consent forms, surgical notes, ward notes and discharge paperwork. Notes also clearly identified when a patient had any allergies.

Medicines

The service used systems and processes to safely prescribe medicines.

The hospital had access to an in-house pharmacy for advice on medicines.

Good

Services for children & young people

For our detailed findings on medicines please see the 'Safe 'section in the surgery report.

Incidents

The service managed patient safety incidents well. Staff recognised and reported incidents and near misses. Leads investigated incidents and shared lessons learned with the whole team and the wider service.

Staff knew what incidents to report and how to report them. All clinical and non-clinical incidents were reported and logged directly onto the hospital's incident reporting system. Staff of all levels were confident to report incidents and how to escalate concerns.

Staff received feedback from investigation of incidents, both internal and external to the service. Staff said they received good feedback on incidents and the sharing and learning from incidents.

The service had no never events. Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.

There had been three incidents relating to children and young people, two of these were safeguarding incidents, both relating to the child missing their appointment. Actions were taken for both incidents with no concerns or follow up required, leading to the matter being closed.

Staff understood the duty of candour. Staff within the service demonstrated an understanding of the duty of candour. The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support to those persons.

Are Services for children & young people effective?

Good

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

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence-based practice.

Staff followed up-to-date policies to plan and deliver high quality care according to best practice and national guidance. We reviewed a selection of policies and guidelines related to children and young people and found they were within their review date.

The hospital did not take part in any national audits or reviews relating to the care of children and did not hold any accreditation relating to the care of children as these weren't relevant to the type of service they provided.

Good

Services for children & young people

An adult care pathway was used for young people admitted for day surgery to ensure a systematic approach was used based on best practice guidance.

Nutrition and hydration

Staff gave children, young people and their families enough drink to meet their needs.

Water dispensers were placed throughout the outpatients waiting area for patients to use when they attended clinic appointments.

Pain relief

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

The hospital did not undertake procedures on children unless they were 16 & 17 years old. These procedures were delivered using an adult care pathway and therefore there was not a pain management policy for children.

Staff prescribed, administered and recorded pain relief accurately. Staff applied anaesthetic cream to a child's hand prior to blood tests.

Patient outcomes

There was no patient outcome monitoring in place to monitor the effectiveness of care and treatment and use the findings to improve them.

The hospital did not collate audit data to monitor the outcomes of children and young people after appointments or procedures.

Within the Children and Young People Committee, the team were reviewing how to undertake clinical audit and were in the process of updating their calendar to ensure there had not been any regulatory changes, legislation changes.

Competent staff

The service made sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them.

The Children and Young people service had a comprehensive induction programme for all new staff recruited. Within the first month new starters would have the opportunity to read policies and be introduced to protocols around infection control, cleaning, equipment, patient information and clinical practice.

Nursing and health care assistants in outpatients completed competencies which were signed off by the Children's Lead demonstrating that they were able to complete specific tasks. Nursing competencies included paediatric basic life support, paediatric early warning score, paediatric Situation, Background, Assessment, Recommendation (SBAR)and chaperoning.

Good

Services for children & young people

During the inspection all three of the Children's nurses appraisals were within date. Appraisals enabled staff to consider their clinical practise and any learning opportunities they considered would be of benefit.

There was a corporate policy for practising privileges. This set out that practising privileges were only granted to doctors who were licenced and registered with the General Medical Council (GMC), held a substantive post within the NHS in the past five years or could demonstrate independent practise over a sustained period, and had relevant clinical experience to practise. Each application for practising privileges was assessed by the Medical Advisory Committee (MAC).

All consultants completed a Paediatric Practice form as part of their practising privileges application.

Multidisciplinary working

Doctors, nurses and other healthcare professionals worked together as a team to benefit children, young people and their families. They supported each other to provide good care.

Staff throughout the hospital were able to communicate with the lead paediatric nurse based at the Saxon Clinic, out of hours or when the hospital's children and young persons lead was off site, if they had concerns about a child or young person. Discussions of this nature were documented in patient notes in line with the service level agreement the paediatric nurse had with the hospital.

The service had access to an in house physiotherapist and pharmacy and worked together to benefit children and young people.

The hospital had links with the local safeguarding team for external safeguarding support. The Children and Young people Lead nurse attended a Safeguarding County wide meeting once every two months for information sharing and learning.

Seven-day services

The service was not designed to provide a seven-day service.

Services were made available outside of school hours to support patient care.

Paediatricians had dedicated Saturday clinics to see patients on the weekend, outside of school hours. Other outpatient clinics had timings throughout the week that included evenings to allow children and young people to attend.

Health promotion

The service did not actively disseminate and promote healthy lifestyle advice to children and young people.

The services did not actively offer health promotion to children and young people or their parents/guardians during consultations or the admission process. If necessary or requested staff, however, could provide advice on patient's health and wellbeing.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Good

Services for children & young people

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

The hospital had a consent for assessment, care and treatment policy in place for guidance to ensure that assessment, care and treatment were carried out in line with legal and professional requirements relating to consent. This was in date and due a review in 2024.

We saw the hospital had a specific consent form for children and young people. The form had both a place for their parent or guardian to sign and for the child or young person to sign if they wanted to.

Staff understood the use of Gillick competencies in relation to children. This is a legal ruling whereby clinicians may accept consent from a child under 16 years of age, who has been assessed as competent to understand the implications of consent and who cannot be persuaded to involve their parents in care and treatment decisions. The understanding required for different interventions will vary considerably and therefore a child under 16 may have the capacity to consent to some interventions but not to others.

Verbal consent was taken for checking vital signs and phlebotomy. Written consent was taken for any minor procedures on the day it was carried out. We checked six patient records and saw that consent had been obtained in all cases.

Are Services for children & young people caring?

Good

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

Compassionate care

Staff treated patients with compassion and kindness but did not always respect their privacy and dignity.

Children, young people and their families said staff treated them well and with kindness. Throughout the inspection, we observed medical and nursing staff talking kindly to the child as well as parents. Staff were friendly and treated patients and their families with respect.

Staff were discreet and responsive when caring for children, young people and their families. Staff took time to interact with children, young people and their families in a respectful and considerate way. Doors were kept closed during consultations so that conversations could not be overheard.

Patients were not always treated with dignity and privacy; staff weighed patients in the corridor which did not maintain patient's privacy and dignity. Patients told us that all staff introduced themselves and said they had been kind, attentive and caring. We spoke with four patients. Patients commented "being very satisfied with the service and staffs' caring and helpful attitude"

The hospital provided chaperones during clinics. We saw staff record this by putting a chaperone sticker with their name on the patient notes.

Good

Services for children & young people

The 2020/21 inpatient survey analysis which incorporated into the adult feedback survey 80% of patients commenting the quality of care as excellent and 83% rated their experience of the service as being very good.

Staff talked with children, young people and their families in a way they could understand, using communication aids where necessary. Staff used a communication book in the outpatient department to record and escalate messages or queries left by parents/guardians to the children & young persons lead/team. This ensured information reached the CYP team and parents/guardians received the correct response.

Emotional support

Staff provided emotional support to children, young people and their families to minimise their distress. They understood children and young people's personal, cultural and religious needs.

Staff gave children, young people and their families help, emotional support and advice when they needed it. Staff told us they had time to spend with patients to reassure them and provide emotional support.

Staff supported children, young people and their families who became distressed in an open environment and helped them maintain their privacy and dignity. The hospital had a quiet room for distressed patients in order for them to maintain their privacy and dignity.

Staff told us if patients needed support services, they had relevant signposting information to give to them.

Understanding and involvement of patients and those close to them

Staff supported and involved children, young people and their families to understand their condition and make decisions about their care and treatment. They ensured a family centred approach.

Staff made sure children, young people and their families understood their care and treatment. Patients told us that they were involved in their care planning and that they were given the opportunity to ask questions about care and treatment. Patients commented that consultants explained procedures to patients in a way that was understood and they had been provided with clear information about their treatment and care.

Staff supported children, young people and their families to make informed decisions about their care. Patients felt that they had been fully supported in making decisions regarding their treatment and that they had all that they needed to know for this.

Patients and their families could give feedback on the service and their treatment and staff supported them to do this. The waiting area had a poster with a Quick Response (QR) code through which patients could comment on the service and the care they received.

Are Services for children & young people responsive?

Good

Our rating of responsive improved. We rated it as good.

Good

Services for children & young people

Service delivery to meet the needs of local people

The service planned and provided care in a way that met the needs of children and young people and the communities served. It also worked with others in the wider system and local organisations to plan care.

The hospital planned and provided services in a way that met the needs of children and young people.

Staff told us, and patients we spoke with confirmed, that the hospital was flexible with appointment dates and offered earlier dates when these became available.

The outpatient waiting area had a designated area for children and their parent/carer. Due to the COVID-19 pandemic, toys had been removed from the area until further notice, because of infection prevention and control concerns.

Patients had access to drinking water in the waiting area. Baby changing facilities were also available in the toilets at the waiting area.

Wi-Fi was available throughout the hospital and was free to use for all people on the premises.

Meeting people's individual needs

The service was inclusive and took account of children, young people and their families' individual needs and preferences. Staff made reasonable adjustments to help children, young people and their families access services. They coordinated care with other services and providers.

Staff used transition plans to support young people moving on to adult services. The hospital had officially ceased all surgery for CYP services in March 2021. Since then, only 16 to17-year-olds could be admitted after having been risk assessed as suitable for admission on an adult pathway.

The hospital had a risk assessment in place for all 16 & 17 year olds who required a surgical procedure (GA or LA) or an interventional procedure in imaging. This was carried out by a children's nurse prior to the procedure to ensure they were suitable to follow the adult pathway

The service made sure staff, children, young people and their families could get help from interpreters or signers when needed. Interpreters were used where patients were seen whose first language was not English. These could be booked 48 hours in advance whilst some languages needed flexibility for booking.

The service had information leaflets available in languages spoken by the children, young people, their families and local community. Information leaflets could be requested at the reception desk and were available in other languages.

Services were designed to meet the needs of children, young people and their families. The hospital site was entirely accessible by wheelchair. Passenger lifts were in place between floors and corridors throughout the hospital were wide enough to accommodate wheelchair access.

Good

Services for children & young people

Staff had access to communication aids to help patients become partners in their care and treatment. Staff used the national 'Hospital Communication Handbook' for patients who had difficulty with communication and/or the written word. This handbook provided a wide range of symbolic pictures to aid communication and was available in the ward and outpatient department.

The service did not collect feedback from children and did not have a survey for children in place.

Access and flow

People could access the service when they needed it.

Paediatric appointments were available throughout the week, including evenings and weekends. The hospital tried to avoid booking younger children after 7pm to support the family maintain evening routines.

All children or young children seen at the hospital were privately funded, there were no waiting lists. Treatment was progressed as quickly as possible, subject to completion of an appropriate risk assessment.

Learning from complaints and concerns

It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff.

The hospital received two complaints relating to the care of children at the service in the last 12 months, both of these related to billing issues.

The service had an in-date complaints policy which provided guidance on how to follow the complaints process and explained how complaints could be resolved via resolution or escalated through independent complaint reviews.

The hospital's website identified they were aligned to the Independent Healthcare Sector Complaints Adjudication Service (ICAS) complaint handling guidance. This service provides an independent adjudication on complaints about ICAS subscribers and investigated complaints once they had been investigated via the hospital's own complaints process.

The hospital's website also directed complainants to an email where they could raise their concerns with the Executive Director of the Hospital.

Parents/guardians we spoke with told us they were unaware of the formal route to raise a complaint but had not had cause to do so. They told us they would speak to the staff, telephone the hospital's reception or view the hospital's website if they felt they had a concern or complaint they wished to raise.

Are Services for children & young people well-led?

Good

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

Good

Services for children & young people

Leadership

Leaders had the integrity, skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff.

A national lead had been appointed for children and young people within the management structure; they were responsible for all aspects of care for children and young people. Staff we spoke with were aware of who this was and told us they were easily accessible for advice and if staff had any concerns.

The Children and Young People Lead held overall responsibility for quality, safety and safeguarding children and young people within the hospital.

Staff spoke highly of the local leadership within the service and commented that they were approachable and welcomed feedback about the service.

We were told senior managers were visible in the department and around the hospital. They spoke of positive professional relationships with the senior leadership team and felt there had been an improvement in oversight alongside the freedom and support to develop staff and the department. Staff at all levels felt they could escalate concerns to senior managers where necessary.

Vision and strategy

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

The service had a universal and shared purpose: to provide the high quality, safe and compassionate care their patients needed and expected. Over the next two years, the service aimed to focus on four key areas which underpinned the creation of a strong foundation for their future success. The service developed this plan by listening to the people and patients and responding to their needs.

There was a clear vision for the hospital which was aligned to the BMI corporate vision and underpinned by the BMI behaviours and values.

Children and young people was a standing agenda item on meetings and the lead paediatric nurse was routinely involved in these.

The Children and Young People national Committee were keen to understand Circle's developing strategy and had an action plan in place to develop a national BMI children and young people strategy with the leads.

Culture

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

Staff we spoke with said they felt respected, supported and valued. Ward managers were accessible and visible throughout the hospital.

Good

Services for children & young people

The service had an open culture where patients, their families and staff could raise concerns without fear. Patients we spoke with said they were comfortable to raise any concerns or issue with staff.

Staff spoke of and we observed positive working relationships between staff within the outpatient department. Staff told us that peers would readily give advice and support as and when needed.

The hospital had a Freedom to Speak up Guardian in post to provide a safe and confidential route for staff to raise concerns about their service.

Governance

Leaders operated effective governance processes, throughout the service and with partner organisations. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.

The hospital had recently launched its national Governance Assurance Framework in May 2021 which set out how the service was governed from ward to board. There was an interactive guide on the intranet setting out full terms of reference and attendees.

The three sets of governance meeting minutes we reviewed showed children and young people services to be a standing agenda item. Agenda items included clinical governance, IPC, reports from heads of department.

Clinical quality and governance matters were reviewed by the Medical Advisory Committee (MAC) which met bi-monthly and was attended by representatives from all specialities. Areas of discussion included a review of applications for practising privileges and where these had been withdrawn, updates from the executive director, director of operations and director of clinical services and clinical governance report. The hospital had a lead consultant paediatrician in post who attended this.

The Children and Young People local Lead was responsible for collating data on individual hospital performance in services for CYP and ensuring that this was reported into the hospital governance structure and displayed on hospital performance boards.

Managing risks, issues and performance

Leaders and teams identified and escalated relevant risks and issues and identified actions to reduce their impact.

The hospital held a risk register which was regularly reviewed to ensure risks were monitored and appropriately managed. Heads of department managed departmental risk registers that fed into the hospital risk register. Risk issues were discussed at the hospital and clinical governance and health and safety committee.

During the time of the inspection, there were no direct issues relating to children and young people on the risk register.

Information Management

The service managed and used information well, using secure electronic systems and paper records.

Good

Services for children & young people

Patient information and records were stored securely in all areas we visited. Staff received information governance awareness training and followed a policy to keep patient information safe and secure.

Leaders used information in reporting, performance management and delivering quality care. Staff undertook audits to make sure information they used was accurate, valid and reliable.

The service had appointed a Caldicott Guardian who had clear understanding of the Caldicott principles and had undertaken further training to support them in their role. Caldicott principles are fundamental rules and regulations that guide a patient's confidentiality. They are the basic rules every healthcare personnel must follow to ensure there is no breach of confidentiality. Staff spoke about sharing information only in the best interest of the patient and as disclosures were only made to protect patients. Notifications were submitted as needed to meet with regulations and used secure methods in line with their policy.

Engagement

Leaders and staff actively and openly engaged with patients and staff to plan and manage services.

Staff meetings were held monthly within the outpatient department at which any important updates were shared including incidents, complaints and patient feedback.

The executive director sent a weekly newsletter to keep staff aware of hospital developments. Staff forums were held which provided updates on corporate developments, hospital performance and staff opportunities.

Learning, continuous improvement and innovation

Staff were committed to continually learning and improving services.

There was evidence of learning from when things had gone wrong.

The service was able to provide evidence from an incident where a child was booked to see a consultant who did not treat under 18's. The procedure was cancelled; learning from this was shared.

Good

Diagnostic imaging

Safe	Good
Effective	Inspected but not rated
Caring	Good
Responsive	Good
Well-led	Good

Are Diagnostic imaging safe?

Good

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

Mandatory training

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

The mandatory training was comprehensive and met the needs of patients and staff. Department staff received mandatory training, which was up to date. Staff were given rostered time to complete their mandatory training which included for example, basic life support (BLS) paediatric basic life support (PBLS), manual handling, PREVENT, (Prevent is about safeguarding people and communities from the threat of terrorism) infection prevention and control, safeguarding, health and safety, fire safety and information governance. Staff told us that they were able to claim back pay if they needed to complete their mandatory training at home.

Staff were alerted electronically when their training was due to expire or if it had expired. Managers monitored training compliance of staff and identified if training was not completed. We reviewed the 'e learning' training matrix for the department which showed the service was at 96% compliance.

Safeguarding

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

All clinical staff in the imaging service were trained to level 3 in safeguarding and child protection and they were 100% compliant in meeting safeguarding training requirements of the hospital.

Staff could give examples of how to protect patients from harassment and discrimination, and how to identify adults and children at risk of, or suffering, significant harm. They knew who the safeguarding lead was and we saw the contact details on the notice boards. Staff demonstrated they understood the process and showed us the child safeguarding folder which contained flow charts, pathways, contacts and useful information.

Good

Diagnostic imaging

Staff followed safe procedures for children visiting the department. Children were accompanied by a parent or carer and were able to wait with them. Staff in the department knew who the paediatric lead nurse was and how to contact her for support if they had any concerns about a child visiting the department.

Safeguarding training included recognition of female genital mutilation (FGM).

Cleanliness, infection control and hygiene

The service controlled infection risk well. Staff used equipment and control measures to protect patients, themselves and others from infection. They kept equipment and the premises visibly clean.

Clinical areas and furnishings were visibly clean and well-maintained. Furnishings were intact with no cracks or tears. The service generally performed well for cleanliness; and good compliance with cleaning audits was displayed in the department. Staff cleaned surfaces in clinical areas and wiped chairs after every use. Changing areas were cleaned between patients and were free of dust.

Staff followed infection control principles including the use of personal protective equipment (PPE). Staff had undertaken training on how to use PPE correctly and we observed all staff were bare below the elbow (BBE) and audits were used to monitor this.

There was an infection prevention and control link in the department who attended relevant hospital meetings and updated the staff at department meetings.

Support staff were able to explain and demonstrate the comprehensive decontamination process used for cleaning and disinfection of surfaces and equipment.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment kept people safe. Staff were trained to use them. Staff managed clinical waste well.

The design of the environment followed national guidance. The waiting area met the current guidelines for social distancing measures. The setting enabled staff to observe and monitor patients waiting. Corridors and rooms were spacious, allowing staff to carry out scans and imaging tasks efficiently.

Rooms where ionizing radiation exposures occurred were clearly signposted with warning lights. When equipment was not available, pertinent staff received an email notification and a notice was put on the door of the imaging room.

Equipment at BMI The Chiltern Hospital included a computed tomography (CT) scanner, a magnetic resonance imaging (MRI) scanner, DEXA (bone density) scanning, digital mammography, ultrasound, and X-ray imaging.

Imaging equipment had appropriate daily and weekly checks; staff showed us these and were able to detail how they were completed.

Good

Diagnostic imaging

The imaging department manager had negotiated a new managed equipment service which included a central contact for all equipment; this allowed for easy telephone access to a manufacturer specific engineer when required. All scanning equipment had annual servicing carried out by the relevant manufacturer and this was planned to avoid disruption. The manager maintained an asset list of all equipment, servicing requirements and due dates.

We reviewed equipment handover procedures and records, along with fault report records; all were seen to be up to date and well documented. Visits by the medical physics expert (MPE) were also well documented and recommendations actioned where necessary. At the time of our visit there were no outstanding actions.

All imaging procedures had risk assessments that had been undertaken by senior staff and the service radiation protection advisor (RPA). Staff wore radiation exposure monitoring devices which were evaluated by a specialist external organisation, and any exposure relayed to the department.

Staff disposed of clinical waste in line with hospital policy, and sharps in line with national guidance. We saw sharps bins were dated and partially closed to prevent spillage.

Assessing and responding to patient risk

Staff identified, responded to and removed or minimised risks to patients. Staff identified and quickly acted upon patients at risk of deterioration.

The service complied with local rules, ionising radiation regulations 2017 (IRR17), and employers' procedures: Ionising radiation (medical exposure) regulations [IR(ME)R. These regulations deal with the safe and effective use of ionising radiation; they were up to date, signed and displayed.

Staff responded promptly to any sudden deterioration in a patient's health. There was mandatory training in basic life support and staff who undertook cannulation had additional training in intensive lifesaving skills. Staff visually monitored patients while imaging was being undertaken, so they could respond rapidly to any patient distress or deterioration. Staff were able to call the resident medical officer (RMO) for support 24 hours a day seven days a week.

Staff completed risk assessments for each patient on arrival, and reviewed this regularly, including after any incident. Referrals for imaging provided some details of patient risks, and staff spoke with patients before undertaking any radiation exposure to ensure exposure was justified.

After inpatients were scanned, staff provided details of procedures and any contrast medicines when handing their care to others or back to the ward staff.

When patients were given intravenous contrast, they were given advice to follow if they became unwell after leaving the department, for example, a 'Contrast and Antispasmodic Aftercare' leaflet.

MRI scans use strong magnets to produce images, these can affect any metal implants or fragments in the body. Metal objects may also interfere with the magnetic field and can cause a safety hazard. Radiographers in the MRI area ensured all staff and patients undertook a metal screening assessment before entering the scanning room.

Staff knew about and dealt with any specific risk issues. The imaging service ensured that people who were or may be pregnant informed a member of staff before they were exposed to any radiation in accordance with IR(ME)R. Documentation completed before the procedure included a standard statement confirming pregnancy status where applicable.

The service could signpost patients to specialist mental health support. The location did not provide mental health service on site. Patients needed to be referred to these services on request by their doctor or were signposted to appropriate services. Staff were supported by a safeguarding lead who could make referrals to specialist teams or private GPs.

We observed staff carrying out imaging procedures; we saw that identity checks, and imaging history were confirmed in detail. This was always followed by an explanation of risks from exposure to radiation.

When imaging was completed scans were processed and loaded into the picture archiving and communication system (PACS) to be viewed by referring consultants or radiologists.

Illuminated signs identified when radiation was active in ionising radiation areas to warn people not to enter. The service was supported by a Radiation Protection Advisor (RPA). A Radiation Protection Advisor is an individual, or corporate body, that meets the Health and Safety Executive criteria of competence and has the necessary experience and expertise to advise on the organisation's use of ionising radiation.

In April 2021 the RPA undertook the annual radiation protection compliance audit for the imaging service and followed this up with a detailed report and recommendations. The RPA concluded that “Fundamental radiations safety culture and basic regulatory compliance was found to be very good.”

A radiation protection supervisor (RPS) was available at all times to provide any extra advice staff may need. An RPS is appointed for the purpose of ensuring compliance with IRR17 for work carried out in an area which is subject to Local Rules.

Staffing

The service had enough staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care. Managers regularly reviewed and adjusted staffing levels and skill mix, and gave bank, agency and locum staff a full induction.

At the time of our visit the imaging consisted of 10 radiographers, four regular bank radiographers, four imaging assistants and two regular bank radiation assistants. There were no vacancies for radiographers and the service was planning to recruit two more radiography assistants. A newly recruited radiographer was due to start in January to support extended hours on the MRI scanner.

The head of department used an electronic staff management dashboard to calculate staffing needs, based on activity within the department. The workforce analysis element of the programme showed the percentage of staff utilisation in the department with a chart indicating required staffing levels versus actual staffing levels. The dashboard was reviewed monthly by the hospital executive team.

Records

Good

Diagnostic imaging

Staff kept detailed records of patients' care and diagnostic procedures. Records were clear, up-to-date, stored securely and easily available to all staff providing care. Staff always had access to up-to-date, accurate and comprehensive information on patients' care and procedures. All staff had access to an electronic records system that they could all update.

We observed staff and patient interactions and the imaging procedures undertaken. Identification details were recorded and checked in the clinical record interactive system (CRIS).

Patient imaging records were comprehensive, and all staff could access any historical images easily in the (PACS) system prior to undertaking the requested procedure.

Staff completed a magnetic resonance imaging (MRI) safety questionnaire with patients, and we saw these were completed in full.

When patients transferred to a new team, there were no delays in staff accessing their records.

Radiographers completed post processing information following procedures; this included recording the name of the operators who undertook the procedure, confirmation of the imaging performed, and associated radiation dose. Radiologists were able to access images once post processing had been completed to assess clinical findings and produce a report.

The computer systems and record programmes could only be accessed by authorised staff using a password.

Medicines

The service used systems and processes to safely prescribe, administer, record and store medicines.

Staff followed systems and processes to safely administer, record and store medicines. When contrast media was administered this was done under a Patient Group Directive (PGD). PGDs are written instructions to supply or administer medicines to patients, usually in planned circumstances. We reviewed PGDs used in the CT scanner, and all were signed by the appropriate staff between 4 August 2020 and 15 September 2021. This was an improvement since our previous inspection in 2019.

Contrast medicines were stored in in a temperature-controlled cupboard which restricted access to them by unauthorised people. Minimum and maximum temperatures were recorded and staff knew what to do if the temperature went out of range.

We saw evidence of learning from experience being shared with the team; one member of staff explained that during the Covid-19 pandemic the team reduced their use of sedation and found that many patients tolerated procedures very well, recovered faster, and were happy to go home earlier. Since then, staff have updated protocols to reflect the reduced use of sedation.

Incidents

Good

Diagnostic imaging

The service managed patient safety incidents well. Staff recognised and reported incidents and near misses. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support. Managers ensured that actions from patient safety alerts were implemented and monitored.

Staff knew what incidents to report and how to report them. Staff raised concerns and reported incidents and near misses in line with hospital policy. Staff at all levels could access the incident reporting system.

The service had no never events, but managers shared learning with the team about never events that happened elsewhere. A never event is a serious incident which is wholly preventable, where guidance or safety recommendations that provide strong systemic protective barriers are available at a national level, and should have been implemented by all healthcare providers.

Staff reported serious incidents clearly and in line with hospital policy. Incidents reportable under IR(ME)R were reported appropriately and investigations carried out by staff trained to do so. We saw example documentation following a near miss incident in the MRI scanning room; the patient and family were involved in the investigation and a risk reduction action plan and learning was shared with the team. Staff met to discuss the feedback and look at improvements to patient care following incidents.

Staff understood the duty of candour. They were open and transparent and gave patients and families a full explanation if and when things went wrong. Level 3 serious incident reports had an area to record when duty of candour had been undertaken, and these had been completed in the records we saw. Managers supported staff after any serious incident and held debriefing sessions.

Staff received feedback following incident investigations, both internal and external to the service. One member of staff explained how they had learned the importance of double and triple checking of patient identification stickers following an incident.

Are Diagnostic imaging effective?

Inspected but not rated

We currently do not rate effective for this core service.

Evidence-based care and treatment

The service provided care and procedures based on national guidance and evidence-based practice. Managers checked to make sure staff followed guidance. Staff protected the rights of patients subject to the Mental Health Act 1983.

Staff followed up-to-date policies to plan and deliver high quality care according to best practice and national guidance. The service had policies available electronically to support good practice. Changes in national guidance were communicated to leaders from the provider and these were implemented at the location.

Staff in the CT and MRI scanning areas kept a folder of standard operating procedures for reference. All staff in the area knew where to find this and the folder was well maintained with clear version control. Examples we reviewed included:

- the MRI Subclavian imaging written in March 2020 for review in March 2023.
- Using Canon Aquilian CT Scanner for cardiovascular imaging written July 2020 for review July 2023.

The folder also included, or referenced best practice guidelines.

The provider senior team shared any new national guidance via a monthly bulletin to all staff. This was reviewed locally and agreed actions were disseminated to the appropriate clinical leads. This included details about the relevance of the new guidance, whether the service was compliant, and any changes to practice required.

Staff protected the rights of patients subject to the Mental Health Act 1983 and followed the Code of Practice. Staff could access up to date policies and refer to them when needed. Patients attending that maybe subject to the Mental Health Act were highlighted to staff in advance of attendance. Staff understood how the Mental Health Act applied to their own role.

Nutrition and hydration

Staff made sure patients did not fast for too long before diagnostic procedures. Staff took into account patients individual needs where food or drink were necessary for the procedure.

Staff made sure patients had enough to eat and drink, including those with specialist nutrition and hydration needs. Patients were provided with information before fasting scans that detailed how long patients should do this for. Radiographers checked this guidance had been followed when speaking with patients. Fresh drinking water was available in all waiting areas.

Pain relief

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

Staff assessed patients' pain. All patients attended as an outpatient or from a ward. Staff assessed patients' pain both before and during imaging procedures. Patients attending from home were advised to bring any medication with them they might require during their attendance. Staff returned inpatients to wards as a priority, for pain relief to be administered if their pain was not controlled.

Patient outcomes

Staff monitored the effectiveness of care. They used the findings to make improvements and achieved good outcomes for patients.

The imaging service undertook internal audits that were monitored at provider level but did not participate in any national clinical audits. Managers and staff carried out a programme of repeated local audits to check improvement over time. Areas audited included checks of documentation used in radiation safety and referral paperwork. These audits ensured standards of radiation safety were met consistently, and bookings were made without delay.

Examples of audit we reviewed included: Contrast media used and recorded in CT scans; the records of the dosage of contrast media used in CT scans in January, February and March 2020; WHO compliance audit for March, April and May

2021. Audits appeared to be well conducted with documented analysis and follow up actions. Managers shared information from the audits and used the information gained from them to improve care and treatment. When areas for improvement were identified this was followed up at the next audit. Senior leaders monitored implementation of improvement and compliance.

Competent staff

The service made sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and development. Staff were experienced, qualified and had the right skills and knowledge to meet the needs of patients.

Radiographers, mammographers and sonographers had undertaken higher educational training to undertake their role. These staff were registered with the Health and Care Professions council (HCPC) and this registration required them to agree to a code of professional conduct to maintain registration.

Radiographers worked with radiologist to undertake review of working practices which included peer review of images and reject audit.

Managers gave all new staff a full induction tailored to their role before they started work. All staff working in the department were provided with a competency based induction pack which gave details of systems in the department and a wide range of other information. These packs contained sign off sheets for staff to become competent in the relevant areas of their role, and staff were also allocated a mentor for support.

Managers supported staff to develop through yearly, constructive appraisals of their work; staff felt appraisals were supportive and helped them in their development. Staff explained how they could keep up to date with relevant guidelines on the portal and iRefer (guidelines published by the College of Radiologists aimed at clinicians, radiologists, radiographers and other healthcare professionals to determine the most appropriate imaging procedures for a wide range of clinical problems and to help clinicians to meet their obligations under IR(ME)R).

The head of department explained that each member of staff had training profiles reflecting their mandatory training requirements. Staff were able update their own training profiles to reflect their developmental learning. For example, the head and deputy managers had recently completed complaints management training and the head of department had also completed a training module in level two incident management.

One member of staff explained she accesses the eLearning for healthcare/national breast academy and did several sessions a month to keep up to date. Other members of staff combined their roles with similar roles in the NHS and were able to share learning and updates to implement practice improvements.

Managers made sure staff received any specialist training for their role, for example training from manufacturers on new equipment and updated software.

Multidisciplinary working

Staff worked together as a team to benefit patients. They supported each other to provide good care.

Good

Diagnostic imaging

Staff worked across health care disciplines and with other agencies when required to care for patients. The service had worked collaboratively with the local NHS acute trust to share care and treatment of patients. Staff reported that collaborative working had improved since the use of the hospital as a “green site “ for NHS surgery during the Covid-19 pandemic in 2020.

Patients could see all the health professionals involved in their care at one-stop clinics. Doctors in outpatient clinics requested additional diagnostic imaging, such as plain film Xray, on the same day. Breast diagnostic clinics were staffed by a multidisciplinary team (MDT) that included clinicians, radiographers, mammographers and radiographic assistants.

Healthcare assistants told us consultants were friendly and approachable. Radiographers told us they had good relationships with radiologists and could contact them at any time.

Diagnostic test results were available to support timely MDT decisions on cancer care, treatment plans and achieve cancer waiting time standards.

There was a daily heads of department communication meeting called a ‘comm cell’, where the senior management team or their representatives came together with the executive director for 15 minutes to discuss the day ahead, and any issues from the previous day. Following the comm cell, managers returned to their own areas and held departmental meetings with their teams, where key messages were delivered. This was an opportunity for any concerns about the day to be discussed, for example staffing issues, and for any updates relating to incidents or issues from the previous 24 hours to be raised.

The ‘comm cell’ noticeboard in the imaging department displayed current key messages and useful contacts.

Seven-day services

Key services were available seven days a week to support timely patient care.

Imaging services for out patients and day cases were available between 7.30 am and 9.30 pm with a radiographer on-call service outside of those hours. The service had appointed an external agency to provide a radiologist on-call service, should this be required at any time. This ensured expertise at every level, thus avoiding delays to patient care.

The MRI scanner was available between the hours of 7.30am and 8pm with half day sessions on Saturdays and some Sundays. From December 2021 the service has commissioned a mobile MRI scanner to augment the current service three days per week including Sundays which will improve access for patients.

Health promotion

Staff gave patients practical support and advice to lead healthier lives.

Staff and patients could access relevant information promoting healthy lifestyles and support. There was information available about the variety of imaging modalities and what would happen during scans; what preparation was required prior to a scan; and self-care advice following a scan. Other information available included leaflets relating to smoking cessation and alcohol and drug misuse.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Good

Diagnostic imaging

Staff supported patients to make informed decisions about their care. They followed national guidance to gain patients' consent. They knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health.

There was a BMI/Circle Health Group corporate consent for examination and treatment policy which outlined a two stage consent process with cooling off times for patients undergoing invasive procedures. Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. All staff received training about the Mental Capacity Act (2005). In conversation with us, staff demonstrated a good understanding about their responsibilities towards the Mental Capacity Act which included a how and when to assess mental capacity of a patient.

Staff gained consent from patients for their care and treatment in line with legislation and guidance. Staff clearly recorded consent in the patients' records. Due to the nature of imaging procedures, consent was documented and gained at each attendance in line with radiation exposure legislation. If patients could not give consent, staff knew that decisions could be made in the best interest of the patient; taking into account patients' wishes, culture and traditions.

Staff we spoke with understood the need for consent and gave patients the option of withdrawing consent and stopping their scan at any time.

Consent training was part of the mandatory training programme and mental capacity was included as part of the mandatory safeguarding training. Staff told us if they had any concerns they would contact the safeguarding lead.

Are Diagnostic imaging caring?

Good

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

Compassionate care

Staff always had access to up-to-date, accurate and comprehensive information on patients' care and procedures. All staff had access to an electronic records system that they could all update.

We saw staff interacted with patients in a way that demonstrated empathy and good levels of care. Radiographers took time to speak with patients during procedures and made sure they were fully informed about what would happen. Staff explained procedures clearly and with compassion, this meant patients were prepared for procedures. If a patient needed additional support or attended with a carer, efforts were made to involve them in these conversations. We saw mammographers in the breast screening unit took time to have detailed and compassionate conversations with women to ensure distress was minimised.

Patients said staff treated them well and with kindness. Patient feedback was gained when appointments were completed and this was positive in nature. One patient told us that all the team were good, and that the x-ray taken today was by a "careful and kind radiographer who had checked her ID, explained the examination and radiation risks and asked her to sign a document to confirm that she wasn't pregnant, had sanitised her hands when she entered the room, and had been very thorough in her positioning."

Recent feedback showed 98% of patients were happy with the care they received and felt it was of good quality.

Good

Diagnostic imaging

Staff followed policy to keep patient care and treatment confidential. In the main waiting area patients were called by full name and all conversations regarding procedures happened once the patient was in a restricted area

Staff understood and respected the personal, cultural, social and religious needs of patients and how they may relate to care needs. Staff told us they could access translation services if required and this was usually known in advance if patients spoke a dialect that was not widely known.

Patients were entitled to a chaperone on request and efforts would be made to provide one that was of the same gender.

Emotional support

Staff provided emotional support to patients, families and carers to minimise their distress. They understood patients' personal, cultural and religious needs.

Staff supported patients who became distressed in an open environment and helped them maintain their privacy and dignity. There were specific areas available where staff spoke with patients if they felt distressed.

Staff told us that if patients expressed concerns or fears around procedures and scans, they took the time to explain how scans were undertaken and would ask the patient to come in a bit earlier so they could see the scanner machine. For patients who had a fear of enclosed spaces, staff asked patients to come into the department before their appointment so they could see the scanner, the room, and to try lying in the scanner to see if they were comfortable in the space.

Staff recognised and understood the emotional impact undergoing diagnostic procedures might have on patients and provided relevant support. Staff also understood the social impact that a person's care, treatment or condition had on their wellbeing and on those close to them. Patients were given clear details of when results would be known and who to contact, to help minimise levels of anxiety while waiting for results.

Understanding and involvement of patients and those close to them

Staff supported and involved patients, families and carers to understand their condition and make decisions about their diagnostic procedures.

Staff made sure patients and those close to them understood their care and treatment, and talked to patients, families and carers in a way they could understand.

Staff were aware of reasonable adjustments that could be made to ensure patients understood the information they were given. This included providing interpreters to support medical discussions within families. Staff could request information on behalf of patients in formats such as large print, braille or other languages. We saw how patients were encouraged to ask questions about their procedures and were offered the opportunity to do so.

Good

Diagnostic imaging

Are Diagnostic imaging responsive?

Good

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

Service delivery to meet the needs of local people

The service planned and provided care in a way that met the needs of local people and the communities served. It also worked with others in the wider system and local organisations to plan care.

Managers planned and organised services, so they met the changing needs of the community it served. The service provided diagnostic imaging services to private patients undergoing elective care. In addition to this during the COVID-19 pandemic the service had supported the local trust by providing services which included diagnostic imaging procedures. This enabled the trust to continue to deliver vital services to patients whose care may otherwise have been delayed. The service minimised the number of times patients needed to attend the hospital, by ensuring patients had access to the required staff and tests on one occasion.

Results were not always available during the single visit, however they were available for referring clinicians before the next appointment. Diagnostic test results were available to support timely multidisciplinary team (MDT) decisions on cancer care, treatment plans and achieve cancer waiting time standards.

The service relieved pressure on other departments. Staff performed some plain film X-rays on request, this enabled effective flow of patient reviews in outpatient areas and avoided multiple patient visits.

Staff ensured that patients who did not attend appointments were contacted. In the first instance staff contacted the patient directly to make sure they had checked on their welfare and to give an opportunity to understand their non-attendance. Managers monitored and took action to minimise missed appointments. Staff told us on the rare occasions when patients did not attend for an appointment, and they could not establish a reason, this was highlighted to the person who had referred them for the scan.

The service relieved pressure on other services when they could treat patients in a day. The service could report on inpatient CT scans within 24 hours of the procedure 99% of the time. This meant that patients could be discharged faster and did not wait on tests. Almost all CT scan results are returned to the referrer within 36 hours with the majority of results from MRI scans within 72 hours.

Meeting people's individual needs

The service was inclusive and took account of patients' individual needs and preferences. Staff made reasonable adjustments to help patients access services. They coordinated care with other services and providers.

Staff made sure patients living with mental health problems, learning disabilities and dementia, received the necessary care to meet all their needs. Referral forms provided staff with the relevant information to communicate and care for patients with any specific needs.

Good

Diagnostic imaging

Staff received training in equality and diversity and had a good understanding of cultural, social and religious needs of patients and demonstrated these values in their work. Patients with reduced mobility could easily access the imaging department which was on the ground floor and corridors were wide enough to accommodate wheelchairs.

The MRI scanner could accommodate bariatric patients up to 30 stone in weight.

The department had a hearing loop available for patients who had a hearing impairment in the main reception area.

Staff acknowledged the importance of impartial interpreters for those whose first language was not English, particularly regarding consent. This meant that staff could be assured that patients were given the full information surrounding their procedure and gave informed consent. This was achieved by using a telephone interpreting service available to staff; leaflets in languages other than English were printed by staff for patients who required them.

Access and flow

People could access the service when they needed it and received the right care promptly. Waiting times from referral to test and from test to results were in line with national standards.

The majority of patients were self-funding or privately insured and booked their appointments via the BMI Healthcare website or through the centralised administration team. Access to appointments had changed due to the Covid-19 pandemic with services prioritised for urgent care in the NHS. At the time of our visit, services had begun to get back to their usual levels and the imaging service was working to catch up with backlog waits by extending opening hours to accommodate this. In particular recruiting extra staff to open up the MRI scanner seven days a week.

Staff did not discuss referral to treatment times in the imaging department but they were conscious that they were responsible for an integral part of the patient pathway. The majority of patients received appointments within a week and most results were returned to the referrer on the same day.

When appointments had to be cancelled due to equipment failure, staff made sure they were rearranged as soon as possible and booked within national targets and guidance. Routine servicing of equipment was always planned in advance to avoid disruption.

Learning from complaints and concerns

It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff. The service included patients in the investigation of their complaint.

Patients, relatives and carers knew how to complain or raise concerns; there were leaflets available telling patients how to do this. Managers spoke with patients where possible, so their input was included in all investigations.

Staff understood the policy on complaints and knew how to handle them; the hospital policy for handing complaints was available on the intranet. Complaint management was undertaken by senior leaders of the service who had recently undertaken further training in complaints management.

Good

Diagnostic imaging

Complaints were discussed at the hospital senior management team meetings, the clinical governance meetings and the medical advisory committee meetings. Issues arising from complaints about the imaging service were shared with the team at staff meetings and we saw minutes of team meetings which confirmed this.

Senior leaders identified themes and learning was used to improve the service, we did not see any recent complaints relating to the imaging service.

Are Diagnostic imaging well-led?

Good

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

Leadership

Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff. They supported staff to develop their skills and take on more senior roles.

Managers were able to detail responsive changes that had been made in the department due to the Covid-19 pandemic, and the plans initiated to improve the service as patient appointments were returning to normal levels.

Staff told us they felt able to approach management and discuss any concerns with them; they felt leaders engaged with and listened to them. The department leadership team had been in post for approximately three years and staff had become accustomed to, and respected their management style.

Leaders supported staff in their development and encouraged them to own their achievements. They had an open-door policy and supported staff to raise concerns and seek out support.

Leaders were knowledgeable in the area they worked in and used their experience to inform decisions. There were regular staff meetings and minutes of these showed discussions of service improvement and shared learning discussion.

A consultant radiologist attended the medical advisory committee (MAC) meetings to make sure the service was represented and there was oversight at that level.

Staff were also positive of the changes that had occurred since BMI Healthcare had come under the ownership of Circle Health Group.

Vision and strategy

The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. Leaders and staff understood and knew how to apply them and monitor progress.

Good

Diagnostic imaging

Leaders demonstrated a vision for their service and were motivated to improve. To achieve this Circle Health Group had developed and launched their new strategy, vision and values in June 2021 and shared with staff. This included the imaging department directly;

" We will invest in the fabric of our hospitals and medical technology and equipment in order to provide excellent environments in which to work and receive care. We will do this by: • Investing in major imaging and medical equipment……."

The service was aligned with the wider plans of the hospital to improve services for patients. Department leaders throughout the hospital were given the opportunity to present their specific priorities to executives and colleagues. Aspirations for the imaging team included new equipment for the breast screening service, to overhaul the service and achieve gold standard, and replacement for the nine year old CT scanner. These aspirations were reflected in conversations we had with staff during our inspection.

Culture

Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service promoted equality and diversity in daily work, and provided opportunities for career development. The service had an open culture where patients, their families and staff could raise concerns without fear.

Staff spoke positively and were proud of their workplace, and said team leaders were approachable and fair. Interactions between the manager and staff were warm and courteous. The manager checked in with staff throughout the working day and encouraged them to feed back any issues. Staff also told us that they felt heard, and that the manager respected and valued them. The manager considered the wellbeing of staff and made sure they were supported. For example, staff were given flexibility during the pandemic so they could manage home and caring commitments.

Staff told us how much they appreciated the flexibility afforded them, they enjoyed the social interactions, competitions, receiving praise for their hard work, and general concern for their wellbeing. They welcomed the opportunities given to them to develop skills, competency and participate in professional studies.

Staff meetings were informative and staff felt comfortable to speak up and contribute. We saw minutes of meetings were available to all staff and covered important issues affecting the department, the hospital and the wider organisation.

We saw documentation which showed how staff had worked with team leaders to address all the concerns raised at the previous inspection; and which harnessed staff thoughts and recollections of improvement achieved and were now embedded in current practice.

The hospital had conducted a staff engagement survey earlier in 2021 to ascertain a baseline of staff views and experience of working at BMI the Chiltern Hospital. The survey covered for example, leadership, personal growth wellbeing, and financial reward. The executives had analysed the results and the ensuing actions showed they were committed to addressing the key issues raised. Staff told us that they had begun to have increased confidence in the company they worked for.

Governance

Good

Diagnostic imaging

Leaders operated effective governance processes, throughout the service and with partner organisations. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.

There was a governance structure that was supported by a range of meetings. Department heads had monthly business meetings which included issues around risk and information governance. There was a monthly clinical governance meeting, which included all aspects of the quality of service, clinical risks and alerts, and service improvements. The imaging manager followed up these meetings with monthly team meetings for her team following an agenda to discuss a range of issues including executive feedback, complaints and incidents. Staff meetings minutes were shared with all staff in the service.

Senior managers had a daily catch up call to discuss issues and concerns, and actions to address them.

The head of the imaging department also attended regular infection prevention and control meetings, health and safety meetings and conducted monthly health and safety audits for the department.

The hospital held annual radiation protection meetings attended by senior executive representation, and other senior leaders from relevant staff groups, including the RPA. We saw minutes of these meetings which included a standard agenda covering all aspects of the imaging service, such as equipment procurement, staff training, radiation incidents and the annual radiological protection audit. This year's audit undertaken in April, had three recommendations with agreed timescales for completion, all of which were actioned by the service.

Managing risks, issues and performance

Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events. Staff contributed to decision-making to help avoid financial pressures compromising the quality of care.

Leaders used information from a variety of sources to ensure they were delivering a quality service. This included patient satisfaction surveys, incident reports, complaints/compliments, training records, audit results, financial reports and continuing professional development files. We saw these were discussed in the minutes of the radiology department team meetings.

During our inspection we were shown the risk register for the department, this featured actions to minimise risk. For example, there were problems with lighting in the MRI scanning room which, as the issue had been addressed, the manager was able to remove from the register.

The senior managers worked well together to identify risks and make improvements. Senior staff had a good understanding of the issues within their areas. The risk register was updated regularly, with risks added to the register relating to patient care, safety performance and current issues.

Risks that needed addressing at a higher level were escalated to the corporate risk register. At the time of our visit there was just one risk relating to the imaging service on the corporate register; this related to potential failure of the MRI scanner due to overheating of the chiller. We could see that actions to mitigate risks were initiated and issues regularly reviewed. Staff we spoke with were aware of the risks in the department and these matched those identified on the risk register.

Good

Diagnostic imaging

The department had several radiation protection supervisors (RPS) who met regularly. Controlled radiation area signs were evident and staff we spoke with knew who the RPSs were.

Managing information

The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were integrated and secure. Data or notifications were consistently submitted to external organisations as required.

The service ensured data or notifications were sent to external bodies when needed. The service leads knew when to submit incident notifications to regulators in line with Ionising Radiation (Medical Exposure) Regulations (IR(ME)R). The service collected, analysed, managed and used information well to support all its activities, using secure electronic systems with security safeguards.

Policies and procedures relating to data management were available to staff electronically, staff completed training in data protection and understood the importance of confidentiality of information.

Engagement

Leaders and staff actively and openly engaged with patients, staff, equality groups, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients.

The service engaged with patients seeking feedback to improve the quality of the services provided. Patient feedback was shared with the team. It was used to improve the service. Staff knew how to support patients to give feedback and raise concerns.

A recent staff survey showed positive results and where there was a less positive response the executive team were committed to improving the outcome for staff.

Patient feedback was collected via a patient satisfaction survey which covered all areas of the hospital and aspects of care with recent results showing that service use**rs rated provision as very good or excellent throughout.**

Learning, continuous improvement and innovation

All staff were committed to continually learning and improving services.

The imaging service was committed to improving services by learning from when things go well and when they go wrong, promoting training and service improvement. The service used incident reporting to identify improvement and this was shared among staff.

The service had responded well to backlog waits for MRI scanning and secured a mobile service to support the current facility to extend access to patients and improve the patient pathway.

Good

Diagnostic imaging

The imaging service had made a change in practice for patients about to undergo breast surgery. A new technique was initiated which helps to reduce stress and anxiety for patients by improving the treatment pathway. The service initiated the use of RFID (radiofrequency identification) tags which provide precision guidance for breast surgeons. The 'tag' consists of beads implanted into the breast at diagnosis. This can be undertaken any time prior to, or on the day of surgery.

Good

Medical care (Including older people's care)

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

Are Medical care (Including older people's care) safe?

Good

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

Mandatory training

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

The service had processes which were followed, staff received and kept up-to-date with their mandatory training. Modules included but were not limited to, basic life and advanced life support, health and safety, infection control including refresher training for COVID -19 management. The data received form the service showed staff had achieved between 85 to 90% compliance with mandatory training.

Clinical staff had completed training in sepsis recognition and management. The provider monitored training compliance to ensure that practises followed current guidelines.

Medical staff received and kept up-to-date with their mandatory training. The service had doctors and anaesthetists who worked under practising privileges. The granting of practising privileges is a well-established process within independent healthcare whereby a medical practitioner is granted permission to work in an independent hospital or clinics They were required to provide evidence from their current NHS role of their compliance with mandatory training as part of their practising privileges. This information was checked and recorded in the individual staff's files.

For our detailed findings on mandatory training, please see the Safe section in the surgery report.

Safeguarding

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

Good

Medical care (Including older people's care)

Nursing staff and allied healthcare professionals received training at level 2 and 3, specific for their role on how to recognise and report abuse. Staff could give examples of what constituted an abuse and how to raise any concerns. Clear guidance was available which staff had access to in order to assist them in raising any safeguarding concerns without delay. They knew how to protect patients from poor care and discrimination, including those with protected characteristics under the Equality Act 2010.

Staff including senior managers were supported to undertake regular updates in safeguarding to maintain their skills and followed procedures aimed at safeguarding children and adults. Safeguarding training data from the service showed high compliance with training for nursing and allied staff. Endoscopy staff had achieved 90% and oncology was at 100%.

The service had a safeguarding lead who attended the quarterly Buckinghamshire wide county multi- disciplinary safeguarding meetings. This was an opportunity to identify any emerging themes and share learning with the staff.

For our detailed findings on safeguarding, please see the Safe section in the surgery report.

Cleanliness, infection control and hygiene

The service controlled infection risk well. Staff used equipment and control measures to protect patients, themselves and others from infection. They kept equipment and the premises visibly clean.

The access and flow of patients attending the units had been reviewed and the service had developed new measures to manage the flow of visitors whilst maintaining effective infection control processes during the pandemic and information was shared with patients.

The service had infection prevention and control measures to prevent the spread of COVID-19. All staff completed twice weekly lateral flow testing. The service had supported staff through the vaccination programme and vaccination status of staff was recorded.

In endoscopy the service was maintaining 25 minutes air exchange from end of endoscopy procedure to minimise the risks of cross infection. All FFP3 masks remained in place until air change time had been completed as these were used per session. FFP3 masks are designed to help protect against infectious respiratory disease and for use in aerosol generating areas.

In the endoscopy unit, the cushion had a tear on one of the theatre trolleys. This posed a high infection control risk as spillage would seep through and could not be effectively cleaned.

Staff worked effectively to prevent infections. The service had reported no incidents of Clostridioides difficile (C. difficile), MRSA, vomiting or diarrhoea outbreaks in the past 12 months.

The service carried out bi- monthly hand washing and environment audits, which included observations of practice and bare below the elbow compliance. We reviewed hand hygiene audit data from October 2020 to August 2021, this showed the service was 100% compliant. Cleaning audits ranged between 83 and 87% for July and August and actions were taken to meet compliance.

The oncology unit had reviewed their patients' pathway during the pandemic to ensure they continued to receive care safely. This included developing new infection control measures, a one way system and extra sinks were fitted in patients' rooms.

There was regular water testing for legionella and bacteriological infections and prioritised high-risk areas to have more regular checks. The most recent legionella test was completed in July 2021 and found no concerns.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment kept people safe. Staff were trained to use them. Staff managed clinical waste well.

The design of the environment followed national guidance. The premises including the oncology unit were bright, well ventilated, clean and well maintained. Consideration was given for people with limited mobility and wheelchair users with ramps and level access available to people using services.

The endoscopy unit was located on the ground floor with easy access to the operating theatre via a passenger lift. The unit consisted of a procedure room and three bedded recovery bays. There was only one recovery bay in use at the time of the inspection. The ventilation was suitable with negative pressure in dirty room, and effective flow of equipment from clean to dirty.

The service had effective arrangements for engineers call out in the event of a breakdown of the endoscope washer-disinfector. This was under a service level agreement with an external company.

Endoscopy equipment was serviced at quarterly and yearly intervals under a service level agreement and records of checks and servicing were available and up to date. The staff carried out weekly checks of some equipment and water testing in line with guidelines.

A resuscitation trolley was available near the endoscopy and oncology units. This was managed safely and fitted with tamper evident tags. Emergency equipment was checked daily and weekly in line with the provider's procedure Staff adhered to this and records seen were fully completed.

The oncology unit was well designed with four patient's rooms with en-suite facilities and four treatment pods which were well furnished with recliners. Patients were overwhelmingly complimentary about the facilities and environment in the unit. They described it as 'excellent and very comfortable'. Patients had direct access to the unit from a separate car park and secure entrance into the unit.

The oncology unit had received the Macmillan Quality Environment Mark (MQEM) award in 2020 which the staff were very proud. This identified and recognised cancer environments that provided high levels of support and care for people affected by cancer. This had been developed in partnership with the Department of Health in England, as it is a core component of the English Cancer Reform Strategy. The environment will be reassessed every three years to ensure that high standards were being maintained.

Patients could reach call bells and we were told staff responded quickly when they requested help and staff carried out regular checks to ensure 'everything is all right.' Patients told us they were encouraged and reminded to use their call bells if they needed any help.

Assessing and responding to patient risk

Staff completed and updated risk assessments for each patient and removed or minimised risks. Staff identified and quickly acted upon patients at risk of deterioration.

Good

Medical care (Including older people's care)

Staff completed risk assessments for each patient on admission, using a recognised tool, and reviewed this regularly, including after any incident or change in treatment. Patients in endoscopy were given clear advice regarding pre-procedure fasting to ensure they did not go for longer period than was necessary without food and fluids. Patient risks were assessed prior to their procedure including those who had diabetes or were on blood thinning medicines.

The endoscopy service had developed an adapted version of the World Health Organisation (WHO) checklist for endoscopy procedures and included this in the patient's pathway document.

The WHO checklist is an initiative designed to strengthen the processes for staff to recognise and address safety issues in relation to invasive procedures. All six patients' records we reviewed had a completed WHO checklist. The service was due to start auditing the WHO checklist every six months.

The service launched the SWARM safety tool in March 2021 which would be triggered within 48 hours of a patient's safety incident. This is a tool which enabled clinical staff to work collaboratively putting patient's safety first. This included 'stop the line' which empowered staff to speak up on potential safety risks where the activity would be paused or ceased.

Patients' records contained test results which were clearly documented and this formed part of the assessments and fitness of patients for chemotherapy treatment and endoscopy procedures to proceed.

In the oncology unit, staff undertook full assessments of the patients such as neuropathy checks, consultant reviews and reduce dosage of chemotherapy as needed. Staff followed the toxicity assessment framework at each visit/ treatment session.

The treatment course, cycle, including cycle number, and individual administration within the cycle were identified and the individual drug doses provided were consistent with their prescription. Staff followed guidelines and used aseptic and non-touch technique, observation of universal precautions and product sterility when administering chemotherapy.

Staff considered sepsis and the signs of sepsis as part of their assessments, in line with the UK oncology nursing society (UKONS). They had completed sepsis training, as part of their competency to deliver chemotherapy. They knew where to access the sepsis policy and could describe what they would do if they suspected sepsis.

In oncology, the service had developed new patient pathway where patients accessed the unit without going through the reception area to reduce their risks to infection.

Staffing

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

The oncology unit had a full team and did not use any agency or bank nurses. Patients were complimentary about the 'excellent staff' and the continuity in their care. They told us that they felt reassured as they saw the same staff who were familiar with their care and treatment.

Good

Medical care (Including older people's care)

The endoscopy service had a lead nurse, a registered nurse and a healthcare assistant for each procedure list. Competent staffing levels and skill mix adhered to the British Society of Gastroenterology (BSG) guidance. Staffing was reviewed during the daily service meetings. Managers had an oversight of staffing ensuring that the procedure list was adequately covered in order to provide safe care. The service was in the process of recruiting additional staff and managers told us they adapted the list according to their staffing compliment.

For our detailed findings on staffing, please see the Safe section in the surgery report.

Records

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

Staff had access to patients' records including results of tests to provide safe and effective care. Patients' records were detailed and included diagnosis, their findings and treatment plan.

Patients records also included care pathways, past medical history, risk assessment, consent form, observations, medicines and discharge plan. Endoscopy records included checklist such as the adapted world health organisation (WHO) five steps to safer surgery which were completed.

Following completion of any procedure, a report was sent to the referring GP and a copy was also given to the patient on discharge. Staff kept detailed records of patients' care and treatment. Records were clear, up-to-date, stored securely and easily available to all staff providing care.

We reviewed six patients' records which were comprehensive and contained good details about patients' assessments and measures to meet their needs.

When patients were transferred to a new team, there were no delays in staff accessing their records. Staff would provide copies of the patients' records when they were transferred out, so the receiving team had up to date information to maintain continuity in patient's care.

For our detailed findings on records, please see the Safe section in the surgery report.

Medicines

The service used systems and processes to safely prescribe, administer, record and store medicines.

Staff stored and managed medicines and prescribing documents in line with the provider's policy. Controlled drugs were dispensed from obtaining them on an individual prescription. This was in line with the Misuse of Drugs Regulations 2001. Controlled drugs (CDs) were stored securely in line with the Misuse of Drugs (Safe Custody) Regulations (1973) and managed in line with the hospital-controlled drug policy.

The CD register was stored securely to minimise the risks of access by unauthorised persons. The registered manager was the nominated controlled drug accountable officer (CDAO) who had overall responsibility for the safe management of controlled medicines. The registered manager and lead pharmacist carried out regular unannounced audits of controlled medicine and records were maintained.

Good

Medical care (Including older people's care)

There was an effective system for managing medicines including those required in an emergency to deal with anaphylactic shock (severe reactions to certain medicines) and for severe bleeding.

Patients' allergy status was clearly recorded on their notes, care pathways and identity band, which alerted staff to the risk. Prescribing was undertaken on dedicated treatment charts and records of administration were clearly documented.

There were clear procedures which were followed for the emergency access to O negative blood as required. This is universal blood type and most used for transfusions in emergency when the blood type is unknown.

The service had a designated pharmacist for the management of oncology medicine. Chemotherapy was stored in a designated area which included a fridge, and this was kept separate from other medicines. All prescriptions for cytotoxic chemotherapy was verified by the oncology pharmacist in line with local policy to ensure calculations, drug dose, route, timing and scheduling were correct.

Any unused chemotherapy preparations were removed by the pharmacy team. Medicine audits took place routinely to monitor compliance. Staff training and competency assessment were provided on the safe use and handling of chemotherapy.

The pharmacy team supported the delivery of effective medicines management. Staff followed current national practice to check patients had the correct medicine. The pharmacist supported patients and provided information regarding their medicine and side effects were discussed. Medicines rooms and refrigerators were monitored, and daily minimum and maximum temperature checks were completed.

Medicines incidents were monitored, there were two incidents in oncology which were related to drug reactions. Patients were treated correctly, and they responded well. The incidents were reported as required to MHRA.

The service had developed patient group directive (PGD) for one of the bowel preparations medicines that patients would be able to access out of hours. Staff told us this was waiting to be ratified before they could be introduced in practice. (PGDs) provide a legal framework that allows some registered health professionals to supply and/or administer specified medicines to a pre-defined group of patients, without them having to see a prescriber (such as a doctor or nurse prescriber).

Incidents

The service managed patient safety incidents well. Staff recognised and reported incidents and near misses. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support. Managers ensured that actions from patient safety alerts were implemented and monitored.

Staff followed their internal process to report, record and sought advice as needed. Incidents were reviewed monthly, and actions were taken to mitigate any risks identified. Examples of actions taken included reviewing procedures and lessons learnt were shared with the staff. There was an established process for the management of safety alerts relating to medicine and equipment. Safety alerts were cascaded to staff, and they told us of recent medicine alert and action they had taken.

Good

Medical care (Including older people's care)

There had been no incidents in oncology and endoscopy that met the serious incident criteria reported for the endoscopy and oncology services. Staff understood duty of candour (DoC) a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support to that person. Staff were confident and aware of their responsibility to inform patients when anything went wrong.

There were no never events reported during the reporting period prior to the inspection. Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.

For our detailed findings on incidents please see the Safe section in the surgery report.

Are Medical care (Including older people's care) effective?

Good

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

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence-based practice. Managers checked to make sure staff followed guidance. Staff protected the rights of patients subject to the Mental Health Act 1983.

The service had procedures and policies which were available to the staff to ensure that care and treatment was delivered in line with national guidelines such as the National Institute for Health and Care Excellence (NICE). Other guidance included the European society of gastrointestinal endoscopy for bowel preparation prior to colonoscopy.

Patients were given information and staff followed fasting guidelines in line with the Royal College of Anaesthetists and National Institute for Health and Care Excellence (NICE).

The service followed the Health Technical Memorandum 01-06 (HTM) for the decontamination of flexible endoscopes.

The endoscopy decontamination area and processes were in line with the British Society of Gastroenterology (BSG) guidelines for decontamination of equipment for gastrointestinal (GI) endoscopy. Flexible endoscopes were compliant with the "Essential Requirements" of the Medical Devices Regulations 2002. Staff followed guidelines for decontamination of endoscopes which included cleaning and high level disinfection at the end of the decontamination process; and maintained in a clinically satisfactory condition up to the point of use.

The management of blood products were in line with Nice Guidance NG125. Staff followed guidelines for the effective storage and monitored the blood fridge temperature and administration of blood products.

Staff followed scalp cooling guidelines for adult Oncology patients. The service used a refrigerated cooling machine to pump a liquid coolant through the cap during chemotherapy treatment to reduce hair loss.

Preparation of chemotherapy treatment was in line with the Royal Pharmaceutical Society of Great Britain guidance. These were prepared by an external provider and delivered to the service in dedicated refrigerated boxes and packaging that shielded the contents from daylight.

Nutrition and hydration

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

Staff made sure patients had enough to eat and drink, including those with specialist nutrition and hydration needs. Specialist support from staff such as dietitians was available for patients who needed it. Patient's nutritional status was assessed when they attended for treatment and staff provided advice and support to maintain a balanced diet.

Staff followed fasting guidance and information was shared with patients to ensure their procedures could be carried out safely.

For our detailed findings on nutrition and hydration, please see the Effective section in the surgery report.

Pain relief

Staff assessed and monitored patients regularly to see if they were in pain and gave pain relief as required.

Staff monitored patients' pain during procedures and were supported to communicate their pain and discomfort. In endoscopy, patients were administered an anaesthetic throat spray prior to their procedures to ensure patients comfort during the procedures.

Staff continuously assessed patients' pain or discomfort during their procedures. Patients were encouraged to report pain and discomfort. Staff included an offer of a pause during procedure if required. Patients told us they had no pain and staff were reassuring throughout their treatment. They had received and were satisfied with the information on pain control and discomfort and they knew what to expect. Staff had access to pain assessment tool for patients who may not be able to verbalise their pain and staff said patients would be supported to use this as needed.

For our detailed findings on pain relief, please see the Effective section in the surgery report.

Patient outcomes

Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for patients. The service had been accredited under relevant clinical accreditation schemes

The service submitted data to the National Endoscopy Data Base on gastrointestinal endoscopy as part of their Joint Advisory group (JAG) accreditation. The service had achieved the nationally recognised JAG accreditation. This is an accreditation patient centred scheme and based on independent assessment against recognised standards.

The service was planning to develop a polyp surveillance tool which would enable the provider to predict cases and workload.

Good

Medical care (Including older people's care)

For our detailed findings on patient outcomes, please see the Effective section in the surgery report.

Competent staff

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

Staff were experienced, qualified and had the skills and knowledge to meet the needs of patients. Staff were supported to complete further training relevant to their role and specific to the needs of the people they cared for.

In oncology staff had completed additional training in the management of chemotherapy in line with the UK oncology nursing society (UKONS). They had developed their skills in venepuncture (inserting a needle into a vein to obtain blood) and cannulation (inserting a needle into a patient's vein to administer intravenous fluids and medicine). Staff also completed a competency based assessment before using cooling caps on patients. Medical staff's competency was discussed at their medical advisory committee meetings and practices reviewed.

The service also had employed phlebotomists who were trained to carry blood tests on patients. They underwent a competency assessment which included a number of observed practices prior to being signed off to work independently.

Managers identified staff's training needs and supported them to develop their skills and knowledge. The service supported staff to undertake training to remain on the professional register and meet their revalidation requirement. Revalidation is a process to ensure staff had undertaken training and development to maintain their skills to remain on the register. The service also checked staff had current registration to allow them to practice.

For our detailed findings on competent staff, please see the Effective section in the surgery report.

Multidisciplinary working

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

Patients benefitted from the multidisciplinary team working together in planning and delivering care and treatment to meet their needs. Staff supported by the other team members at the service. In oncology there was an effective team working between the nursing and pharmacy staff in ensuring that chemotherapy was delivered safely to patients. The oncology pharmacist liaised with the staff and checked patient's blood results and supplied chemotherapy treatment.

Staff told us they worked closely with the theatre team and could give example when the team had come from theatre to support staff and patients. Staff held regular and effective multidisciplinary meetings to discuss patients, review risks and improve patients' care.

For our detailed findings on multidisciplinary working, please see the Effective section in the surgery report.

Seven-day services

The oncology and endoscopy services did not provide a seven day service.

Good

Medical care (Including older people's care)

The endoscopy and oncology services operated between 8am and 6pm, Monday to Friday and did not provide any emergency care or treatment. Patients followed an elective pathway for their procedures. This information was also available to patients when choosing services. The pharmacy team was available six days a week.

Patients were provided with a contact number following discharge to enable them to seek advice and support out of hours.

For our detailed findings on seven day services, please see the Effective section in the surgery report.

Health promotion

Staff gave patients practical support and advice to lead healthier lives.

Staff assessed each patient's health when admitted and provided support for any individual needs to live a healthier lifestyle. Patients were given advice on diet and fluids following treatment, to help ensure they maintained a healthy dietary intake.

The endoscopy and oncology units had developed pathways to promote safe care. Patients in oncology for example came into the service from a dedicated car park and had direct access to the unit to minimise risks to patients.

The hospital used laminated health promoting posters relating to COVID-19 in public areas. These reminded patients of the importance of social distancing and washing hands to reduce the risk of transmission of the virus. Leaflets to support healthier lifestyle were available online or could be printed as requested.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

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

The service had a consent policy, which was based on guidance of the national guidance for consent for Systemic Anti-Cancer Therapy (SACT). Specific consent forms were used for all patients undergoing SACT regimen in line with Department of Health guidance.

There was guidance for staff on obtaining valid consent, having due regard to the Mental Capacity Act 2005 (MCA). Staff had access to the policy and had received training in completing stage two consent in line with the provider's guidance. As part of the policy, failure to obtain consent prior to examination or treatment would require staff to report this as an incident in line with the provider's incident management process.

We reviewed consent forms for endoscopy which showed these were fully completed, signed and dated to ensure they were valid. The consultants gained consent from patients prior to the procedures which also highlighted any associated risks.

Staff made sure patients consented to treatment based on all the information available. At the pre- assessment stage, patients were given information about the procedure in order to assist them in making informed decisions about their care and treatment.

Good

Medical care (Including older people's care)

Staff protected the rights of patients subject to the Mental Health Act and followed the Code of Practice. All staff we spoke with had a good understanding of the Mental Health Act and could explain how they would ensure a patient's rights were protected. Staff completed training in consent and Mental Capacity Act 2005 and knew how to access support if they had any concerns regarding consent. They told us they would follow guidance to ensure decisions were made in patients' best interest and took into consideration patients' wishes.

For our detailed findings on consent, please see the Effective section in the surgery report.

Are Medical care (Including older people's care) caring?

Good

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

Compassionate care

Staff consistently treated patients with compassion and kindness. There was a strong and visible person-centred culture. Staff were highly motivated to offer care that promoted and respected people's privacy and dignity. Staff provided care in a holistic way considering the whole person

Patients provided us with overwhelmingly positive feedback about how staff treated them, with compassion and kindness. Their feedback showed a strong sense of a person-centred culture with the service.

Staff spent time explaining care and treatment to patients including ensuring they were fully informed of the length of their treatment and any side effects. Patients using the cooling cap in oncology were given information on scalp cooling and the opportunity to discuss its contents, to see the scalp cooling machine and to try on the cold caps prior to their first chemotherapy appointment. The appropriate cap size was selected and the size documented in the patient's records. Staff were sensitive in discussion with patients and kept them fully informed about the nature and length of the procedure, success rates, side effects and the potential risks. Patients were informed that they may discontinue the procedure at any time if they found it too physically or psychologically traumatic or if they failed to retain their hair.

Patients told us the staff went above and beyond and ensured they were treated with care and compassion. Another patient said that staff ensured they had heating pads, duvet and extra blankets to counteract the effect of the cold caps. Staff ensured patients privacy and dignity was respected at all times. Patients commented that 'the staff treat you with utmost care'. Another patient told us 'it's really good that you don't have to come through the reception area' as they had a separate entrance to the oncology unit.

We were unable to comment on PLACE data across services as the provider told us the audit was suspended in 2020 due to the pandemic. The next PLACE audit was scheduled for October 2021.

Emotional support

Staff provided emotional support to patients, families and carers to minimise their distress. They understood patients' personal, cultural and religious needs

Good

Medical care (Including older people's care)

Staff gave patients and those close to them help, emotional support and advice when they needed it. Patients commented that the staff were very aware of the impact of chemotherapy and were there 'on the journey' with them. Staff supported patients who became distressed and helped them to express their feelings. Patients were continuously given explanation and we received positive feedback about the emotional support and reassurance they received to relieve their anxiety.

For our detailed findings on emotional support, please see the Caring section of the surgery report.

Understanding and involvement of patients and those close to them

Staff supported patients, families and carers to understand their condition and make decisions about their care and treatment.

Patients were given appropriate and timely information to assist them in making decisions about their care and treatment and alleviate their anxiety. Staff recognised the impact of care and treatment provided on the patient and those close to them.

Patients were fully involved in their care and they told us they found it easy to discuss their care as they had developed good relationship with the staff in oncology service. They told us that staff also involved their family as appropriate as they were part of 'the team'.

For our detailed findings on understanding and involvement of patients and those close to them, please see the Caring section of the surgery report.

Are Medical care (Including older people's care) responsive?

Good

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

Service delivery to meet the needs of local people

The service planned and provided care in a way that met the needs of local people and the communities served. It also worked with others in the wider system and local organisations to plan care.

The oncology and endoscopy services were planned and responsive to meet the needs of the local community. The Oncology service worked flexibly and provided up to ten chemotherapy treatment sessions per day. Tuesday was planned as haematology day, where patients received longer treatment and were accommodated in the four available rooms.

Leaders were working with local commissioners to alleviate pressure on the wider health system and the endoscopy service was undertaking some flexible cystoscopy procedures. Managers monitored and acted to minimise missed appointments. They followed their process and contacted patients who did not attend appointments, and consultants informed of non- attendance and actions taken such as rebooking. They tailored services to meet the needs of individual people and delivered the services in a way to ensure flexibility, choice and continuity of care.

Good

Medical care (Including older people's care)

For our detailed findings on service delivery to meet people's needs, please see the Responsive section in the surgery report.

Meeting people's individual needs

The service was inclusive and took account of patients' individual needs and preferences. Staff made reasonable adjustments to help patients access services. They coordinated care with other services and providers.

The environment was designed to meet the diverse needs of needs of patients. People with limited mobility and wheelchair users could easily access all areas of the service and there was a passenger lift suitable for wheelchairs.

The provider had arrangements in place with local services for referrals and transfers of patients. Contingency plans were in place and had consultants support for any urgent care and transfer to the local trust.

Patients received written information ahead of their appointment which included specific instructions and information about what to expect as part of their care and treatment.

The oncology service had developed a library of information for patients specific to their care and treatment.

The provider had adopted the accessible information standard (AIS). A standard which aims to make sure people who have a disability, impairment or sensory loss can access information they can understand and receive the communication support they need from health and care services.

There was clear guidance for staff and information on how to access leaflets and other information to support the patients. This included large prints and in different languages, screen reader, information in different languages, hearing loops and easy read.

For our detailed findings on meeting people's individual needs, please see the Responsive section in the surgery report.

Access and flow

People could access the service when they needed it and received the right care promptly. Waiting times from referral to treatment and arrangements to admit, treat and discharge patients were in line with national standards.

In the reporting period from August 2020 to August 2021, there were 1274 episodes of care for oncology. All patients were either privately/self-funded or insured. Patients could access the service when they needed, and Oncology continued to provide care and treatment during the pandemic.

There were 1196 endoscopy patients treated as day cases for the same period. This data included 418 NHS funded patients. There were 451 flexible cystoscopy procedures which was 31.7% of the overall cases. The service was not operating at full capacity as staff told us they were using one of the three available trolleys. The service was planning not to undertake any cystoscopy procedures in October 2021 due to staffing shortage. The provider was also exploring pathway alternatives to improve efficiency of the service.

Good

Medical care (Including older people's care)

For our detailed findings on access and flow, please see the Responsive section in the surgery report.

Learning from complaints and concerns

It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff. The service included patients in the investigation of their complaint

The service had a complaint policy and procedure which was available to staff, and they knew how to access it. Information on how to raise a concern or complaint was available to patients and their relatives.

During the 12 months prior to inspection, the service had received one complaint for endoscopy which was investigated and responded to. The oncology unit had received no complaints and 18 compliments during the same reporting period. Patients and relatives told us they had no complaints about the service and staff 'were wonderful'.

The registered manager was responsible for looking at all complaints at the service and escalated them as necessary. Staff told us they received few complaints and would always try and resolve any concerns as soon as possible.

There was a clear process in place for capturing and learning from any concerns. Following investigation of a complaint, action for endoscopy was developed for staff to log and make follow up phone calls to all patients following their procedures, and to ensure that patients have a follow up outpatient appointment upon discharge where relevant.

For our detailed findings on learning from complaints and concerns, please see the Responsive section in the surgery report.

Are Medical care (Including older people's care) well-led?

Good

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

Leadership

Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service. They supported staff to develop their skills and take on more senior roles.

There was a clear leadership structure from service level to senior management level which staff said worked well. The hospital was led by an executive director who had overall responsibility for the hospital. All meetings within the governance framework were well attended with clear lines of accountability throughout the structure.

The senior leadership team met monthly and there was a four-weekly cycle of focus which looked at risks, staffing, business development, quality and facilities. There was an ongoing action plan that meant that action was decided for each issue raised and the actions were allocated to a designated person. The action plan was then reviewed and updated at each meeting and progress against action plans were assessed.

Good

Medical care (Including older people's care)

Staff were supported to undertake training and development courses to develop their skills. Staff at all levels clearly understood their roles and responsibilities and minutes of meetings showed they contributed to these.

For our detailed findings on leadership, please see the Well led section in the surgery report.

Vision and strategy

The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. Leaders and staff understood and knew how to apply them and monitor progress.

The hospital's vision and strategy was *to provide the high quality, safe and compassionate care to meet patients' needs and expectation*. To achieve this a Circle Health Group philosophy was launched in June 2021. There were four key areas of focus over the next two years: people, quality, infrastructure and technology. There were strategic plans as to how the key areas were to be achieved and how success was to be measured.

Underpinning the key areas were the underlying values that guided the group and its employees. Those being:-

- We value people who are selfless and compassionate
- We value people who are collaborative and committed
- We value people who are agile and brave
- We value people who are tenacious and creative

The vision was to develop the endoscopy service and sustain the level of activity for oncology. The service had appointed a specialist cancer nurse and oncology bank nurse with specialist knowledge in breast care and gynaecology. This aimed at improving holistic care for patients and be instrumental in development of the patient pathway.

For our detailed findings on vision and strategy, please see the Well led section in the surgery report.

Culture

Staff felt respected, supported and valued. There was a strong culture of teamwork and support across all levels of the service. The service had an open culture where patients, their families and staff could freely raise concerns. Staff were focused on the needs of patients receiving care and shared a common goal to improve the quality and safety of care and people's experiences

Leaders operated an open door culture and the senior management teams were visible at the service. The staff in oncology were proud of the culture and support from senior management. Staff felt able to raise any concerns including the quality of services and risks There was an open and inclusive culture, where people were valued and treated with integrity and compassion

Teams worked collaboratively, and we saw examples of positive cross-team working to provide joined up care for patients. There were particularly strong links between the pharmacy and oncology teams. They worked cohesively supporting each other which positively impacted on patients. They were focussed on the needs of the patients ensuring they were supported throughout their treatment pathway and improve the care delivery.

Good

Medical care (Including older people's care)

For our detailed findings on culture, please see the Well led section in the surgery report.

Governance

Leaders operated effective governance processes, throughout the service and with partner organisations. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.

There was well developed and effective governance structure. The committee consisted executive director, clinical service managers, senior management team, consultants and medical directors. The meetings were structured around the clinical dashboard and discussions were focussed on this. All meetings within the governance framework were well attended where there were clear lines of accountability. Governance meeting has continued as planned during the pandemic Staff at all levels clearly understood their roles and responsibilities and fed back to the meetings.

The service had developed policies and procedures which were reviewed regularly to ensure they remained valid and current and in line with good practice guidelines. These included multi- disciplinary team discussions of patients with breast cancer and emergency transfer of patients, classification & removal of polyp which had all been reviewed in 2020.

For our detailed findings on governance, please see the Well led section in the surgery report.

Managing risks, issues and performance

Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events.

The risk register was reviewed with the quality and risk manager. This was shared with all staff in the department and displayed in the oncology office. The clinical service manager was planning regular meetings to be held with the Quality and Risk Manager to ensure that risks were reviewed and up to date.

The provider's risk register contained risks for individual services. Minutes of oncology meetings showed that risks were reviewed, and action plans developed to mitigate them as needed. In oncology this included ensuring the safe management of spillage kits for both non cytotoxic and cytotoxic substances. This clinical room had restricted access for authorised personnel and was locked. Wheeled trolleys were used for transportation of cytotoxic drugs and the sharp bins to discard used chemotherapy substances were colour coded in line with guidance.

The endoscopy service was following the green pathway and had stopped using the oncology unit due to the risks of COVID-19 strains and its higher transmission rate, and patients were admitted to the ward. We spoke to senior staff about risks within their service and they confirmed the risk register was discussed as part of the service performance review meeting.

The global rating scale (GRS) and user group review had been recently completed by a lead consultant. The GRS is an assessment tool that enables endoscopy to look at how well they were providing patient centred care. There were no concerns following the review of consultant practices. All criteria were being met within notifiable ranges of performance for all procedures.

Managing information

Good

Medical care (Including older people's care)

The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were integrated and secure.

Leaders used information in reporting, performance management and delivering quality care. Staff undertook audits to make sure information they used was accurate, valid and reliable.

Leaders proactively collected information and analysed it to drive improvements in care. Staff completed training in information governance, and staff we spoke with understood their responsibilities regarding information management.

The service had appointed a Caldicott Guardian who had clear understanding of the Caldicott principles and had undertaken further training to support them in their role. Caldicott principles are fundamental rules and regulations that guide a patient's confidentiality. They are the basic rules every healthcare personnel must follow to ensure there is no breach of confidentiality. Staff spoke about sharing information only in the best interest of the patient and as disclosures were only made to protect patients. Notifications were submitted as needed to meet with regulations and used secure methods in line with their policy.

For our detailed findings on managing information, please see the Well led section in the surgery report.

Engagement

Leaders and staff actively and openly engaged with patients, staff, equality groups, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients.

The service worked proactively and had a joint up approach to gathering feedback from people using services. Patients were encouraged to comment on their care through patient satisfaction questionnaires available on site and online.

Feedback from people we spoke with was overwhelmingly positive and also those we reviewed as displayed in the oncology service. The hospital reviewed and monitored patient satisfaction through their clinical governance committee and used the information to inform improvement and learning.

For our detailed findings on engagement, please see the well led section in the surgery report

Learning, continuous improvement and innovation

The oncology service had received the Macmillan Quality Environment Mark (MQEM) award in 2020 which identifies and recognises cancer environments that provide high levels of support and care for people affected by cancer. This has been developed in partnership with the Department of Health in England, as it is a core component of the English Cancer Reform Strategy.

Endoscopy service was developing a polyp surveillance tool which would enable the provider to predict cases and workload.

Good

Surgery

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

Are Surgery safe?

Good

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

Mandatory training

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

The hospital followed the BMI/Circle Health Group mandatory training policy which defined the mandatory training requirements of staff including bank workers. Mandatory training was split into departments and job roles. Staff working in the surgery service would have a personalised list of mandatory training for them to complete.

We assessed the mandatory training requirements and it was comprehensive and met the needs of patients and staff. Staff completed training through face to face and e-learning modules.

BMI The Chiltern Hospital set a target of 90% for completion of mandatory training. As of September 2021, compliance with mandatory training for staff working across the whole hospital was 88%, and for staff working in the surgery service was 85%.

Senior staff through conversation with the inspection team, could demonstrate that they reviewed and had oversight of the hospital's mandatory training completion rates both hospital-wide and in the surgery service.

Staff we spoke with told us although there were no barriers to accessing mandatory training, it was not always easy to find the time to complete their mandatory training in their normal working hours. To mitigate this, and in line with the corporate mandatory training policy, staff could access on-line training at home. Staff would be paid for the time taken to complete their training in non-working hours. In addition, face to face training had been stopped during the COVID-19 pandemic to avoid the spread of the virus. At the time of our inspection, face to face training had restarted and staff were catching up on the training that had been delayed. Senior staff told us this was the reason some of the mandatory training completion rates were below the expected target set by the hospital.

Safeguarding

Good

Surgery

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff received training specific for their role on how to recognise and report abuse

The hospital followed the BMI/Circle Health Group safeguarding adults and safeguarding children and young people policies. These policies provided staff with guidance on how to identify abuse and the processes to follow if needing to raise a safeguarding concern. These policies covered other elements of safeguarding such as radicalisation and female genital mutilation.

Safeguarding was part of the staffs' induction and mandatory training. Staff had the appropriate level of adult and children safeguarding training for their role and could recognise the signs of abuse. The hospital had a safeguarding training completion rate of 98.7%. Consultants submitted evidence that they had completed their mandatory safeguarding training in their substantive post, for their practising privileges to be renewed.

The director of clinical services (DCS) was the lead for safeguarding at the hospital and had oversight of any referrals made in order to support staff and patients.

Most staff had not raised a safeguarding concern whilst working at the hospital but knew who the hospital safeguarding lead was, could demonstrate what constituted as abuse, and explain the safeguarding processes they would follow if they had concerns about a patient.

Safety was promoted in recruitment procedures and employment checks. Staff had Disclosure and Barring Service (DBS) checks completed before they could work at the hospital. DBS checks help employers make safer recruitment decisions and prevent unsuitable people from working with vulnerable people.

The hospital had a corporate policy for provision of chaperones during examination, treatment and care which provided staff with guidance about the role and responsibilities of chaperones. Staff were aware of this policy. Patients were given information in their *Your visit to our hospital* leaflet on how to request a chaperone.

Cleanliness, infection control and hygiene

The service controlled infection risk well. The service used systems to identify and prevent surgical site infections. Staff used equipment and control measures to protect patients, themselves and others from infection. They kept equipment and the premises visibly clean.

BMI The Chiltern hospital had infection control policies and procedures to help control infection risk. These and other related policies covered the actions required by staff to minimise the risk of infection and cross infection in the hospital and the surgery service. In addition, new protocols and procedures had been produced in response to the COVID-19 pandemic. This included a new procedure for when staff, patients and visitors arrived at the hospital, and for patients who needed to home isolate and have a negative COVID-19 test prior to their elective surgery.

COVID-19 was still a risk when the inspection took place and therefore COVID-19 measures were in place at the hospital. During our inspection we saw the following COVID-19 measures carried out to protect patients, visitors and staff.

- Temperature checks and face masks available at the entrance to the hospital.
- Rapid lateral flow tests available to test day patients and visitors for COVID-19 at the entrance.
- Hand sanitiser available throughout the hospital.
- Signs to remind patients, visitors and staff of the need for social distancing to reduce the spread of the virus.

- Posters highlighting the importance of good hand hygiene.

Staff could explain the procedures they would follow if they had concerns about a patient or visitor's infection status.

All staff completed twice weekly lateral flow testing and records of these were maintained. The vaccination status of all staff was recorded in their personnel records. Records showed a high uptake of vaccination amongst the clinical and non-clinical staff.

All areas of the surgery service we inspected, including the theatres and wards, were visibly clean and tidy. The hospital, since the last inspection in January 2019 had continued with its programme of replacing carpet and fabric furnishings, which posed an infection control risk as not wipe clean. On this inspection we saw suitable flooring and furnishings throughout the hospital and the surgery service which was clean and well-maintained.

The hospital had housekeeping staff who were responsible for cleaning patient and public areas, in accordance with daily and weekly checklists. Cleaning records were up-to-date and demonstrated areas were cleaned regularly and deep cleaned when needed. Cleaning equipment was stored securely in locked cupboards. This meant unauthorised persons could not access hazardous cleaning materials.

Staff used *I am clean* stickers on equipment in the clinical areas to identify that items had been cleaned and were ready for use.

Staff were required to complete IPC training during their induction and then annually at the level appropriate to their role as part of their mandatory training. We observed staff following good general infection control practices to minimise the spread of any infection; they wore face masks, were bare below the elbow and cleaned their hands before and after contact with every patient. Staff had access to hand washing facilities and personal protective equipment, such as gloves and aprons in a variety of sizes. Since our last inspection clinical handwashing sinks had been installed along the ward corridors and in patients' bedrooms. This meant staff had the facilities needed to effectively wash their hands to help prevent avoidable health acquired infections.

There were effective systems to ensure standards of hygiene and cleanliness were regularly monitored, and results were used to improve IPC practices if needed. The hospital had a designated lead for IPC who was available to provide support, advice, training and updates for staff. They also monitored compliance with IPC policies via the audit programme. The IPC lead told us they were supported by IPC link nurses in the clinical areas. Their role was to increase awareness of infection control issues in their own area and to motivate staff to improve practice.

The audit programme was used to increase and maintain standards and help prevent the spread of infection. We saw evidence IPC and audits were discussed during ward and theatre meetings and issues were raised and an action plan put in place.

The hospital had quarterly IPC meetings. We reviewed minutes from these meetings and could see it was an effective way to monitor, promote and maintain IPC standards at the hospital. Actions from meetings were given an owner and progress was reviewed at the next meeting.

The hospital had a health and safety meeting. There was a set agenda which included water flushing round the hospital, the results of water testing and risk assessments for legionella and pseudomonas. We reviewed documentation that showed that regular water testing was being carried out.

The hospital had a microbiologist on call to give advice and who attended the IPC committee meetings. From the minutes we reviewed we could see the microbiologist attended these meetings.

Nursing staff carried out infection control risk assessments on all patients as part of their pre-admission assessment process. This included details about any recent illnesses; MRSA status and possible exposure to MRSA or infectious diseases in the month prior to pre-admission screening. This facilitated the identification of infection risks at the earliest possible time in the patient's care pathway to ensure correct infection prevention and control practices were instigated.

The hospital provided patients with a leaflet in their pre-admission information pack that explained how good hand hygiene prevented and controlled infection. It included information about hand washing, good hand washing technique and when the use of hand sanitiser gel was appropriate. The pack also included information on surgical site infection. This included information for the patient on how to spot the signs and symptoms of an infection and what action needed to be taken.

The hospital had two laminar flow operating theatres, a system of circulating filtered air to reduce the risk of airborne contamination. This worked to prevent airborne bacteria from getting into open wounds, as well as removing and reducing levels of bacteria on exposed surgical instruments.

Staff followed good practice guidance and maintained clean and dirty flow within the operating theatres. This included limiting the number of staff entering the operating theatre during surgery and restricting the movement of personnel in the operating theatre to a minimum.

The hospital had a contract in place for decontamination and sterilisation of surgical instruments, which took place off-site. The BMI/Circle Health Group, and this hospital, used a track and trace system to trace all reusable accessories to ensure appropriate maintenance, correct decontamination and traceability to associated patients.

The hospital had recorded eight surgical site infections in the reporting period September 2020 to August 2021 which was a rate of 0.1% of the total number of procedures performed at the hospital. The IPC lead told us and we saw evidence in the IPC meeting minutes, that surgical site infections were reviewed to see if trends could be identified and areas of infection control improved on. The hospital reported no incidences of c.difficle, methicillin sensitive staphylococcus aureus (MSSA) and methicillin resistant staphylococcus aureus (MRSA) between September 2020 to August 2021.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment kept people safe. Staff were trained to use them. Staff managed clinical waste well.

Since our last inspection in 2019, investment in the infrastructure of the hospital had continued. This included the remaining carpets being removed and replaced with clinical appropriate flooring, the passenger lifts being replaced, a new heating and cooling system installed in consulting rooms and the air-conditioning system being replaced throughout the hospital, ward bedroom upgrades and new boilers being installed.

The surgery service had suitable facilities to meet the needs of patients for the type of care delivered. The theatre suite had swipe card access meaning only people with authorisation could gain entry into the area. There were three theatres, two with laminar flow systems, which were used mainly for implant surgeries, and one without, which was used for general surgery. The recovery area had space for four trolleys for patients recovering from surgery. Each bay had the required equipment as recommended by the Association of Anaesthetists of Great Britain and Ireland (AAGBI).

Good

Surgery

The service had two surgical wards with 56 bedrooms in total the majority being en-suite. The rooms were comfortably furnished which patients said met their needs. Each patient room and bathroom had emergency call bells, which were used to alert staff when urgent assistance was required.

The hospital participated in the Patient-Led Assessments of the Care Environment (PLACE) assessments. PLACE assessments provide a framework for assessing quality against common guidelines and standards in order to quantify the environment's cleanliness, food and hydration provision, the extent to which the provision of care with privacy and dignity is supported, and whether the premises are equipped to meet the needs of people with dementia or with a disability. Due to the COVID-19 pandemic PLACE assessments had been cancelled for 2020. The hospital's PLACE audit results for 2019 showed a score of 95.5% for the condition, appearance, and maintenance. The assessment for condition, appearance, and maintenance covers areas such as decoration, the condition of fixtures and fittings, tidiness, signage, lighting (including access to natural light), linen, access to car parking, waste management, and the external appearance of buildings and maintenance of grounds.

Senior staff working in the surgery service carried out environmental risk assessments. We reviewed these assessments and found them to be thorough and in date. Hazards were identified, such as certain equipment and chemicals used in the areas, who was at risk and the controls to mitigate the risks.

During our inspection, we observed staff kept meeting rooms, cleaning and storage cupboards, and utility rooms locked and secured at all times. This meant access to areas unsuitable for patients was controlled.

Both wards and the theatre suite had resuscitation trolleys which were secured with anti-tamper tags making it clear if someone had accessed the equipment. Staff, as per hospital policy, performed daily checks on the resuscitation equipment stored on top of the resuscitation trolleys and weekly checks on the contents. The theatre suite had a difficult airways trolley which was checked weekly. Records we reviewed during our inspection showed all equipment checks were carried out meaning there was a consistent and regular approach to safety checks.

In theatres, staff carried out daily checks of anaesthetic equipment prior to the start of the surgery list in line with the Association of Anaesthetists of Great Britain and Ireland guidelines. They followed the anaesthetic equipment checklist and recorded this once completed. This provided assurance that equipment was ready for use and fully compliant.

The hospital had its own onsite maintenance team who kept records of equipment across all departments, this included service history and electrical testing. We carried out a random check of equipment in the theatre suite and on the wards. All items we checked had a label indicating it had been checked for electrical safety and had been serviced. This provided the assurance equipment was safe to be used.

Staff told us they had enough equipment to provide safe and effective care and treatment to patients. We checked a sample of consumable items for expiration dates and all were in-date. Storerooms were tidy, well organised and items stored correctly according to policies and procedures. This meant consumables were easily located for staff.

The hospital had a tracking system for details of specific implants and equipment to be recorded and reported to the national joint registry. We saw that all equipment, implants and prosthesis were tracked and traced. All records that we looked at had clear evidence of this with batch numbers recorded.

Staff understood their responsibility to ensure they segregated and disposed of clinical waste according to the hospital's waste management policy. During our inspection we saw the correct management of containers for sharps and the use of coloured bags to correctly segregate hazardous and non-hazardous waste. Staff removed clinical waste from the clinical areas at regular intervals to reduce infection control risks. It was stored securely until collected by an external supplier whom the hospital contracted to dispose of clinical waste.

Assessing and responding to patient risk

Staff completed and updated risk assessments for each patient and removed or minimised risks. Staff identified and quickly acted upon patients at risk of deterioration

The hospital had an admission criteria which meant the hospital only admitted patients whom the hospital had facilities to care for. Patients with complex co-morbidity and bariatric patients would not routinely be admitted for treatment. Admission exceptions were only considered on the presentation of all relevant clinical evidence, a risk assessment and the mitigation of risk and with the agreement from all parties involved in the care of the patient.

The service had developed pre- and post-surgery principles and procedure management during COVID-19. There were clear elective surgery pathways which had been instigated during the pandemic and were followed.

Patients undergoing elective surgery had a pre-assessment to ensure they met the inclusion criteria for surgery and key risks identified that may lead to patient's complications during the anaesthetic, surgery, or post-operative period. This assessment was carried out by a registered nurse. It also provided an opportunity to ensure that patients were fully informed about the surgical procedure and the post-operative recovery period.

The service used criteria based on type of surgery to determine which patients received telephone or video link assessments rather than face-to-face assessments. For example, patients undergoing a local anaesthetic would normally have a telephone pre-assessment and patients having a general anaesthetic would be assessed in a nurse led pre-operative assessment clinic at the hospital prior to their surgery. During our inspection we observed a pre-assessment telephone screening and found all questions were covered and potential risks identified, recorded and passed to the relevant teams.

Patients were swabbed to assess for any colonisation of MRSA at the pre-assessment clinic as per hospital policy. If results were found to be positive the patient was provided with a treatment protocol to use at home, according to the hospital's MRSA policy. If necessary, surgery would be deferred until patient had a negative swab result.

Staff completed risks assessments for patients on admission to the hospital using national recognised tools. These assessments included risks of malnutrition, fall risk assessment, venous thromboembolism (VTE) and known allergies. Care plans were developed using this information to provide care and treatment and minimise risks as identified. Patients with known allergies were seen to wear a red wristband. This alerted staff to the patient's allergic status and helped mitigate the risk of allergic reactions.

During our inspection we observed the theatre team used the five steps to safer surgery, which included the World Health Organisation (WHO) surgical safety checklist. The WHO checklist is a nationally recognised system of checks designed to prevent avoidable harm and mistakes during surgical procedures. These checks consisted of team briefing, sign in (before anaesthesia), time out (before surgery starts), sign out (at the end of the procedure) and debrief. We observed all five steps of the WHO checklist and saw staff fully completed and engaged in all the required checks. We noted the WHO checks was embedded in practice and within the theatre culture.

Good

Surgery

The hospital audited the WHO checklists and good compliance was demonstrated. Regular feedback was given to the surgical team to make sure the checklist was used correctly and fully. Patient records we reviewed showed the good compliance with the checklist.

Staff had immediate access to blood products, to stabilise patients with life threatening haemorrhage. The blood fridge temperature and stock was checked and recorded daily.

We observed patients being transferred from theatre to the recovery area, and saw the anaesthetist, surgeon and scrub nurse verbally handed over the care and treatment carried out in theatre and discussed medication which had been prescribed for both recovery and the ward.

Whilst in the recovery unit patients' health and wellbeing was monitored using the nationally recognised national early warning scores developed by the Royal College of Physicians (NEWS2) for the detection and response to clinical deterioration in adult patients. This is a key element of patient safety and improving patient outcome. Records showed staff used NEWS2 tool to identify deteriorating patients in the recovery areas and on the wards and any changes were escalated appropriately.

If a patient deteriorated, the resident medical officer (RMO) would review and liaise with the consultants for advice about managing increased risks or to consider transfer to an acute hospital if needed. The hospital had service level agreements in place with the local NHS trust for transferring patients for medical reasons. Staff told us they followed the BMI/Circle Health Group policy for the transferring of patients if a transfer was required. In addition, the service had an on-call theatre team in case a patient had to be returned to theatre.

Between September 2020 and August 2021 there had been five unplanned transfers, which was 0.08% of all day-case and inpatient admissions, all were due to clinical deterioration not predictable. All transfers were carried in a timely way with no issues with the process. In the same timeframe there had been no readmission of patients to theatre.

The hospital had a sepsis screening tool and sepsis care pathway for staff to use if they suspected a patient had sepsis. The tool was aligned with current best practice. Staff we spoke with were aware of the screening tool and pathway and told us they would escalate any patients displaying these symptoms to the RMO. Sepsis training was part of the mandatory training Care and Communication of the Deteriorating Patient (CCDP) module. At the time of inspection, only 55.1% of staff who were required to have this training had completed it. We were told post inspection the deadline for staff to complete this training was 31 December 2021.

Consultants were required by the practising privileges agreement they worked under, to be contactable at all times when they had inpatients in the hospital. Furthermore, they needed to be available to attend the hospital within an agreed timeframe to respond to any urgent concerns. The RMO and nurses told us that consultants were easily contactable out of hours, such as at night or over a weekend should staff be concerned with a patient's condition. Individual consultants remained responsible for the overall care of their admitted patients.

Theatre staff attended a safety huddle each morning, where the operating list was discussed. Any potential patient risks or issues were highlighted and planned for. Theatre lists were printed on white paper. However, if any changes had been made to the list, for patient safety the lists were reprinted onto green paper which gave staff a visible reminder that something had changed.

Good

Surgery

Nursing staff on the wards undertook handover between each shift which included an update on all patients currently admitted and highlighted any specific concerns such as infection risks or safeguarding concerns. During our inspection we saw effective communication of key information to keep patients safe between staff of all grades and roles.

The hospital had a daily comms cell meeting held at 9am, Monday to Friday. Representatives from each department attended these meetings. The meeting covered a range of subjects and included current patient risk in the hospital. This enabled staff to gain a wider view of risk throughout the hospital. The hospital's resuscitation team's responsibilities were reviewed at the daily comms cell meeting. Each member of the team was allocated a specific role such as leader, airway management, defibrillation, recorder and runner. This was in line with best practice guidance issued by the Resus Council (UK).

Staff working in the surgery service told us the hospital carried out emergency scenarios such as fire and cardiac arrest to simulate what they would do in an emergency. Staff were provided with feedback and any lessons learnt were shared with the department.

All staff at the hospital completed adult basic life support, immediate or advanced life support training depending on their role. Data provided by the hospital post inspection showed life support training was below the target set by the hospital due to face to face training being suspended during the COVID-19 pandemic. Basis life support training was at 78% and immediate life support training was 76%. At the time of our inspection, additional training sessions were being arranged so staff could catch up on the training that had been delayed.

Patients who had concerns following discharge, including day surgery would be given information on how to contact the hospital to access advice. Included in their discharge information was a leaflet on monitoring surgical wounds for infection. This gave patients information on wound care when they went home, the signs and symptoms of an infection and who to call if there was a problem. Ward staff would routinely call patients 48 hours after discharge to check how the patient was recovering and this was recorded in the patient's records.

Staffing

The service had enough staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix, and gave bank, agency and locum staff a full induction.

The service staffed the ward and theatres appropriately to ensure the right staff were on site to provide appropriate care and treatment. Patient admissions were known in advance and staffing levels calculated to ensure safe staffing levels were planned according to the number of patients using BMI staffing guidance and best practice.

In the operating theatre, there was adequately skilled staff to manage the elective surgery list. The theatre manager followed the Association for Perioperative Practice (AFPP) guidelines. The AFPP recommended minimum theatre staffing levels of two scrub practitioners, one circulating staff member, one registered anaesthetic assistant practitioner and one recovery practitioner for each theatre list. We observed and records showed theatre staffing met these recommendations. Senior theatre staff told us they reviewed their staffing daily to ensure the theatre list could go ahead.

Staffing levels on the ward were calculated using an evidence based electronic patient acuity and dependency monitoring tool. The tool could be manually adjusted to take account of individual patient needs. On the day of our inspection the ward was staffed with the planned number of staff to ensure safe staffing.

Good

Surgery

Any shortages in staffing in the surgery service and across the hospital were discussed at the daily comms cell meeting, which was attended by a representative from all hospital departments. Plans would be put in place to ensure services were staffed safely, for example approving the need for additional staff or cancelling a surgical list if needed.

Senior staff in the service told us there were ongoing difficulties with recruitment and this was recorded on their risk register. At the time of our inspection there were three vacancies in the theatre team and two staff awaiting a start date. The ward had two registered nursing vacancies and four nurses awaiting start dates. This meant the service was reliant on bank and agency staffing for safe staffing levels. However, where vacancies occurred, the service filled the role with regularly used bank or agency staff. This meant they were fully embedded and accustomed to the working practices of the hospital and the teams they worked in.

Medical staffing

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

Each patient was admitted to the hospital under the care of a named consultant with the relevant experience in that area of medicine. Consultants led and delivered the surgical service at the hospital under practising privileges. A practising privilege is, “Permission to act as a medical practitioner in that hospital” (Health and Social Care Act, 2008). The hospital had granted 135 consultants/health professionals practising privileges, including but not limited to; specialist surgeons such as orthopaedic, ear nose and throat and urology, and anaesthetists.

There was a corporate Practising Privileges Policy for Consultant Medical and Dental Practitioners. The policy set out the requirements for each consultant concerning their indemnity, appraisal, General Medical Council registration, Disclosure and a Barring Service (DBS) check, DBS assists employers make safer recruitment decisions and prevents unsuitable or unqualified people from working with vulnerable groups, and yearly mandatory and appraisal proof of compliance.

All consultant surgeons, paediatricians and anaesthetists had to complete an application for admitting rights. This information was used by the hospital management team to determine whether the person had the required skills and experience to carry out treatments at the hospital. Consultants had to demonstrate they were competent to perform the procedures included as part of their practising privileges and they were working within their normal scope of practice. Medical staff who could not demonstrate they had the relevant skills were not granted practising privileges.

There were robust processes in place for reviewing practising privileges at the hospital. The hospital’s executive director reviewed these every two years, however, certain information such as mandatory training and appraisal information were reviewed yearly.

The hospital maintained a medical advisory committee (MAC) for governance of doctors working in the service to ensure they continued to meet the standards to practice at the hospital and made sure any new consultant was only granted practising privileges if deemed competent and safe to practice.

Clinical staff in the surgery service told us they had a good working relationship with their consultants, they were comfortable contacting them when the need arose and found them to be helpful. During our inspection we saw interactions between the nursing teams and the consultants and found them to be friendly, professional and with mutual respect.

Nursing and theatre staff told us they could contact any consultant, out of hours or when not on-site, if they needed advice about the best care and treatment for a patient and they would attend the service if required. The consultants undertook a daily review of the patients under their care and plan of care was developed and communicated to the clinical staff and recorded in the patients' notes.

Day to day medical cover was supplied by the resident medical officer (RMO) who provided a 24 hours a day, seven days a week service, on a rotational basis. RMOs were employed through a formal contract with an agency. They worked a one week on one week off rota. This ensured that their duty weeks were balanced with consolidated periods of rest.

The RMO was the doctor responsible for the care of the patients in the absence of the consultant. They provided support to the clinical team in the event of an emergency or with patients requiring additional medical support. The RMO was trained in advanced life support and held a bleep for immediate response, for example, in the case of cardiac arrest. Nursing staff told us the RMOs were approachable and responsive when required.

Records

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

Patients admitted to the hospital for a procedure had a care record. This was a single and complete record in a booklet form, containing all information from when a patient had been booked in for a procedure until follow up care after discharge had finished. These records were used for every patient and were multidisciplinary, meaning each clinical team wrote in the same set of records, including the surgical team.

Staff used specific care pathway paperwork for each patient which ensured they kept the relevant records for that procedure. For example, patients admitted for hip surgery had their clinical entries recorded in the 'Primary hip replacement care pathway' documentation.

We reviewed four sets of patient records and found these to include the relevant assessments of care needs, risk assessments and were patient centred and personalised. Records seen were accurate, comprehensive and provided a clear picture of the care and treatment each patient received from their initial contact through to discharge.

We saw evidence in the patient records of ward to theatre handover and theatre checklists completed. This ensured continuation of patient care between the teams.

Where appropriate patient care records contained stickers identifying equipment and implants used during surgery. This meant that they could clearly be tracked and traced.

All patient care records were in paper format and kept on the ward for three to five days post discharge. This was in case a patient contacted the ward with a question or concern regarding their surgery after returning home. Records were easily available to staff providing care, stored securely and locked away when not in use. This meant there was restricted access to prevent unauthorised access to confidential patients' records.

Theatre staff maintained a log of implants on their prosthetics register to enable traceability if an incident occurred. Theatre personnel retained a sticker from each implant in the register as well as in the patient notes.

Discharge letters were sent electronically to the patients' GPs immediately after discharge, with details of the treatment, including follow up care and medications provided. This ensured continuation of patient care.

Once patients had been discharged and no further follow up care was required, records would be retained and stored securely within the medical records department. This department had responsibility for filing, storing and maintaining an adequate medical record for patients treated. Staff within this department ensured medical records were readily accessible for each episode of patient care and tracked round the hospital.

During our inspection we visited the medical records department. The area was small and had capacity issues for the amount of records stored there. The team were in the process of boxing up the records of patients no longer receiving treatment at the hospital so they could be stored off site to free up space. However, this was difficult to do during working hours as there was insufficient space to sort through records and complete the daily tasks of the department. During our inspection we found two boxes of medical records blocking the emergency exit. We raised this with the hospital's executive director at the time of the inspection and they were moved. Post inspection, the executive director sent us the action plan which had been developed to solve their capacity issues. This included the appointment of two new members of staff to work outside the department's normal working hours to sort through records and speed up the archiving process.

Medicines

The service used systems and processes to safely prescribe, administer, record and store medicines.

Staff followed the hospital's policies and procedures when prescribing, administering, recording and storing medicines. The hospital had two on-site pharmacists that were responsible for the supply and top up of medicines used in the theatre area and inpatient wards. Nursing staff told us pharmacy staff provided a good service and were available and accessible when needed.

Staff followed their standard operating procedure for access to the pharmacy out of hours and at weekends. Any medicines removed were recorded in the pharmacy register and signed out. The on call pharmacist was contacted for any controlled drug (CD) if this was required out of hours. The pharmacy technician undertook a stock check of medicines which ensured the stock level was adequately maintained. There were arrangements in place for supply of medicines out of hours under a service level agreement.

During our inspection we found medicines were stored appropriately in locked cupboards on the wards and in the theatre area. We checked a selection of medicines in the surgery service and found all were in date and kept in line with manufacturers advice. Stock matched the records. Fridge temperatures were recorded daily, and staff sought advice from the pharmacy team when the temperatures were found to be outside recommended ranges.

The service was registered with the Home Office and held a controlled drug (CD) licence as required and in line with the Misuse of Drug Act 1971. The service had a CD accountable officer. We reviewed the CD register and a sample of CDs which showed all CDs were stored securely and any CD administered had two signatures recorded as required. Stock matched the register. Staff carried out daily checks of their CD stock and records were clearly maintained. Staff were clear and knowledgeable about the managements of CDs. We observed staff dispensing and administering a CD for one patient. They ensured the CD register was signed only after this had been administered which was good practice.

Since our last inspection in 2019 the hospital had reviewed all the patient group directions (PGD) and the hospital's processes. A PGD provides a legal framework that allows some registered health professionals to supply and/ or

administer a specified medicine(s) to a pre-defined group of patients, without them having to see a doctor. A PGD is used in situations that offer an advantage to patient care, without compromising patient safety. The hospital's procedure was to conduct an audit six months after implementation of a PGD to ensure the practice met what was written within the PGD. We reviewed the hospital's PGDs and found them to be authorised and in date for use.

Medicines prescribed on the medicine chart were dated and signed by the prescriber. Prescriptions detailed the dose and the time the medicine needed to be administered. Nurses signed to demonstrate they had administered the medicine to the patient.

Staff reviewed patients' medicines regularly and provided specific advice to patients about their medicines. The resident medical officer (RMO) sought advice from the consultant surgeon or anaesthetist prior to changing any patient's medicine as the consultant had overall responsibility for the patients' care.

The pharmacy team completed unannounced medicine audits. The team shared audit results at the monthly medicines management meetings with the heads of departments for them to decide on action plans if any were needed. Medicines incidents were reviewed, investigated and learning from these were shared with staff. Staff gave an example of the change in the prescription of a certain pain tablet to reduce risk of error.

Incidents

The service managed patient safety incidents well. Staff recognised and reported incidents and near misses. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support. Managers ensured that actions from patient safety alerts were implemented and monitored.

All incidents were reported in line with the BMI/Circle Health Group incident management policy. The policy included definitions of incidents and their level of harm and how incidents should be reported, investigated and actions taken.

The hospital used an electronic reporting system for reporting incidents. All grades of staff could access the incident reporting system. Staff said they knew what constituted as an incident and were encouraged to report incidents or near misses so that effective measures could be taken to minimise ongoing risk to people or the organisation. There was a no-blame culture and staff said they felt confident in reporting incidents.

Incidents were discussed at the monthly clinical governance meetings. We reviewed three sets of minutes and saw evidence incidents and adverse events were discussed, investigations into incidents reviewed, the actions taken to reduce risk and reduce the likelihood of reoccurrence put in place and to see if there were any trends emerging. Incident reporting was seen as a tool to drive improvement. Incident information from the clinical governance meeting was fed back by the heads of department to their teams. This happened in a number of ways, via team meetings, emails and during handovers.

Staff we spoke with said they received feedback from reported incidents, both those relating to their immediate area of work and those that had been reported elsewhere in the hospital. This promoted shared learning from incidents throughout the hospital. Staff could give us examples of when change was needed as a result of an incident. For example, changing the amount of equipment stored in theatres. Staff confirmed managers supported them when they were involved in incidents. Staff were encouraged to reflect on incidents they had been involved in.

Good

Surgery

Minutes from the medical advisory committee (MAC) meetings showed incidents were discussed at these meetings. This showed that consultants had awareness of incidents being reported at the hospital.

There was an effective process for investigating any incident that may cause harm to patients. A senior manager undertook a root cause analysis (RCA) following any incident and an action plan was developed to minimise the risk of re-occurrence. Investigation outcomes were shared with staff as part of lessons learnt. The hospital had one incident under investigation at the time of our inspection.

There had been no never events from September 2020 to August 2021. A never event is a serious incident which is wholly preventable, where guidance or safety recommendations that provide strong systemic protective barriers are available at a national level, and should have been implemented by all healthcare providers.

Staff we spoke with in the surgical service could explain duty of candour and understood their responsibility to be open and honest with patients and their relatives when something had gone wrong. The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain notifiable safety incidents and provide reasonable support to that person. There was a BMI/Circle Health Group being open and duty of candour. It was the responsibility of the senior management team to ensure the principles of the duty of candour had been completed.

Patient safety alerts were a set agenda at the monthly governance meeting. Heads of departments ensured actions from patient safety alerts were acted upon where needed and information shared with staff.

Safety Thermometer

The service used monitoring results well to improve safety. Staff collected safety information and shared it with staff, patients and visitors.

The hospital used the safety thermometer to monitor patient safety. The safety thermometer is a measurement tool for improvement in health care, which focuses on the most common harms to patients, pressure ulcers, catheter or urinary tract infections, venous thromboembolism episodes and patient falls.

The hospital collected this data from patients and used it to monitor performance and put in measures to improve patient care. The hospital wards displayed the safety information for patients and visitors to view.

The service had a good track record on providing harm free care. In the reporting period September 2020 to August 2021, the service had reported no hospital acquired infection. In addition, there had been no incidents of falls with harm and hospital acquired pressure ulcers reported.

Are Surgery effective?

Good

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

Evidence-based care and treatment

Good

Surgery

The service provided care and treatment based on national guidance and evidence-based practice. Managers checked to make sure staff followed guidance. Staff protected the rights of patients subject to the Mental Health Act 1983.

The service had up-to-date policies and procedures to ensure care and treatment was delivered in line with national guidance and best practice. Policies we reviewed referenced national guidance including the National Institute for Health and Care Excellence (NICE), The Royal College of Surgeons' Standards for consultant led surgical care and the recommendations from the Association of Anaesthetists of Great Britain and Ireland (AAGBI).

Patients were assessed using the American Society of Anaesthesiologist (ASA) grading system for pre-operative health of surgical patients. This is a system to record the overall health status of a patient prior to surgery. The system enabled the staff and anaesthetists to plan specific post-operative care for patients as required.

Staff followed guidance for surgical site infection prevention and treatment in line with NICE guideline (NG125) which included antiseptic skin preparations and antibiotics before skin closures.

In the operating theatres, staff monitored patients' temperatures in line with NICE Clinical Guideline CG65- Hypothermia: prevention and management in adults having surgery.

Updates to policies, due to change in guidance and tracking of policy review dates, were carried out at a corporate level and cascaded to the hospital for implementation. Changes to policies was a standing agenda item at the hospital's monthly clinical governance meeting. Changes in working practice was the responsibility of the head of department to execute and staff were required to sign to say they had read the update to the policy. Changes to policies and procedures was also a standing agenda on the medical advisory committee (MAC) meeting. Staff could access policy documents on the hospital's database. These measures ensured staff working in the service were following up-to-date practices and providing safe care to patients.

Staff protected the rights of patients subject to the Mental Health Act and followed the Code of Practice. Awareness of the requirements of the acts was included in mandatory training.

The hospital completed a range of audits throughout the year to ensure healthcare was being provided in line with their policies, national guidance and standards. This included the BMI/Circle Health Group audit programme, a rolling programme of set audits. Audit results were collated and used to benchmark against the other hospitals of a similar size within the BMI/Circle Health Group. The hospital had started to promote a culture of patient safety and wanted staff to see how the audit programme contributed to this.

Nutrition and hydration

Staff gave patients enough food and drink to meet their needs and improve their health. They used special feeding and hydration techniques when necessary. Staff followed national guidelines to make sure patients fasting before surgery were not without food for long periods. The service made adjustments for patients' religious, cultural and other needs.

Nursing staff asked patients about any food intolerance or allergies as part of their pre-assessment. This also included specific dietary or cultural requirements, such as vegetarian or halal. This information was passed to the catering team so suitable food could be provided for the patient during their stay.

Good

Surgery

Patients were advised about pre-surgery fasting times (that is omitting food and fluids except water before operation) during the pre-assessment process. The service followed the Royal College of Anaesthetists guidance about pre-operative fasting to ensure patients fasted for the safest minimal time possible. Written information about pre-surgery fasting times was also sent to the patient which reminded patients that fasting included smoking, chewing gum and sweets. The service offered patients staggered admissions to ensure they did not fast for longer periods than necessary.

Staff used the Malnutrition Universal Screening Tool (MUST) to assess, monitor and record patients' nutrition and hydration needs throughout their hospital journey. Fluid balance charts were used to monitor patients' fluid intake. We reviewed patient records and saw that these were consistently completed. Nausea and vomiting was formally assessed and patients were prescribed anti-emetic medicines (medicines to prevent / relieve sickness) if required.

We observed patients had access to hot and cold drinks and meals were presented well. Staff told us patients were offered support with food and fluids, although most patients did not require assistance.

Feedback from patients relating to meals was positive. The Patient-Led Assessment of the Care Environment (PLACE) audit results for 2019 showed a score of 94.4% for the ward food score. Due to the COVID-19 pandemic PLACE assessments had been cancelled for 2020.

Pain relief

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

Patients had access to a variety of pain relief as appropriate for their surgery. Staff completed regular assessments to ensure that patients' pain was controlled and administered pain control as prescribed. Staff assessed patient's pain using a recognised tool and gave pain relief in line with individual needs and best practice.

We reviewed patient care records and observed the ward round and saw pain was assessed, documented and managed throughout the patients' care. Staff took appropriate actions when patients' pain was not well controlled. For example, we observed the resident medical officer (RMO) and pharmacist discussing a change to the patient's pain prescription. Patients were also prescribed anti sickness medicines to manage the side effects of some pain-relieving medicines if required.

Nursing staff discussed post-operative pain relief with patients as part of their pre-assessment and gave them written information as well to support these discussions. Pain management was part of the patient discharge process. Pharmacy and nursing staff would speak with patients about their pain medicines and gave clear instructions on its use at home.

Patients we spoke with said their pain was managed well and pain relief was available to them when they needed it.

Patient outcomes

Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for patients.

The hospital had systems and processes in place to monitor, audit and benchmark the quality of services, and the outcomes for patients receiving care and treatment.

Good

Surgery

The hospital participated in national audit programmes such as the National Joint Registry (NRJ), Patient Reported Outcome Measures (PROMs) and the Patient Led Assessment of the Care Environment (PLACE). Data from these audits provided an indication of the outcome or quality of care delivered to patients by the service.

National Joint Registry (NJR) recorded outcomes at this hospital for patients that underwent hip and total knee replacement procedures. Hospitals were required to submit 100% of their eligible information to the National Joint Registry. In the reporting period September 2020 to August 2021, the service had achieved 100% for their NJR submission. The NJR also reported on the quality of the information submitted by this hospital. This showed the hospital was compliant with their submission of the data to the NJR.

The hospital submitted data to the Private Healthcare Information Network (PHIN). PHIN is an independent, not-for-profit organisation. It publishes key performance measures on their website to help patients make informed decisions where to have their care and treatment, by providing patients with straightforward and easy-to-understand information about the quality and safety of care in the private healthcare sector.

We reviewed data submitted to these audit programmes and saw outcomes for patients was overall positive and met national standards.

The staff also carried out regular audit of the National Safety Standards for Invasive Procedures (NatSSIPs). This is a national safety standard aiming to reduce the number of safety incidents for invasive procedures in which surgical Never Events could occur. The latest audit for September 2020 to August 2021 showed the service had achieved 100% compliance in their audit.

The service participated in the hospital's audit programme which demonstrated compliance and identified areas for improvements to improve patient care, treatment and outcomes. Results from audits were monitored and discussed at the hospital's clinical governance and medical advisory committees on a monthly basis as well as at a regional and corporate level. If actions were required, this would be fed back to the departments.

Competent staff

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

All staff with a professional qualification were subject to pre-employment checks to ensure their professional qualification was active and with no restrictions in place.

All staff working at the hospital had an induction programme relevant to their role and the department they worked in. Induction included a corporate induction and a local orientation. New staff were required to complete e-learning and face-to-face training. Clinical staff working in the surgery service worked in a supernumerary capacity alongside an experienced staff member until they were competent to work alone.

Staff completed competency training depending on their role and the area they worked in. This ensured staff had the appropriate skills and knowledge to manage patients safely and effectively. Each member of staff, including bank staff, had their own training folder where evidence of training taken and completed competency training was kept.

Good

Surgery

The hospital had recently recruited a clinical educator to support the learning and development needs of staff. Staff working in the surgery service talked highly of the support provided by the clinical educator since the role had been introduced.

The service supported staff to undertake training in order to maintain their professional registration and revalidation. Revalidation is a process to ensure staff had undertaken training and development to maintain their skills to remain on the professional registers.

The theatre department had one afternoon per month when there were no surgical procedures performed which the team used for training and development.

Managers supported staff to progress through regular development meetings and yearly constructive appraisals of their work. Staff had the opportunity to discuss training needs and were supported to develop their skills and knowledge. We were told one member of the surgical team was undertaking an operating department practitioner apprenticeship. Staff told us they found the appraisal process useful and they were encouraged to identify any learning needs they had, and any training they wanted to undertake. Poor or variable performance was identified through the appraisal process, complaints, incidents and feedback. Staff were supported by their managers to improve their practice where indicated.

Multidisciplinary working

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

The hospital had a daily communications cell meeting, which took place every morning and was attended by the senior management team and a representative from each department in the hospital. All staff contributed to provide an overview of the hospital's activity. Any relevant information was taken back to each department and cascaded to the team. Management and staff described the meeting as an opportunity for different teams to come together and to discuss the hospital as a whole.

During our inspection we observed effective multidisciplinary working between different teams involved in patient care and treatment in the surgery service. There was clear communication between staff and we observed safe and effective handovers of care, between the ward, theatre and recovery staff. We observed physiotherapists and the pharmacy team gave support to patients and clinical staff pre and post operatively.

Seven-day services

Key services were available seven days a week to support timely patient care.

The hospital did not provide emergency care. All surgical patients followed the elective pathway and admissions were booked in advance

The operating theatres operated six days a week. Theatre staff were on-call should there be any unplanned returns to theatre. For this, they provided an emergency service twenty-four hours a day and seven days a week and had an established on-call rota. Nursing cover was available on the wards when the hospital was open both during the day and overnight for patients who required an overnight stay.

Good

Surgery

Consultants undertook a daily review of their patients and either visited or telephoned the service for an update at weekends. Consultants were available out of hours, during weekends and on call 24 hours a day for patients in their care. The resident medical officer (RMO) was based on-site at the hospital and provided a 24 hour a day, seven days a week service. The RMO provided clinical support to consultants, staff and patients.

Allied health professionals including physiotherapy and radiology staff provided care and support out-of-hours. The pharmacy service was available during the day six days a week. Outside of these hours the RMO and nursing staff dispensed medications which had already been prescribed, with access to an on-call pharmacist as needed.

Health promotion

Staff gave patients practical support and advice to lead healthier lives.

Patients attended pre-operative assessment appointments where their suitability for surgery was checked. This included the completion of a health questionnaire, and an opportunity for the nurse to provide advice or refer patients on to other appropriate services if they required these services.

Patients having joint surgery, such as for hip or knee replacement, would see a physiotherapist on a one to one basis with tailored information specific for the patient. Patients were given pre-operative and post-operative exercises and assessed for need of occupational therapy or support from social services.

COVID-19 was still a risk when our inspection took place and therefore COVID-19 measures were in place at the hospital. This included, as a preventative measure, limiting the number of objects in communal areas, such as patient information leaflets. However, leaflets were available via the clinical staff, consultants and allied health professionals.

The hospital used laminated health promoting posters relating to COVID-19 in public areas. These reminded patients of the importance of social distancing and washing hands to reduce the risk of transmission of the virus.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

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

There was a BMI/Circle Health Group corporate consent for examination and treatment policy. This included, the training required to take consent, whose responsibility it was to obtain consent and when to use implied, verbal and written consent.

Patients were given information about their procedure both verbally and in writing by the consultants and nursing staff to make an informed decision about their procedure. Patients said doctors fully explained their treatment and additional information could be provided if required.

Consent forms we reviewed within the patients' records were fully completed and detailed the procedure planned and the risks and benefits of the procedure. The hospital consent forms complied with Department of Health guidance. The service had a two-stage consent process. Patients' records showed consent was reviewed on the day of their surgery as part of their pre- operative checklist.

Good

Surgery

Staff followed their internal process for seeking consent from patients when providing care and treatment in line with legislation and guidance and this was clearly recorded. We observed staff asking patients' verbal consent prior to examinations, observations and delivery of care.

Staff told us the majority of admitted patients had the capacity to make their own decisions. Patients who lacked capacity were identified during the pre-operative assessment process to determine whether they could be admitted for treatment at the hospital. Patients were risk assessed on an individual basis and adjustments put in place to deliver safe care to the patient if needed. Staff we spoke with had not cared for patients who lacked capacity in the service but told us they would follow guidance to ensure decisions were made in patients' best interest and took into consideration patients' wishes.

Staff received and kept up to date with training in the Mental Capacity Act and Deprivation of Liberty Safeguards. Staff could describe and knew how to access policies and get accurate advice on the Mental Capacity Act and Deprivation of Liberty Safeguards.

Are Surgery caring?

Good

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

Compassionate care

Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.

Staff throughout the surgery service put patients at the centre of what they did. During our inspection we saw pleasant interactions between staff and patients. We saw staff treat patients with warmth and care, they were courteous, professional and demonstrated compassion to all patients.

We saw theatre staff offered caring and compassionate care, safeguarding the patients' dignity including when they were not conscious. For example, we saw theatre staff ensure that patients were not left exposed unnecessarily.

Staff were discreet and responsive when caring for patients. Staff understood and respected the individual needs of each patient and showed understanding and a non-judgmental attitude when caring for or discussing patients. Peoples' privacy and dignity was always considered. Staff always knocked before entering a room. The hospital used a light system on the doors to inpatient bedrooms which was a discreet way of letting staff know when not to enter the room or there was an infection risk.

Patients we spoke with during our inspection commented positively about the care and treatment they had received.

The hospital monitored patient feedback from their patient satisfaction survey and the NHS Friends and Family Test (FFT). The FFT is a tool that gives people that use the service the opportunity to highlight both good and poor patient experience. From Aug 2020 to Jul 2021 overall hospital had received an average satisfied rate of 98.7%. The 2019 Patient

Good

Surgery

Led Assessment of the Clinical Environment (PLACE) privacy, dignity and well-being score was 83.7% which was lower than national score of 86.1%. Due to the COVID-19 pandemic PLACE assessments had been cancelled for 2020. The patient satisfaction survey showed from Aug 2020 to July 2021 patients' assessment of overall quality of care was very good or excellent for an average of 99.5% of patients who completed the survey.

Emotional support

Staff provided emotional support to patients, families and carers to minimise their distress. They understood patients' personal, cultural and religious needs.

When talking to staff, it was clear how passionate they were about caring for their patients and how they put patients' needs at the forefront of everything they did.

Staff working in the surgery service showed sensitivity and support to patients and those close to them. Staff understood the emotional impact of them having surgery. Staff told us they sometimes saw patients who appeared anxious due to the nature of their visits. They understood the need to give patients appropriate and timely support and information to cope emotionally with their care, treatment or condition. Theatre staff told us if needed they would give additional reassurance to a patient if they were anxious about their surgery. We observed this during the inspection.

During our inspection we saw staff giving emotional support to patients. They understood that each patient was an individual and took time to get to know their patients. This meant they could give the right emotional support for that patient when needed.

Understanding and involvement of patients and those close to them

Staff supported patients, families and carers to understand their condition and make decisions about their care and treatment.

Patients told us they felt involved in the planning of their care. They told us they had received full information about their diagnosis and treatment and the care and support which would be offered following the procedure. Staff provided written information to support the verbal information given.

Patients told us that staff clearly explained the risks and benefits of treatment to them before admission. Patients we spoke with told us they had opportunity to ask questions about their treatment. This meant that patients were involved in making shared decisions about their care and treatment.

Staff told us that costs and payment methods were discussed with patients before admission. Patients we spoke with confirmed this and said written information was provided to them.

Are Surgery responsive?

Good

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

Good

Surgery

Service delivery to meet the needs of local people

The service planned and provided care in a way that met the needs of local people and the communities served. It also worked with others in the wider system and local organisations to plan care.

Managers planned and organised services to meet the needs of those who chose to use the service. Admissions to the surgical ward were all elective and planned in advance. The hospital had an admission criteria which meant the hospital only admitted patients whom the hospital had facilities to care for.

There were no facilities for emergency admissions; commissioners and the local NHS trust were aware of this. The hospital had service level agreements in place with the local NHS trust for transferring patients for medical reasons.

Most patients who attended the hospital were privately funded or insured patients. In addition, the hospital also participated in the NHS e-Referral Service for certain procedures. Through this service, NHS patients who required an outpatient appointment or surgical procedure were able to choose both the hospital they attended and the time and date of their treatment. Between September 2020 and August 2021 71% of surgical patients were non-NHS funded and 29% were NHS funded.

The hospital had supported the local health community during the COVID-19 pandemic. They had worked closely with the local clinical commissioning group (CCG) and NHS trust to provide a range of services and specialities. This included identifying how the hospital could be used to provide COVID-19 safe environments to services that had been paused at the local trust. Feedback from the CCG and the trust was positive with them saying the hospital had been flexible and mobilised services quickly for patients. The working arrangements during the pandemic had led to stronger relationships and more collaboration between the hospital and local health community.

Meeting people's individual needs

The service was inclusive and took account of patients' individual needs and preferences. Staff made reasonable adjustments to help patients access services. They coordinated care with other services and providers.

Surgical patients' individual needs were discussed during booking and pre-admission assessment. This information was used by staff to provide safe care and treatment and mitigate any possible risk to the patient. If during pre-admission assessment staff identified the service could not meet the patient's needs, staff would not treat the patient at the hospital and refer the patient to an alternative health care provider who could support the patient. The hospital did not have the facilities to support the care of patients with high complex needs. Therefore, this patient group was not admitted to the hospital. However, patients who had a learning disability or dementia could be admitted following the appropriate risk assessments had been carried out.

Staff we spoke with told us they had completed dementia awareness training but rarely treated patients living with dementia. There was 98% of staff at the hospital had completed mandatory dementia training.

Patients received information letters and leaflets explaining about their surgical procedures and what to expect throughout their hospital visits. These leaflets were designed to address patients' questions about their forthcoming procedures. Information included details on preparing for hospital, what to bring with you and what to expect following the treatment.

Good

Surgery

Nurses gave patients detailed explanations about their admission and treatment in addition to written information. We observed clear explanations being given during pre-assessment appointments and reassurance being given to patients who were anxious about their care treatment.

The hospital had put in measures to meet the Accessible Information Standard (AIS). A standard which aims to make sure people who have a disability, impairment or sensory loss can access information they can understand and receive the communication support they need from health and care services.

Staff working in the surgery service used a discrete colour coding system to identify patients who needed additional support. Staff told us this was a good visual reminder for them that they might need to use a different communication style when caring for the patient.

Staff told us hospital leaflets were available in other languages for patients whose first language was not English or could be provided in large print and braille. The service had access to an interpreting service for patients whose first language was not English. There were hearing loops, a special type of sound system used by people with hearing aids and access to sign language tools to support patients with hearing difficulty. This meant staff were assured patients fully understood the information that was provided to them.

Access and flow

People could access the service when they needed it and received the right care promptly. Waiting times from referral to treatment and arrangements to admit, treat and discharge patients were in line with national standards.

The hospital followed corporate and local policies and procedures for the management of the patient's journey, from the time of booking the appointment until discharge and after care. Staff we spoke with were aware of these policies and procedures.

The hospital offered a flexible service that included variable appointment times and choices regarding when patients would like their treatment, subject to consultant and nurse availability.

The hospital had established a clear booking process for appointments and hospital admissions. Patients we spoke with told us the hospital had a good and efficient booking process.

The surgery service could conduct their patient pre-assessment either over the telephone or face-to-face dependent on the type of surgery they were having.

The hospital offered either day-case or inpatient surgical procedures. Day-case surgery did not require an overnight hospital stay. Inpatient surgery required the patient to remain overnight or longer after the surgery was completed, for care or observation. Day-case patients were told to bring an overnight bag with them just in case they were required to stay overnight. For example, if the patient was nauseous after surgery or had no support at home. We were given examples by staff when this had happened.

Patients were added by the booking team to the hospital's patient information management system. This meant patient details and appointments could be tracked by staff working throughout the hospital.

Good

Surgery

As per NHS guidelines, NHS patients attending the hospital had their referral to treatment time (RTT) recorded. Information provided by the hospital post inspection showed there was a RTT of 65% for NHS surgical patients. This meant the hospital did not meet the target of 92% of NHS admitted patients beginning treatment within 18 weeks of referral. Senior staff told us these factors which were contributing to the breaches in RTT. These included some patients were nervous about coming into the hospital for surgery whilst COVID-19 was still a risk factor and some patients' and their families could not commit to the self-isolation rules before an operation.

The hospital cancelled 31 procedures from October 2020 to September 2021 for non-clinical reasons which was less than 0.5% of the total number of procedures performed at the hospital. The service monitored cancellations to look for trends, themes and contributing factors. During this time period the highest factor in non-clinical cancellations was patients' choice not to have the operation. Miscommunication and staff availability due to the impact of COVID-19 were the second highest factors.

The hospital had been closed for elective surgery during the height of the COVID-19 pandemic and this meant some surgeries had been delayed. During this time, the hospital reviewed all patients waiting for treatment to make sure higher risk patients were signposted to other healthcare providers or were prioritised for when the hospital re-opened to elective surgery.

The hospital provided an on-call theatre team however, in the event of a patient deteriorating and requiring further intervention there was a service level agreement (SLA) in place with the local NHS trust to transfer patients for more complex care and treatment.

Patient feedback was positive, saying they had access to timely appointments, care and treatment which met their specific needs.

Learning from complaints and concerns

It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff. The service included patients in the investigation of their complaint.

The hospital followed the BMI/Circle Health Group complaints policy which gave clear processes and timeframes for dealing with complaints. The hospital's executive director had overall responsibility for the management of complaints.

All staff we spoke with were aware of the complaints procedure. Clinical staff told us they always tried to resolve any issues or complaints at the time they were raised. If this was not possible, patients could be referred to the nurse in charge in the first instance.

Patients could make complaints in various ways, verbally, by telephone and in writing by letter or email. There was a hospital leaflet explaining the complaint procedure and the BMI Healthcare website had a detailed page explaining the complaint procedure and how to make a complaint.

The hospital received 114 complaints between September 2020 and August 2021 with 24 complaints relating to the surgery service, 20 from the ward and four from theatre. This was a rate of 0.37% of all surgical admissions at the hospital. Complaints content varied from lack of communication to private room conditions. None of these complaints had been referred to the ombudsman or the Independent Healthcare Sector Complaints Adjudication Service (ISCAS).

Good

Surgery

We saw evidence that hospital complaints were discussed and addressed at the clinical governance meetings and in the medical advisory committee meeting. Any complaint themes or trends were analysed and actions put in place to stop them occurring again.

Staff said learning from complaints and concerns would be communicated to them mainly at handovers, team meetings, emails and notice boards. Complaints were also discussed at the daily comms meeting meaning heads of departments heard about complaints from elsewhere in the hospital. This promoted shared learning from incidents throughout the hospital.

Are Surgery well-led?

Good

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

Leadership

Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff. They supported staff to develop their skills and take on more senior roles.

The hospital had a clear management structure in place with defined lines of responsibility and accountability.

The hospital was led by an executive director (ED), who had overall responsibility for the hospital. They were supported by the director of clinical services and the director of operations. The heads of departments, which included the theatre and the ward heads of department, the infection prevention control (IPC) lead, paediatric lead nurse and the quality and risk manager were all managed by the director of clinical services. The non-clinical service leads, such as engineering and the patient administration manager, were managed by the director of operations.

The senior management team supported staff to develop their skills. The heads of departments, since the last CQC inspection in 2019, had been provided with development opportunities to grow their leadership and communication skills. This had equipped them with the necessary tools to run and support their teams, and to identify any gaps in their knowledge which needed additional support or training.

When we spoke to the heads of departments in the surgery service, they had a good understanding of the challenges to quality and sustainability in each of their areas and were able to tell us the actions needed to address them. They told us they felt supported by the senior management team and the other heads of departments. They were able to discuss any issues with them, were listened to and their views respected.

Staff working in the theatre and the inpatient wards spoke highly about their managers and felt supported and valued. Managers were highly visible and approachable and we saw evidence of this on the inspection.

Vision and Strategy

Good

Surgery

The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. Leaders and staff understood and knew how to apply them and monitor progress.

The hospital was committed to the Circle Health Group's purpose which was *to provide the high quality, safe and compassionate care our patients need and expect*. To achieve this a Circle Health Group philosophy had been launched in June 2021. There were four key areas that were to be focused on over the next two years, those being people, quality, infrastructure and technology. There were strategic plans how the key areas were to be achieved and how success was to be measured.

Underpinning the key areas were the underlying values that guided the group and its employees. Those being:-

- We value people who are selfless and compassionate
- We value people who are collaborative and committed
- We value people who are agile and brave
- We value people who are tenacious and creative

Staff we spoke with during our inspection believed in the philosophy and were working to embed it in their everyday working practices. The philosophy was displayed throughout the hospital and the surgery areas.

The hospital had plans in place to support the corporate vision and had their own mission statement to help achieve it of *prioritising our patients and staff ensuring a safe environment, whilst preserving an effective and responsive service being well led by a professional, caring and trustworthy culture*. The hospital's business plan was aligned to the corporate and hospital's strategic priorities. We were given examples during our inspection on how the hospital and the surgery service was working towards this. For example, investing in their staff, facilities and focusing on patient safety.

Culture

Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service promoted equality and diversity in daily work, and provided opportunities for career development. The service had an open culture where patients, their families and staff could raise concerns without fear.

Staff were welcoming, helpful and professional in their communication with each other, patients and visitors. Staff described good teamwork and respect amongst their colleagues, and we could see this in practice when we inspected the theatre and ward areas.

Staff we spoke with felt supported, respected and valued in their working environments. Staff told us they felt supported as individuals in their roles but also as part of the wider hospital too. Staff spoke positively and passionately about the care and the service they provided. Quality and patient experience were seen as a priority and responsibility for everyone.

We were told the senior management team were approachable and visible and had an open door policy to discuss concerns. The hospital had a freedom to speak up guardian to ensure staff could raise concerns in a safe and supportive way.

Good

Surgery

The BMI/Circle Health Group collected and published data relating to the Workforce Race Equality Standard (WRES). This was a programme that supported continuous improvement through robust action planning to tackle the root causes of discrimination. Independent healthcare providers have been required to publish their WRES data since 2017.

WRES data from 2020 showed no trends identified and no responses which raised concerns in the BMI/Circle Health Group. However, a lower percentage of black and ethnic minority employees felt the employer offered equal opportunities for career progression or promotion when compared to white employees, 69% to 76% respectively. BMI/Circle Health Group and the hospital used the WRES data to gain a greater understanding, put action plans in place and to drive equality and diversity in the workplace.

The hospital had a multi-cultural and multi-ethnic workforce that was valued, and they felt respected. The surgery service staff promoted equality and diversity in their daily work and we were told the hospital provided equal opportunities for career development. This was a real strength of the hospital and surgery service.

Governance

Leaders operated effective governance processes, throughout the service and with partner organisations. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.

BMI/Circle Health Group had launched a new governance assurance framework in May 2021. The framework set out how the company governed transparently from ward to board and how this drove the continuous improvement of their clinical, corporate, staff and financial performance. The framework included terms of reference and the attendees required for each meeting that fed into the framework. Each meeting had a purpose and there were clear lines of accountability. All levels of governance and management functioned effectively and interacted with each other appropriately.

At a hospital level, meetings were held where specific operational issues were discussed, such as the health and safety, the infection prevention and control group and medicine management meetings. We reviewed minutes from these meetings and saw, they were effective and included the set of decisions, outcomes and next steps or actions taken.

Information from these operational meetings, plus additional information such as patient outcomes and audit results, fed into the monthly hospital clinical governance committee meeting. We reviewed these meeting minutes and could see they were planned, structured and followed a set agenda. They were thorough in their content with evidence of quality issues of safety, risk, clinical effectiveness and patient experience being discussed and actions taken if needed.

BMI The Chiltern Hospital's information and data would feed up to the BMI/Circle Health Group regional governance meetings and then up to the board. This gave the board oversight of the quality and safety of care and treatment from the hospital and other hospitals in the group, which they used to make corporate strategic decisions.

Heads of departments (HODs) attended the hospital's monthly clinical governance meetings and discussed how their departments were performing. They could see the key quality issues of safety, risk, clinical effectiveness and patient experience for their departments and hospital wide. It was up to the HODs to disseminate this information to their teams and to act on any issues arising. We were told by heads of departments information would be shared with their teams in many ways including, at handovers, on notice boards and in departmental meetings and this was backed up by conversations had during our inspection with staff working in the surgery service.

Good

Surgery

Post inspection we reviewed minutes from the theatre and ward departmental meetings. Meetings had a set agenda which included standard agenda items such as, the risk register, infection control and audits, and other issues needing to be discussed, such as staffing levels. This showed that information was shared, discussed and actions acted upon within the department teams.

Governance was discussed at the medical advisory committee (MAC) and information from the MAC meetings fed into the clinical governance committee. The MAC's role was to ensure clinical services, procedures or interventions were provided by competent medical practitioners at the hospital. This involved reviewing consultant contracts, maintaining safe practicing standards and granting practising privileges. The MAC would also discuss new procedures to be undertaken to ensure they were safe, equipment was available and staff had relevant training. The MAC minutes showed discussions including key governance issues, such as incidents, complaints and practising privileges were discussed.

Arrangements were in place to manage and monitor contracts and service level agreements with partners and third-party providers. Contracts were reviewed on an annual basis, which included a review of quality indicators and feedback, where appropriate.

Management of risk, issues and performance

Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events. Staff contributed to decision-making to help avoid financial pressures compromising the quality of care.

There were clear and effective processes for identifying, recording, managing and mitigating risks. The hospital followed the BMI/Circle Health Group risk management policy. This policy detailed the aim of risk management, explained what risk was and how to identify, record, review and mitigate risk.

The hospital operated a hospital risk register which was reviewed at the clinical governance meeting any new risks were added and risks already on the register were monitored and appropriately managed.

The departments had their own risk registers which were managed by the heads of departments and fed into the hospital risk register. We reviewed the risk register from the surgery service and could see risks on the register reflected what staff had told us during the inspection. For example, staffing levels and impact of COVID-19

From talking to staff and reviewing documentation we saw evidence the surgery service and senior hospital managers were able to recognise, rate and monitor risk. This meant the hospital and surgery service could identify issues that could cause harm to patients and staff and threaten the achievement of their services.

There was a systematic corporate programme of clinical and internal audit to monitor quality, operational and financial processes in BMI hospitals. During our inspection we could see from speaking with staff and reviewing documentation that the surgery service was carrying out these audits and, identifying and taking action where required.

Information Management

The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were integrated and secure. Data or notifications were consistently submitted to external organisations as required.

Good

Surgery

The hospital had clear service performance measures, which were reported and monitored by the hospital, BMI/Circle Health Group and the local commissioners. Data collection was detailed and included data on a range of performance measures and quality indicators, such as audit results and patient feedback. We saw evidence that areas of good and poor performance were highlighted and used to challenge and drive forward improvements.

Where relevant, performance was tracked over time to highlight unexpected variations in performance which warranted investigation. This meant staff could identify, at a glance, areas of increased performance or performance trends and areas that required investigation and improvement.

The hospital used information technology (IT) systems to effectively monitor and improve the quality of care. For example, there was a computer system where incidents, near misses and complaints were recorded. The hospital employed specialist staff to manage the IT systems and to collect, monitor and analyse patient safety data. It was their role to make sure data collected was accurate, valid, reliable, timely and relevant.

There were effective arrangements to ensure data and statutory notifications were submitted to external bodies as required, such as local commissioners and the Care Quality Commission (CQC). There was transparency and openness with all stakeholders about performance.

Staff had access to a range of policies, procedures and guidance which was available on the hospital's electronic system. Staff also told us IT systems were used to access the e-learning modules required for mandatory training

Information governance was included as part of mandatory training for staff. Staff understood the need to maintain patient confidentiality and understood their responsibilities under the General Data Protection Regulations. The hospital had appointed a hospital data protection officer and a Caldicott guardian. A Caldicott guardian is a senior person responsible for protecting the confidentiality of people's health and care information and making sure it is used properly.

Engagement

Leaders and staff actively and openly engaged with patients, staff and the public to plan and manage services. They collaborated with partner organisations to help improve services for patients.

The hospital and surgery service actively encouraged patients to give feedback about their experience to help improve services. For example, through patient satisfaction questionnaires, feedback and suggestion cards, and to complete reviews on search engine websites. The hospital reviewed and monitored patient satisfaction through their clinical governance committee and used the information to inform improvement and learning and to celebrate success.

The hospital had a presence on social media which included an informative website for people wanting to find out about the hospital and the services that it offered. The importance of this website was demonstrated during the COVID-19 pandemic keeping the public up to date when some services had needed to close or change due to government restrictions.

The hospital engaged with hospital staff in many ways, through strategic and planning days, meet the senior management days, a monthly newsletter and noticeboards in the hospital. The hospital also produced a staff wellbeing handbook. Staff we spoke with during our inspection in the surgery service said the senior management team engaged well with them and their views were sought. There was a staff forum which gave employees an arena to discuss and seek practical solutions to improving their working experience. Staff were also positive of the communication they received from the wider BMI/Circle Health Group which updated them on the health groups wider activities.

Staff were invited to take part in the annual staff survey. In 2021 the survey was carried out by an external agency on behalf of BMI/Circle Health Group. Results could be looked at as a Group or as an individual hospital and benchmarked against the other hospitals in the group. BMI The Chiltern Hospital had analysed the results and had a series of next steps with action plans and timelines. The hospital had already strengthened communication channels with staff and a review of staff reward and recognition had occurred. Staff we spoke with in the surgery service could tell us of changes that had occurred due to the staff survey results.

The service worked with local health community to meet the needs of the local population. This had increased during the COVID-19 pandemic when they had provided a range of services and specialities to help support the local NHS trust and clinical commissioning group.

The hospital produced a consultant newsletter to keep them up to date with marketing, clinical and hospital updates. The hospital also produced a newsletter for GPs which gave them information on education and training opportunities, updates from the hospital and how to refer patients.

Learning, continuous improvement and innovation

All staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them. Leaders encouraged innovation and participation in research.

The hospital was committed to improve the quality of services offered to patients. There was a focus on continuous learning and improvement. The theatre team offered apprenticeships and training opportunities which helped to develop the skills and offered career progression to individuals in the team. In addition, it meant the service could grow their own talent which helped with staff retention.

The hospital was promoting a culture of patient safety. The Circle operating system (COS) had been launched at the hospital in March 2021. This was an established methodology that empowered all staff to work together and put patient safety at the heart of everything they did. Staff in the surgery service told us of tools that had been introduced to them such as Stop the Line and SWARM. Stop the Line empowered anyone who encountered a situation that might have caused harm to a patient or other damage to immediately make a report to the person in charge requesting that the activity is creased. SWARM was used to problem solve at the time and place of an issue by the people who were affected. Although these new tools were not yet embedded staff told us how Stop the Line and SWARM had been used when an issue had arisen in the operating theatre. They could see how it was an effective way of resolving an issue as it happened, as a team, to create and maintain a strong safety culture.

Since the last inspection in 2019 the hospital had appointed; a clinical chair to provide clinical leadership and to oversee the development of robust systems of clinical governance, medical performance and the application of medical professional standards at the hospital; and a practice educator who had the responsibility to provide support and education to clinical staff to improve their professional practice. Staff we spoke with were positive about both of these appointments and the support and expertise they offered.