BMI The Cavell Hospital

Quality Report

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

Ratings

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

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

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

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

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

Summary of findings

Letter from the Chief Inspector of Hospitals

BMI The Cavell Hospital is operated by BMI Healthcare Limited. The hospital provided inpatient and day care services and had a total of 27 beds. hospital has two theatres, endoscopy, phlebotomy and minor operations room, outpatients and diagnostic imaging department.

The hospital provides surgery, medical care, outpatients and diagnostic imaging. We inspected surgery, medical care and outpatients.

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

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

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

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

Services we rate

Our rating of this hospital improved. We rated it as good overall.

We found the following areas of good practice:

- Staff understood how to protect patients from abuse. Staff had training on how to recognise and report abuse and they knew how to apply it.
- Staff used control measures to prevent the spread of infection. The treatment and consultation rooms we saw were clean. Trolleys were also clean.
- The service managed patient safety incidents well. Staff recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service.
- The service provided care and treatment based on national guidance and evidence of its effectiveness. Managers checked to make sure staff followed guidance.
- Staff gave patients enough food and drink to meet their needs and improve their health.
- Staff of different kinds worked together as a team to benefit patients. Doctors, nurses and other healthcare professionals supported each other to provide good care.
- Staff cared for patients with compassion. Feedback from patients confirmed that staff treated them well and with kindness.
- Staff provided emotional support to patients to minimise their distress.
- Staff involved patients and those close to them in decisions about their care and treatment.
- The service planned and provided services in a way that met the needs of local people.
- The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with staff. We were given examples where the service had learned from complaints. Patients told us that when something was not to their satisfaction and they raised it with staff, the response was constructive and helpful.
- The service took account of patients' individual needs.
- The service had a vision for what it wanted to achieve. The strategy was developed by the corporate senior management team, with objectives cascaded to the hospital teams.

Summary of findings

- The service managed and used information to support its activities, using secure electronic systems with security safeguards. The service worked to good information governance processes.
- The service engaged well with patients and staff, the public and local organisations to plan and manage appropriate services.

However, we also found areas of practice that require improvement:

Medical Care

- The service lacked an effective system to assess, respond to and manage risks to oncology patients during out of hours including medical emergencies. For example, the oncology 24 hours help line was not always staffed by appropriately trained oncology staff.
- Not all staff had received an annual appraisal. Current appraisal rates for nursing staff were 75% which was below the hospital standard of 90%. This was still an on-going issue and no improvement noted since the last inspection. The hospital aimed to complete staff appraisal by June 2019.
- The hospital wide pain audits showed low compliance in the completion of pain assessment.
- The nurses working in the endoscopy unit had not been endoscopy trained.
- There was low morale among the endoscopy staff due to insufficient break times when the clinics were over booked and the lack of an endoscopy lead. There was a vacancy for the new role of an endoscopy clinical support manager.

Surgery

- There continued to be some issues where records were not always available, clear or up-to-date, especially in pre-operative assessment.
- The service did not always have enough permanent nursing staff. During our inspection there were not enough permanent staff members in pre-operative assessment.
- Not all staff received an annual appraisal. The hospital standard was 90% and the service reported 70% of theatre staff completed an annual appraisal. On the ward, 76% of nursing staff completed an annual appraisal. Annual appraisal rates for healthcare assistants was 60% on the ward.

Outpatients

- Although the service followed best practice most of the time, we found some issues with the storage of medicines. Resuscitation trolleys were not in a temperature controlled area as advised by the pharmacist due to the storage of medicines on them. Sachets of fluids were found on nurse trolleys kept in treatment rooms that were not temperature controlled.
- Not all staff were not aware of the General Data Protection Regulation 2016 (GDPR).
- Patients were not always kept informed of delayed appointment times. Waiting times for clinics were not displayed in waiting areas.

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

Nigel Acheson
Deputy Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Medical care (including older people's care)	Good	We rated this service as good overall and good in each domain of safe, effective, caring, responsive and well-led.
Surgery	Good	Surgery was the main activity of the hospital. Where our findings on surgery also apply to other services, we do not repeat the information but cross-refer to the surgery section. Staffing on wards was managed jointly with medical care. We rated this service as good overall and good in each domain of safe, effective, caring, responsive and well-led.
Outpatients	Good	We rated this service as good overall because it was safe, caring, and responsive and well-led. We do not rate the effective domain in outpatients.

Summary of findings

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Good

BMI The Cavell Hospital

Services we looked at

Medical care (including older people's care); Surgery; Outpatients

Summary of this inspection

Background to BMI The Cavell Hospital

BMI The Cavell Hospital in Enfield, London is operated by BMI Healthcare Limited. The hospital has 27 beds and provides a range of services including surgical procedures, surgical and medical inpatient care and outpatient consultations with a 'walk in walk out' unit, a dedicated endoscopy unit, CT scanning and MRI facilities.

There are two operating theatres, 13 outpatient consulting rooms, and a minor procedures room, minor treatment room, imaging suite and a physiotherapy department.

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

Our inspection team

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

Why we carried out this inspection

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

How we carried out this inspection

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

Information about BMI The Cavell Hospital

BMI The Cavell Hospital provides a wide range of services. Surgical services are a significant proportion of hospital activity. The shared medical and surgical ward is comprised of 27 beds and these services were provided by medical consultants with practicing privileges, consultant surgeons, a resident medical officer (RMO), nures, health care assistants, a pharmacist, allied health professionals and administrative assistants.

Outpatient services are provided from 13 consulting rooms, in addition to a minor procedure room, minor treatment room, imaging suite and a physiotherapy department. Consultants see patients across a broad range of specialties supported by a team of nursing and healthcare assistant staff. There is multidisciplinary team support that includes pharmacy, physiotherapy, phlebotomy and infection control. A sister BMI hospital is located a mile away and the same hospital leadership team manage both hospitals. Both outpatient teams report to one outpatient manager who works across both sites.

Summary of this inspection

The hospital is registered to provide the following regulated activities:

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

During our inspection, we visited the medical and surgical ward, the outpatient department, and theatres and recovery. We spoke with approximately 35 members of staff, including: senior managers, reception staff, nursing staff, allied health professionals, consultant physicians, resident medical officer, a pharmacist, health care assistants, operating department practitioners and ward clerk administrators. We spoke with 11 patients and relatives throughout surgical, medical and outpatient services. We observed interactions between patients and staff. In addition, we considered the environment and looked at records, including 17 patient records. Before and during our inspection, we also reviewed performance information about the service.

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

Activity (March 2018 to February 2019)

- The top three surgical procedures performed during the reporting period were; hysteroscopy (593 procedures), injections or aspirations of joints, cysts or bursas under guided imaging (412 procedures), and multiple arthroscopic knee operations (214 procedures).
- Between January and December 2018, outpatient attendances (first attendances and follow up attendances in the time period) totalled 16,706. The proportion of outpatient activity broken down by speciality is as follows: gynaecology 20%, rheumatology 10%, ear, nose and throat 9%, orthopaedics 15%, oncology 10%, dermatology 8%, oral maxillofacial surgery 5%, general medicine 4%, pain management 5%, urology 5%, ophthalmology 2%, general surgery 5% and plastic surgery 2%.

The hospital had 320 doctors and dentists under the rules of practising privileges. The hospital employed 26 registered nurses,19 healthcare assistants and operation department practitioners and 56 other hospital staff.

Track record on safety:

- No Never events
- Clinical incidents (January 2018 to December 2018): there were 184 clinical incidents reported;116 were categorised as no harm, 62 were categorised as low harm, five were categorised as moderate harm and none were categorised as severe harm and one was categorised as resulting in death.
- There were no serious injuries reported from January 2018 to December 2018.
- There were no incidents of hospital acquired Meticillin-resistant Staphylococcus aureus (MRSA), Meticillin-sensitive Staphylococcus aureus (MSSA), E. coli or Clostridium difficile (C. diff).
- From March 2018 to February 2019, the provider received 50 complaints.

Services provided at the hospital under service level agreement:

- Pathology
- Histology

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

Good

We rated safe as good because:

- The service had established systems for reporting, investigating, and learning from incidents and serious adverse events. There was an improved open culture of reporting incidents and learning was shared with staff to make improvements.
- Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.
- The service controlled infection risk well. Staff kept the equipment and the premises clean. They used control measures to prevent the spread of infection.
- The service had suitable premises and equipment and looked after them well.
- Staff completed and updated risk assessments for each patient. They kept clear records and asked for support when necessary.

However:

- The service lacked an effective system to assess, respond to and manage risks to oncology patients during out of hours including medical emergencies. For example, the oncology 24 hours help line was not always staffed by appropriately trained oncology staff.
- Although the service in outpatients followed best practice most of the time, we found some issues with the storage of medicines. Resuscitation trolleys were not in a temperature-controlled area as advised by the pharmacist due to the storage of medicines on them. Sachets of fluids were found on nurse trolleys kept in treatment rooms that were not temperature controlled.
- There continued to be some issues where records were not always available, clear or up-to-date, especially in pre-operative assessment.
- The service did not always have enough permanent nursing staff. During our inspection there were not enough permanent staff members in pre-operative assessment.

Are services effective?

Good

We rated effective as good because:

Summary of this inspection

- The service provided care and treatment based on national guidance and evidence of its effectiveness. Managers checked to make sure staff followed guidance.
- Staff gave patients enough food and drink to meet their needs and improve their health.
- Staff assessed and monitored patients regularly to see if they were in pain. They supported patients, used suitable assessment tools and gave additional pain relief to ease pain.
- Staff of different kinds worked together as a team to benefit patients. Doctors, nurses and other healthcare professionals supported each other to provide good care.

Are services caring?

Good

We rated caring as good because:

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

Are services responsive?

Good

We rated responsive as good because:

- The service planned and provided services in a way that met the needs of local people.
- The service took account of patients' individual needs.
- People could access the service when they needed it.
- The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with all staff.

However,

- At the last inspection we found that the hospital did not monitor patients' waiting times from the time to arrival to the appointment. At this inspection patients told us that waiting beyond appointment times was common, often for long periods of up to an hour. They felt they received a good service from the doctors and did not mind if the doctor was delayed or overrunning but just wanted to be informed of this. Waiting times for clinics were not displayed in waiting areas. There was

a notice on display at the reception desk that advised patients to report to reception if they had been waiting more than 20 minutes. This was an action taken from a complaint regarding waiting times.

- There was an access policy that required six weeks' notice of any clinic cancellation. We were told this was difficult to implement, as clinics were cancelled at late notice.

Are services well-led?

Good

We rated well-led as good because:

- Managers at all levels in the service had the right skills and abilities to run a service providing high-quality sustainable care.
- The service systematically improved service quality and safeguarded high standards of care by creating an environment for excellent clinical care to flourish.
- The service had a vision for what it wanted to achieve. The strategy was developed by the corporate senior management team, with objectives cascaded to the hospital teams.
- The service managed and used information to support its activities, using secure electronic systems with security safeguards. The service worked to good information governance processes.
- The service engaged well with patients and staff, the public and local organisations to plan and manage appropriate services.
- Following the inspection the provider made immediate plans to enhance the capability of its staff in dealing with the clinical management of oncology.

However:

- Not all staff were not aware of the General Data Protection Regulation 2016 (GDPR).
- There was low morale among the endoscopy staff due to insufficient break times when the clinics were over booked and the lack of an endoscopy lead. There was a vacancy for the new role of an endoscopy clinical support manager.

Detailed findings from this inspection

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Medical care (including older people's care)	Good	Good	Good	Good	Good	Good
Surgery	Good	Good	Good	Good	Good	Good
Outpatients	Good	Not rated	Good	Good	Good	Good
Overall	Good	Good	Good	Good	Good	Good

Medical care (including older people's care)

Good

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

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

Good

Mandatory Training

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

- Mandatory training included a range of patient safety topics such as infection prevention and control, safeguarding, medical gases, consent and dementia awareness.
- The hospital set a target of 90% for completion of all mandatory training courses. The hospital data showed an overall 94% compliance for the medical service which was better than the hospital target and an improvement from the last inspection (89%). The hospital reported an overall 96.2% compliance for the oncology ward, 92% for the endoscopy unit and 93.2% for the wards. This was an improvement from the last inspection. Staff training compliance at the hospital was better than their sister hospital site.
- The annual adult basic life support mandatory training showed 100% overall compliance and while staff achieved 90% on the annual immediate life support (ILS) compliance. The oncology unit was the only medical area that achieved 100% on the ILS training. The endoscopy staff did not meet the hospital target on the ILS training, which was 80% with the remaining one staff in progress of completing their training. Endoscopy staff told us due to shortage of staff they sometimes experienced challenges in completing their training.
- Staff told us they received a reminder from the human resource (HR) department for their due and outstanding mandatory training and were given protected time to complete their training. They also said if they asked their managers to attend other training or learning sessions, the senior nurse and managers worked to accommodate their request.
- Temporary and locum staff were required to provide evidence of mandatory training compliance from their employers.
- Consultants and clinicians with practising privileges were not required to complete training via the hospital system but assurance of mandatory training was checked by the executive director and medical advisory committee. Consultants were required to produce confirmation of their appraisal documents and completed annual mandatory training such as basic life support, safeguarding, mental capacity training, and where relevant, paediatric training to level 3) to the executive director. Consultants routinely received regular updates on new policies and any other relevant information they required following the quarterly medical advisory committee meeting and via the consultant newsletter and emails.
- The resident medical officers (RMOs) were managed via an external employment agency which they received mandatory training from. They had access to the hospital on-line training system.

Safeguarding

Good

Medical care (including older people's care)

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

- The hospital had appropriate systems, processes, and practices to safeguard patients from avoidable harm, abuse and neglect that reflected relevant legislation and local requirements.
- Staff told us they had access to the hospital's safeguarding policy through the hospital intranet and knew how to access the safeguarding team for advice and guidance when required. Staff had good understanding on safeguarding issues including modern day slavery, human trafficking, and female genital mutilation (FGM). They knew how to raise or report safeguarding concerns.
- Service had a safeguarding lead and staff we spoke to knew who they were. They felt supported by the safeguarding team with the safeguarding concerns and queries they had escalated to them.
- Safeguarding training included safeguarding vulnerable adult and safeguarding level 1 and 2. Staff achieved had 100% compliance on all their safeguarding training on the wards, oncology, and endoscopy units.
- The medical service only treated adult patient and staff were not required to undertake the safeguarding level 3 patient. However staff were required to complete other additional safeguarding training as part of the mandatory training. Staff achieved 100% in the protecting people at risk of radicalisation (PREVENT) training and the safeguarding– chaperoning training. The ward and oncology unit achieved 100% on the FGM training while four of the staff in endoscopy (80%) had completed this training. This was an improvement since the last inspection.
- The hospital reported one safeguarding incidents on the wards in the last 12 months before inspection.

Cleanliness, infection control and hygiene

Although staff kept themselves, equipment, and the premises clean however the service did not controlled infection risk well. There were no clinical sinks in all the patients' bedroom for staff to wash their hands to minimise the risk of cross infection and contamination.

- The medical wards and communal areas appeared tidy and visibly clean. At the last inspection we had concerns on the oncology unit around the cleanliness of equipment and the use of the unit by other patients. During this inspection, we saw improvement and the unit and equipment were cleaned in line with the hospital policy and national guidance. We observed and staff we spoke told us that only the oncology patients were cared for in the unit to prevent the risk of immuno-compromised patients getting an infection.
- The inpatient rooms were single occupancy on the wards and two isolation rooms with anterooms that were used in the event of a patient needing such precautions. Staff used isolation signs on the wards to advice staff and patients when isolation or precautions were needed.
- The service carried out regular water quality testing for gram-negative bacteria (coliforms), E.coli, pseudomonas and total viable count on the medical wards areas and hand washing sinks.
- Cleaning of the medical ward areas was scheduled daily and between patient discharge or transfer. Staff also requested the deep cleaning of rooms or bed areas if a patient had Methicillin-resistant Staphylococcus aureus (MRSA) or an infected wound. There were two housekeepers scheduled to clean the ward daily and cleaning cover was till 9pm.
- Cleaning schedules were in place on the medical ward areas and equipment. 'I am clean' stickers were in use in all the medical areas visited to indicate when equipment was cleaned. Patient we spoke to spoke positively on the cleanliness of the hospital and wards.
- For the period of April 2017 to March 2018 the hospital reported zero cases of MRSA, Methicillin-sensitive Staphylococcus aureus (MSSA), C.difficile and E.coli.
- The service had an infection prevention and control (IPC) team that met monthly to discuss any IPC concerns, review IPC risks and address issues identified at the previous inspections. We reviewed the IPC meeting minutes and saw the IPC risk register was reviewed regularly at the meetings. The hospital had an IPC lead nurse who was supported by the director of clinical service and consultants and staff knew how to access them for support.
- The service provided staff with personal protective equipment (PPE), to prevent and protect people from a healthcare-associated infection. Staff adhered to the

hospital's 'arms bare below the elbow' policy to enable effective hand washing and reduce the risk of spreading infections. Posters on 'go bare below the elbow', sepsis and six steps to hand hygiene were displayed on the medical wards.

- There was access to hand washing facilities, hand sanitiser and a supply of PPE, which included sterile gloves, gowns, and aprons, in all areas. Staff applying hand sanitising gel when they entered clinical areas. Staff disinfected their hands between patient contact, in accordance with national guidance (National Institute for Health and Care Excellence (NICE) Infection prevention and control: QS61). There were displayed posters on the WHO 5 moments of hand hygiene in all areas.
- The decontamination of endoscopy instruments was carried out in accordance with the Department of Health (DoH) guidance HTM 01-06. Staff we spoke with understood their responsibilities in this process. The endoscopy area was clean and tidy, and there was a daily and weekly cleaning rota in place in the unit.
- The December 2018 IPC hand hygiene audit showed an overall 100% compliance on the 31 standards audited.
- The hospital took part in the 2018 patient led assessments of the care environment (PLACE) audit. The hospital scored 98% for cleanliness which was similar to the national average of 98.5%. The hospital scored 91% for condition, appearance and maintenance which was below the national average of 94%. The hospital had an on-going refurbishment plan to improve the hospital environment, which included bedroom decoration and replacement of carpet with flooring, installation of compliant clinical hand wash sinks and replacement of blinds in the patient bedroom.
- The 2019 hospital antimicrobial stewardship audit showed an overall 86% compliance on the standards audited.
- There were spillage kits for the safe disposal of body fluids in the medical areas. All kits were within the expiry date.
- Disposable curtains with an antibacterial covering were used in all treatment areas we visited and were clearly labelled with the date of when they were last changed.

Environment and equipment

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

- The service had processes to ensure equipment was maintained and tested for electrical safety, to ensure it was fit for purpose and safe for patient use.
- The inpatient and clinical facilities were designed in line with Department of Health (DoH) guidance HBN 04-01.
- The cleaning and decontamination of all reusable equipment for endoscopy procedure were all up to date and managed in line with the Department of Health HTM01-06 guidance. Staff kept records on the decontamination of scopes and the 2019 audits undertaken by managers showed 98% compliance.
- The oncology ward had achieved a 'Quality environmental mark' by a leading cancer support charity for the high standard of the environment.
- The hospital had an on-going refurbishment programme which included the removal of carpets from clinical areas and installation of hand hygiene sinks. We noted some clinical sinks had been installed in a number of the patient's bedrooms on the wards, endoscopy, and oncology areas.
- There was appropriate emergency equipment on the medical wards including resuscitation equipment, fire cylinder, fire blankets, defibrillator, emergency eye wash, oxygen cylinder and cardiac arrest. The service had systems to ensure emergency equipment was checked daily and records confirmed staff completed these checks as required. We checked a range of consumable items from the resuscitation trolley, including syringes, airways and naso-gastric tubes and emergency medicines and they were all were in-date. All resuscitation trolley drawers seen were secured with a tamper evident tag.
- There were arrangements to safely manage waste and clinical specimens. Waste was handled appropriately with separate colour-coded arrangements for general waste, clinical waste, and sharps. We observed general, sharps and clinical waste bags were changed frequently by staff. Staff used sharps bin appropriately and these were not overfilled, dated, and signed by staff in a timely manner.
- All Control of Substances Hazardous to Health (COSHH) items in all the medical wards areas were locked and labelled appropriately to prevent or reduce staff and patient exposure to substances that are hazardous to their health. This was in line with the Health Regulations 2002 regulations and hospital policy.

- Water quality testing were carried out for gram-negative bacteria (coliforms), E.coli, pseudomonas, and total viable count (TVC) on the medical wards' areas such as the endoscopy and hand washing sinks in areas such as the oncology wards. Total viable count, helps gives a quantitative estimate of the concentration of microorganisms such as bacteria, yeast or mould spores in a sample. The TVC count in endoscopy was completed twice a week by the maintenance team and audits showed 98% compliance was positive.
- The service had a plan for the 2018/19 influenza (flu) vaccination programme for staff to minimise the risk of cross infection. The hospital reported that 58% of clinical and non-clinical staff have had their flu jab. There was no target for staff completing their flu jab.

Assessing and responding to patient risk

Although staff could recognise and respond to signs of patient's health deterioration and emergencies however there was not an effective system to assess, respond to and manage risks to oncology patients during out of hours including medical emergencies.

- Staff completed a medical pathway risk assessments to assess patients during admission and ward rounds using national risk assessment tools in areas such nutrition, mobility, falls risk, medical history, mental health history, skin integrity, social needs, high blood pressure, MRSA, venous thromboembolism (VTE), diabetes and high body mass index (BMI). VTE is a condition in which a blood clot forms most often in the deep veins of the leg, groin, or arm. This was confirmed in the patients' records we reviewed. The medical pathway also included specific assessments on nursing intervention, pre-assessment, diagnostics, IV site, bed rail risk assessment, pain management care plan, integrated care pathway for patients with indwelling urinary catheter. Staff were required to have at least two hourly comfort round and carry out these risk assessment including ensuring bed rails were in use and that the call bell and bed table were within patient reach to prevent falls.
- Patient records demonstrated risk assessments were undertaken. This included assessments for: blood borne virus, IPC infection risk assessment tool, smoking assessment, urinary catheter, NEWS, falls, MRSA screening, VTE, sepsis assessment and care plans seen in patients' notes. The MDT staff completed combined risk assessment that related to fluid intake and anaesthetic records.
- All medical patients were triaged using a pre-admission medical screening tool and while the oncology patients were triaged using UK Oncology Nursing Society (UKONS) screening tools. Patients were also individually risk assessed during admission and their treatment to ensure that treatment plans were tailored to their needs. We saw that staff frequently assessed patients during their procedures such as endoscopy.
- We saw staff gave patients an "alert card' for non-vitamin k anticoagulant which they were always required to carry due to the risk of bleeding and patients on vitamin k should be stopped before endoscopy or invasive procedures.
- There was a process to ensure resident medical officers (RMOs) were involved in the admission of patients, which ensured patients were seen quickly and risks were identified and addressed.
- The hospital had a hospital admission policy that outlined the admission criteria and out of hours admission. All patients were admitted to the medical service under the care of a named consultant. There was an out of hours decision support tool that guided staff on the admission criteria, ensuring patient had a detailed medical report for admission and having the appropriate staffing and skill mix to ensure safe admission and reduce patient risk.
- Out of hours patients were able to phone the inpatient ward nurses for advice. All oncology patients were given a chemotherapy booklet containing information about their treatment as well as telephone numbers for the unit and out of hours. Patients were encouraged to telephone the advice line if they have any concerns or queries but were advised that they may be directed to attend the local A&E department. The hospital data showed that there had been two oncology patients transfer to a local A&E in the last 12 months. Patients were also given an alert card with contact numbers and treatment regime. However, there was no oncology specialist staff during out of hours to manage the 24 hour oncology telephone helpline or assess patients if admitted unto the wards overnight. The wards staff were expected to manage the 24 hours helpline and assess patients using the UKONS triage tool out of hours

and liaise with the RMOs or contact the oncology nurses for advice. The ward staff had the oncology nurses and consultants contact numbers if they need to ask for advice on patients care. Senior staff told us the ward staff were trained to use the UKONS triage tool as part of their induction.

- Although ward nurses did not have the UKONS triage tool most senior nurses had completed the training. The hospital's RMOs attended oncology training as part of their induction and were aware of the UKONS tool and policies for the good practice of acute oncology symptoms.
- Patients contacting the hospital out of hours with concerns about their oncology care were at first triaged by the ward nurses. The ward nurses could refer the patients to the RMO or a specialist oncology nurse, who where available out of hours. The hospital was not an intensive acute site and in the case of an emergency patients were advised to attend their local NHS emergency department. Patients were provided with a small diary which they were told to keep with them. The diary contained important information about their treatment and blood results as well as local contact numbers.
- Patients were taught to use the diary to help them understand the significance of any side effects and as a guide for them to be aware of normal side effects and when to seek medical advice. They are also encouraged to make notes in their diary, on an ongoing basis throughout their treatment, around any side effects they have experienced, which can then be discussed at their next consultation. On some occasions the hospitals had admitted patients who were feeling unwell during their treatment. The care team would consist of the ward nursing team, the specialist oncology nursing team under the guidance of their oncology consultant supported by a physician with a special interest in cancer care.
- The hospital currently did not have a formal arrangement with local NHS hospitals in terms of managing emergencies. However, they had a 24 hour RMO who was available to triage and assess any unwell oncology patient and had access to the patient's consultant for review and advice. Should a patient be advised to attend there local emergency department they are informed to take their chemotherapy diary with them, with details of their treatment. If patients were transferred via the unit, a referral letter would accompany the patient. Senior staff told us that mostly the patient's oncologist may practice in the NHS facility patients were transferred to and was often available to give advice to the medical team. The hospital contact details are in all the patients' diary for further information to be sought if necessary.
- Senior managers told us if they had an oncology patient diagnosed with neutropenic sepsis they will be transferred or referred to a local NHS hospital as the service did not have appropriate facilities to support these patients. The decision to admit a patient out of hours was the responsibilities of the ward manager and senior nurse and in the event of any concerns regarding suitability of admission this were referred to the associate director of clinical services or the director of clinical services.
- The hospital 2018 VTE audit showed that 100% of patients were assessed on admission. The hospital holds a VTE exemplar centre status by the DoH. The hospital reported one hospital acquired VTE in the last 12 months.
- The endoscopy service used the World Health Organisation (WHO) safety checklist for patients throughout the perioperative journey, to prevent or avoid serious patient harm during their procedure. This was in line with national recommendations (NPSA Patient Safety Alert: WHO Surgical Safety Checklist). The hospital WHO surgical safety checklist audits carried out on the 19 December 2018 showed 97.2% overall compliance. From observation and record reviewed we saw that WHO checklist were fully completed by staff.
- The service used the National Early Warning Score (NEWS), designed to allow early recognition and deterioration in patient by monitoring physical parameters, such as blood pressure, heart rate and temperature. Nursing staff used the NEWS and knew the threshold for escalation to the RMO. The RMO were available on the wards and ensured prompt identification and managing of deteriorating patients. Staff also carried out further investigations such as blood tests as required. Staff told us there have been improvements in staff competency on NEWS score and managing deteriorating patient.
- The hospital December 2018 NEWS audit showed 93% compliance on the standard audited. There was an action plan address the areas of low compliance. During

inspection we observed displayed posters which prompted staff to ensure the NEWS score were completed and calculated accurately. This was an improvement from the last inspection.

- Staff also carried out secondary assessment using the ABCDE (Airway, Breathing, Circulation, Disability, Exposure)systematic approach for assessing deteriorating or critically ill patient risk and would carry out additional urine test, which can also alert staff of patients that were deteriorating.
- Since the last inspection, the hospital had renewed their defibrillator in May 2019, which would be used during patient emergencies such as cardiac arrest. This is an improvement in the managing of patient risk.
- Staff received training on emergencies such as fire emergencies, blood transfusion and cardiac arrest. The annual adult basic life support mandatory training showed 100% overall compliance and while staff achieved 90% on the annual immediate life support (ILS) compliance. The hospital carried out regular resuscitation scenarios and held a twice-daily resuscitation huddle for staff. Staff we spoke told us they also had regular fire drills. For example, there had been a cardiac resuscitation drill in March 2019 and a fire drill in January 2019.
- In oncology, staff told us there have been no extravasation complications in 10 years, and vomiting was unusual because of the comprehensive anticipatory antiemetic treatment given. Extravasationis the accidental leakage of certain medicines into the body from an IV drip in the vein. Staff told us they had very few neutropenic sepsis incidents because all breast cancer patients were given preventive a medicine used to reduce low levels of white blood cells in chemotherapy).
- There were five unplanned transfers to another hospital and zero unplanned re-admissions to the service for the period of January to December 2018.Staff told us they have had an unplanned transfer for a medical patient to a nearest local hospital’s coronary unit in December 2018 following an endoscopy procedure.
- The hospital had a falls team that comprised of the physiotherapist, clinical services manager and pharmacy manager. Staff completed a falls algorithm for patients that have had a fall or were at risk. There were regular falls meeting carried out by the falls team and with minutes on the shared drive, which all MDT staff could access for update. Staff were required to complete a ‘stand up to go test’ assessment for patients within 15 seconds and if any concerns a referral were made to the physiotherapist for full assessment. Staff told us there were plans in place to set up a falls group in future to improve patient outcome.
- There was a physiotherapy falls referral protocol, patient falls care plan and BMI falls pathway that advised staff on steps to take on falls’ management.
- Staff were required to complete an e-learning training on aggression to manage patient risk and risks to themselves. Staff we spoke to told us they rarely experienced violence and aggression from patients, however when this occurred they knew how to manage the situation and risks.

Staffing

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

- The hospital used the BMI Healthcare nursing staffing planner tool to determine staffing levels. The regular staff to patient ratio was 1:6. Senior staff used the tool to allocate staff in advance based on pre-determined nursing demand and acuity of patients. The day unit staffing requirement was determined by the number of hours each patient would be in the unit. The ward sister prepared the staff roster two weeks in advance and it was reviewed at the daily communication meeting. Staff we spoke with said there was sufficient staff to meet acuity.
- During inspection we saw the required and actual staffing were displayed on the wards which reflected the acuity on the wards. Temporary staff were also used to achieve safe staffing levels. Staff told us the hospital had a process for managing the bank and agency staff to ensure they were able to meet the requirements for patients on the wards and specialist wards.
- The hospital reported that all shifts were filled and achieved by use of permanent and temporary staff in the last three months before the inspection.
- The hospital staffing for the inpatient wards as at February 2019 was 18.5 whole time equivalents (WTE) for the nurses and 5.6WTE for the HCAs. The hospital reported 55.9WTE for other clinical and non-clinical staff across the hospital.
- During inspection, there were two trained nurses and two HCA and a clinical services manager on duty. The

nursing staff can be two to three on each shift depending on acuity. Staff told us acuity may change depending on the age and independence of patients admitted on the ward. The nurse sister would request for additional staff when they had more patient admitted as day cases or endoscopy procedure. The expected staffing level was one nurse to seven to nine patients depending on acuity and patient needs. During inspection they were six overnight patient, seven admission and four scheduled discharge, which meant safe staffing level and acuity.

- The oncology ward had four specialist nurses and a trainee associate nurse trained to give therapist depending on patient acuity. The oncology unit also had a dedicated administrative staff covering the unit. The unit was well staffed, and no concerns on staffing.
- The endoscopy was staffed with two senior scrub and recovery nurses, a preceptorship nurse, an administrative staff and an HCA. Staff told us they also used a bank HCA for the endoscopy procedure. Staff we spoke to told us they felt the unit was short staffed and an additional nurse was needed as a floater.
- There was a dedicated physiotherapist on the ward who worked fulltime on both hospital sites Monday to Friday, 9am to 5pm. The hospital also had a part time physiotherapist who covered weekend shifts.
- The hospital also had six administrative staff receptionists that covered the inpatient wards on both hospital sites.
- The staffing ratio of nurses to HCA was 3.3 to 1 within the same period.
- The average sickness rate for period of December 2018 to February 2019 was 0% for the nursing staff.
- As at 1 February 2019, the vacancy rate was 7% for HCAs and 0% for the nurses.
- The overall turnover rate for staff for the period of March 2018 to February 2019 was 20% for the HCAs. Staff told us they had good turnover rate and people had worked in the service for a long time.
- Senior staff told us there was an on-going recruitment for nursing staff and bank staff were used to cover shifts. The hospital was looking to arrange an agency staff to cover the ward and endoscopy unit permanently.
- A senior nurse was in charge as a contact point for nursing staff, consultants, and patients 24-hours a day, seven days a week and the wards were well staffed.

Medical staffing

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

- Consultants worked under practising privileges agreements in the service. Under practising privileges, a medical practitioner is granted permission to work within an independent hospital. The medical advisory committee (MAC) was responsible for granting practice privileges and was overseen by the medical director. Consultants with practicing privileges had their appraisal and revalidation undertaken by their respective NHS trusts. Staff we spoke to told us the process for managing practice privileges and consultant's' scope of practice was robust.
- In the oncology unit, there were three oncologists and a haematologist that worked under practicing privileges.
- As at 1 February 2019, the hospital reported there were 320 doctors practising under rules or privileges over six months.
- The hospital reported three suspensions and no removed practice privilege or supervised practice of medical staff in the last 12 months before the inspection.
- The service had anaesthetists that covered the wards and the endoscopy procedures in theatre. There was no formal rota for on call consultant surgeons or physicians. The relevant staff would be contacted directly by staff when needed. Staff told us this arrangement worked and no concerns identified.
- The RMOs were provided under contract with an external agency that provided training and support. The RMOs provided 24-hour 7 day a week service on a two-week rotational basis. Senior staff told us that the RMOs were selected specifically to enable them to manage a varied patient caseload and particular requirements. The hospital had two inpatient RMOs who rotated for at least six months to ensure continuity of care. The resident medical officer (RMO) provided day to day medical service and dealt with any routine and emergency situations in consultation with the relevant consultant. Out of hours, consultants provided either telephone advice or attended in person.
- The RMOs held a bleep at night and had appropriate rest period in line with best practice and guidance.

Good

Medical care (including older people's care)

- Staff reported no issues around medical staffing cover and the consultant and RMOs came promptly to the wards when needed for advice, assessment, or emergencies for the medical patients.

Records

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

- The hospital used paper and electronic system to record patient needs and care plans, medical decision-making, reviews, and risk assessments.
- Staff told us all patient notes were kept securely in the hospital following discharge and doctors could have copies of the patient discharge letters.
- Staff had access to the BMI clinician app through a remote log in that allowed real time information to the clinic list, theatre list, booking request and individual patient view information. Staff we spoke told us they had timely access to patients record on the wards and theatre for the endoscopy procedures as the administrative staff contacted the records department a day ahead of patient's admission and record would be available on the wards before patient's arrival. This was an improvement since the last inspection.
- The hospital data showed all patients were seen by staff with their records readily available in the last three months before inspection. Staff told us since the last inspection, patient that contacted the hospital out of hours; their notes were made available in a locked cupboard which staff could access their assessment and diagnostic results such as blood test. This was an improvement since the last inspection.
- Following a patient endoscopy procedure, results were available to patient within a day and to the consultant within five minutes.
- We saw that staff stored patient records securely, and when electronic records were not in use staff logged off their computer.
- We looked at eight sets of patient records and their prescription charts during inspection. Staff documentation on patients' records was concise, legible, and written in accordance with the Nursing and Midwifery Council (NMC) record keeping guidance. There was evidence of discussion and collaboration with patients and their relatives by the MDT staff. We saw evidence that staff carried our risk assessments and reviewed patients' past medical history on the patients notes reviewed. We saw evidence in patients' records that staff had completed the safety checks undertaken during an endoscopy procedure using the World Health Organisation (WHO) 'Five Steps to Safer Surgery.
- The hospital undertook monthly audits of patient's health records, which included monitoring of risk assessments such as falls and pressure areas. The health record documentation December audit in 2018 audit showed an overall 86% compliance for the standards audited.
- The oncology ward carried out the UKONS triage tool documentation audit on the 23 October 2018. The result showed an overall 82% compliance on nine standards audited. The result showed that the staff that had completed the UKONS triage tool did not always had an up to date competency for that advanced skills. Following the inspection, senior managers told us the nurses have been booked for a course in June 2019.
- The hospital data showed that all staff received training on documentation and legal aspects in relation to confidentiality and retention.
- Information governance was part of the mandatory training programme which all staff were required to attend.

Medicines

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

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

reconciliation was completed and recorded while identified areas of discrepancy were actioned and processes were audited. This was an improvement from the last inspection.

- At the last inspection we had concerns around the governance of authorised signatories of staff that could order medicines and the lack of antimicrobial stewardship and controlled drug audits. During this inspection we saw improvement and that the concerns had been addressed.
- A list of authorized signatories of staff that can order medicines were kept by the hospital pharmacy team, so that staff who undertook this responsibility could be identified. We reviewed the lists held in the pharmacy department and noted these were complete and in date. This was an improvement from the last inspection.
- Medicines were also stored in locked fridges and trolleys within locked clinical treatment rooms and only relevant clinical staff could access them. All medicines stocked on the wards were managed safely. There was system in place on the wards which alerted staff through a red flashing light signal when the medicines room was opened and unsecured.
- All medicines stored in the fridge and cupboards were all in date. We also saw that emergency medicines and cytotoxic spillage kits were available on the wards and regularly checked by staff.
- Medicines were supplied by the onsite pharmacy staff. Staff ordered, dispensed, and disposed of medicines safely and securely. There were effective arrangements to facilitate medicines supplies and advice out of hours. Clinical pharmacy services were available every day from 9am to 5pm and the RMOs had permission to access the pharmacy out of hours to obtain any medicines which wards had run out of. There were also labelled pack of to take away (TTA) medicines on the ward which were dispensed by the nurses and checked by RMO during out of pharmacy hours. Nursing and medical staff were required to complete patient details and name of the medicines dispensed in the TTA book on the wards which would be reviewed by the pharmacist the next day.
- Staff told us the pharmacy team were visible, accessible and a valuable resource in identifying issues with medicines and encouraging improvement. Staff told us the pharmacists always double-checked prescriptions to reduce the chance of error or side effects, and they explained medicines information to patients. In all the areas we inspected there was good clinical input by the pharmacy team, providing advice to staff and patients, and making clinical interventions with medicines to improve patient safety. The pharmacists also counselled patients on how to take their medicines at discharge with leaflets given.
- The hospital had a new pharmacy manager that had recommenced the bi-monthly medicines meeting where all medications incidents and action were reviewed. The manager had also implemented a daily antimicrobial stewardship prescribing round which was now embedded in both hospital sites.
- The hospital had two oncology pharmacists who were part of the Systemic Anti-Cancer Therapy (SACT) network that supported staff and patients in choosing appropriate treatment and care to improve patient outcomes. The oncology pharmacy team visited patients daily and had a weekly catch up meeting with the oncology team.
- The prescribing and administration of chemotherapy to patients was managed electronically and safely. Each electronic prescription prescribed by the consultants were clinically checked by a specialist oncology pharmacist prior to being individually prepared on site by the pharmacists.
- Arrangements were in place to ensure that medicines incidents were reported, recorded, and investigated and staff we spoke with knew how to report incidents involving medicines. Staff knew how to report medication errors. Senior staff told us there had been five medicines incidents across both hospital sites in the last two months before inspection. The themes included legibility of record and the calculation of supply, administration and wasted record. The pharmacist staff also discussed and shared medicines incidents themes to MDT staff across the hospital or in UK at team meetings.
- Prescribers had induction training in prudent antimicrobial use and were familiar with the antimicrobial resistance and stewardship practice.
- The service carried out a range of nine medicines audits to assess how they were performing, and to identify areas for improvement. These included audits such as controlled drugs, missed dose, antimicrobial, medicines reconciliation, intervention monitoring, dispensing turnaround and medicine management audit.

Good

Medical care (including older people's care)

- The hospital December 2018 controlled audits showed 100% compliance on the wards and 95% in the endoscopy unit. There was an endoscopy controlled drug action plan which was developed to address the areas of concerns.
- The service carried out a medicine's management audit on the endoscopy unit in January 2019 which showed an overall 97% compliance on the 31 standards audited. The standards audited included environmental control, security and storage, medicines administration, emergency medicines. Full compliance was not met in the labelling of fluids stored in the warming cabinet.
- The hospital carried out a pharmacy intervention audit in March 2019. The interventions made by the pharmacist included clarify key pieces of information such as the start timing, dates and correcting the duration of VTE prophylaxis where the start dates, and times have not been written on the chart. Other interventions included flagging patient on long term anticoagulant, preventing additional VTE prophylaxis, identifying missing signatures of prescribers such as anaesthetists to ensure the drug charts are legal and ensured the charts were signed as soon as possible. Other interventions included educating patients about their take home medication such as analgesics, screening of oncology prescriptions and recommending adding medication that had been missed.
- The March 2019 antibiotics audit showed 100% prescription were compliant with the local policy and had allergy status indicated. None of the infections were hospital acquired and 60% antibiotics were prescribed according to blood culture taken. The clinical indication for the use of antibiotics was documented and prescribers were contactable when needed. However only 20% of prescription stated the duration or review date. The recommendation included prescribers to clearly indicate treatment duration.
- The National Institute for Health and Care Excellence (NICE) guidance states 100% of patient should have an accurate drug history taken and medicines reconciled within 24 hours of admission. The hospital medicines reconciliation audit for the period of October to November 2018 showed 70% compliance against the four standards. The standard audited included allergy's status, medication history at pre-assessment, medicines reconciliation in 24 hours and pharmacist documentation. There was an action plan with two of the three actions on the action plan had been completed.
- Fridge temperatures and clinical room ambient temperatures were monitored and recorded daily for the period of January to April 2019. During inspection we saw all fridge and room ambient temperatures were within the expected range. For example, the fridge temperatures were expected to be within the range of two to eight degree centigrade and during inspection it was 5.5 degree centigrade. Staff were compliant in the monitoring of the ambient and room temperature and the fridge temperature were regularly calibrated.
- We reviewed eight patient drug charts during inspection. Patients' allergies were recorded on prescription chart in line with NICE guidance. Patients regular medicines prescribed included the route, frequency, all signed by prescriber and no missed doses. Medicines that are taken when needed (PRN) all included frequency and maximum dose in 24 hours.
- Safety medicines leaflets were available and given to patients which included safe use of antibiotics contained its useage, allergies and side effects. The leaflets also contained unlicensed medicine, use of non-steroidal anti-inflammatory drugs (NSAIDS).

Incidents

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

- Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.
- From April 2018 to March 2019, the hospital reported no incidents which were classified as never events for medical care.
- For the period of April 2018 to March 2019 the hospital reported 25 incidents for the medical services. The top

reported incidents were deterioration (16%), clinical communication (12%), medication error, confidentiality, cancelled operation, falls, expected death, pathology, radiology, VTE and surgical complication.

- The hospital reported 184 incidents reported for the period of January to December 2018 in all the services of which 63% were no harm, 33.7% low harm and 2.7% were categorised as moderate harm.
- No incidents were reported as leading to “severe” harm for the period of January 2018 to March 2019.
- The hospital reported no inpatient death in last 12 months before inspection. Staff told us that all unexpected death would be investigated using a root cause analysis and findings would be reported under the clinical governance committee meeting. Findings from the death investigation would be shared with the patients and their family, staff and the regional and corporate quality team. Unexpected death would also be discussed at the BMI regional quality assurance committee and their national clinical governance committee meetings.
- Since the last inspection, the hospital had introduced a new risk management electronic incident reporting system since December 2016. Staff told us this was to ensure all staff had access to reporting incidents and near misses. This was an improvement from the last inspection. Staff told us they were encouraged to report incidents by their managers and felt confident to do so. Staff knew how to report incidents and the most staff we spoke with had reported an incident. Staff told us that senior managers had oversight of incidents reported and gave investigation feedback and learning to staff.
- The hospital had a monthly lesson learned workshop which was chaired by the risk and quality assurance team and where all MDT staff including housekeepers attended. Learning from incidents, risks and complaints were discussed and shared with staff. We reviewed three lesson learnt workshop bulletin which showed several examples of learning from incidents and complaints. This included the pharmacy team devising a chart of ‘to take away’ medicines and licensing requirement that staff could refer to if they need to dispense medicines out of hours. The hospital had introduced a reminder system for staff to ensure they check all necessary equipment needed for patients procedure or surgery where available a day before admission to prevent last minute cancellations.
- Staff we spoke to had good understanding of recent incidents that had occurred such as patient falls and had received feedback on reported incidents. Staff told us there was a no blame culture and they received appropriate support from colleagues and managers following an adverse incident.
- Senior managers told us they had a good incident reporting culture and the hospital had an action tracker to monitor all incidents reported and been investigated. This was an improvement from the last inspection where we found low incidents reporting on medicines management.
- Incidents were well investigated and we saw evidence of learning and change to practice. For example, following an incident in oncology, staff were required to delay treatment where neutrophil count was below the acceptable range and check results from the ward against the laboratory result to ensure no variance. Staff we also required to send in writing to the provider lead chemotherapy pharmacist when a consultant wished to go ahead with treatment were neutrophil count varied from protocol. Staff told us there had been a reduction in sepsis incidents following recent training on sepsis and managing deteriorating patient.
- The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain ‘notifiable safety incidents and provide reasonable support to that person, under Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.
- For the period of 2017/18, there were three reported incidents that required the duty of candour in the hospital. Meetings were held with patients and their relatives to discuss what had occurred along with treatment plans.
- Staff we spoke to had good understood on the duty of candour and its implication to practice. During inspection the hospital had a duty of candour card which contained information like details of the staff carrying out the duty of candour, person receiving information and apology and a checklist of five outcomes staff had to be completed and tick when completing the duty of candour process. This card would then be placed in the patients records when completed.

Safety Thermometer

Good

Medical care (including older people's care)

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

- The safety thermometer is used to record the prevalence of patient harm and to provide immediate information and analysis for frontline teams to monitor their performance in delivering harm free care. It measured the proportion of patients that experienced 'harm free' days from pressure ulcers, falls, urinary tract infections (UTI) in patients with a catheter and venous thromboembolism. Measurement at the frontline is intended to focus attention on patient harms and their elimination.
- Staff we spoke to were aware of their responsibility to reduce and reports incidents such as falls, pressure ulcers, urinary tract infection relating to the use of catheters.
- Safety thermometer data were displayed in hospital areas which showed information about incidents and patient satisfaction.
- The hospital data showed that in April 2018 the service reported no new hospital- acquired VTE, pressure ulcers and UTI for the period. The service reported there have been five incidents of falls across both hospital sites.

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

Good

Evidence-based care and treatment

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

- The medical service had effective systems to ensure policies, protocols and clinical pathways were reviewed regularly and reflected national guidance and legislations.
- Guidelines were available on the hospital intranet and were updated and guided by the Royal College of Physicians (RCOP), Royal College of Nursing, UK Oncology Nursing Society (UKONS) and National Institute for Health and Care Excellence (NICE) guidance when reviewed. We saw the pharmacists used the NHS England controlled drugs (CDs) guidance to inform their practice. Staff we spoke to were aware of how to access their policies and guidance.
- At the last inspection some staff did not always adhere to the hospital policy in the management of neutropenic sepsis. During this inspection, there was an improvement in staff practice and no concerns were noted.
- The pharmacy team worked with a local NHS hospital pharmacy team to review their guidelines for antimicrobial guidance to ensure it is evidence based, in line with best practice to improve patient safety and outcome.
- The service used current evidence-based guidance and quality standards to inform the delivery of care and treatment patients. The hospital had an annual audit calendar which set out the audits to be undertaken across the hospital. The audits included patient health records, hand hygiene, VTE, hand hygiene, controlled drugs and medicines management. This was an improvement from the last inspection.
- Staff were informed of changes to national guidance and local policies and procedures through their newsletter, staff meetings, handovers, and various governance meetings.
- The oncology consultants and nurses were part of the London cancer network and UK Oncology Nursing Society (UKONS) and had access to evidence-based resources, trainings and which had helped improve patient outcomes and introduced best practice into the service.
- The hospital had an admission policy which included a local standard operating procedure (SOP) for all patients and an out of hours draft SOP for oncology patients. The out of hours SOP for the oncology patients reviewed was a draft document written by the lead oncology nurse and waiting for approval by the clinical governance committees. Their was lack of involvement of the medical advisory committee in creating the oncology SOP which meant the service had not sought professional and expert advice as needed to identify and make improvements. The oncology service did not have a comprehensive procedure or protocol in place at the time of the inspection to guide staff in caring for oncology patients.

- The endoscopy service was not Joint Advisory Group (JAG) accredited and had a scheduled visit in May 2019.

Nutrition and hydration

Staff gave patients enough food and drink to meet their needs and improve their health. They used special feeding and hydration techniques when necessary. The service made adjustments for patients' religious, cultural, and other preferences.

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

- Patient told us they were given an adequate choice of cold or hot food and water regularly by staff and the food were of high standard, exemplary and very tasty.
- The hospital food was outsourced to catering company. The 2018 Patient-led assessments of the care environment (PLACE) showed the hospital scored 99% for the ward food which was better than national average (90.5%).

Pain relief

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

- Staff used the numeric or smiley face pain score to assess patient pain depending on the needs of patient, which was recorded in the pain chart record.
- The 2018 hospital pain management audit showed an overall 51% compliance against all standard audited. There was poor performance on the evidence on documentation, assessment and use of non-pharmacological pain management used.
- Pain relief was also captured via the patient satisfaction surveys to monitor the way staff assessed and explained pain management to patients and the pain relief that was then offered.
- Patient we spoke to during inspection reported excellent pain control by staff and they had received pain killers as part of their TTO (to take out) medicines.
- During inspection we saw patients were given hospital leaflets on a guide to pain relief and management during their admission. Information on pain included pain and nausea assessment, before surgery or endoscopy procedure, types of pain killers and other pain control techniques such as deep breathing and heat or cold compresses.
- Palliative pain specialists were available to support oncology patients through the palliative care services at patients' home by the community Macmillan nurses or through a referral to local hospices.
- The oncology service also provided a service to patient by insertion of implantable catheter when appropriate so that bloods tests and chemotherapies were given painlessly for the duration of the patient's treatment which could last several months.

Patient outcomes

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

- The hospital measured patient outcomes via a range of measures which included mortality, transfers out, infection rates, readmission rates, referral to treatment times, patient satisfaction scores, incidents, complaints, staff questionnaires, audits, Friends and Family Tests, and mandatory training rates. The hospital took part in

the CQUINs audit schedule in the North West London and Herts Valley region. The hospital data showed they 90% completion rate on the number of audits completed in their audit plan.

- Between January to December 2018 there were zero unplanned re-admission of medical in patient within 28 days.
- Between January 2018 and December 2018 there were five unplanned transfers to acute NHS hospitals for the medical patient in endoscopy and wards.
- The hospital reported there had been no patient death in the last 12 months before inspection.

Competent staff

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

- The service had system for the induction and training of clinical and non-clinical staff. The service had a framework for assessing staff competency and governance process for managing staff professional registrations.
- All staff including agency staff underwent a hospital induction and orientation programme, which included mandatory and department specific training.
- The RMOs spent time with the pharmacy team as part of their induction process and covered areas such as TTA (to take away) medicines, out of service medicines arrangement and prescription writing with the aim of improving their skills and knowledge on medicines management. Staff told us student nurses also had the opportunity to shadow the pharmacy team for a day.
- Staff were supported by their managers to maintain their professional skills, competencies and experience through internal and external training, study days and career progression. Nursing staff we spoke to told us they were supported by the senior nurses in attending relevant courses and compiling their CPD evidence for their revalidation. Courses were usually advertised quarterly to encourage and enable staff prepare in advance.
- The hospital preceptorship nurse that were required to shadow their colleagues in the theatre, endoscopy, recovery, wards in order to improve their competencies around clinical practices such as preparation for surgery, admission, discharge, and biopsies. Preceptorship nurses seen during inspection were still completing their preceptorship competencies and reported they were well supported by their colleagues and managers.
- Medical and nursing staff told us they had received revalidation support from colleagues and senior staff. Staff were up to date their professional revalidation. This meant we were assured the service had appropriate measures to ensure all staff were up-to-date and fit to practice.
- We saw all medical staff working or practicing under rules or privileges had completed their professional revalidation. The medical advisory committee (MAC) reviewed each application for practicing privileges. The MAC advisory function covered granting, renewal, restriction, suspension, and withdrawal of practicing privileges. Consultants completed their annual appraisal at their individual NHS trust and kept up to date with CPD through regular attendance at national and international meetings.
- There were processes in place for managing staff appraisals. The appraisal rate was 76% compliance for the nurses and HCAs and 60% for the inpatient staff while the nurses in theatre and endoscopy staff achieved 70% compliance. The oncology staff told us their appraisal was not up to date as the lead oncology nurse was not trained to do their appraisal and their previous clinical lead had left the hospital in September 2018. Following the inspection, the hospital told us the appraisal completion was on-going completion and all outstanding appraisals would be completed by the end of June 2019. The nurse in charge and the senior nurses completed the appraisals of the HCAs.
- The RMOs were supported by an allocated medical staffing manager assigned by their agency that provided mentoring and carried out their annual appraisals.
- Medical staff had attended an orthopaedic conference for GPs and a monthly GP education events run. This was highlighted as one of the hospital 2018 key success.
- The pharmacy team updated their skills and competency through evidence-based practice and best practice. the pharmacy staff kept up to date with latest medicines guidance, trends through the pharmacy journal which were shared with colleagues and other MDT staff. For example, the pharmacy discussed and shared a recent article by the NHS Improvement on medication errors.

- The pharmacy manager was on a Chartered Management Institute (CMI) level 5 course which was funded by the hospital. The manager reported good support with the training from the executive director.
- Physiotherapist had their Health and Care Professions Council (HCPC) revalidation every two years. They also had monthly peer review and were required to shadow and evaluate each other, which was included in their CPD. Physiotherapy staff told us they had access to lots of orthopaedic training and external training on respiratory disease and monthly seminars to discuss trends and up to date practice on physiotherapy. Staff told us they had a bi-monthly system where staff that had attended any training or seminars would teach their colleagues what they have learnt. Topics that had been covered through this forum included manipulation, paediatric course, and respiration.
- The IPC link practitioner had attended an aseptic non-touch technique (ANTT) conference in December and BMI were looking at achieving a gold accreditation in 2020 to improve patient outcome.
- The IPC lead nurse held monthly IPC link nurses meeting across the hospital sites to strengthen the link nursing group support and provide a forum for training and guidance. The group shared local best practice and reviewed latest national trends and guidance.
- The hospital had rolled out customer care training for all staff as part of an initiative to improve staff communication and patient experience.
- Staff had also received a falls refresher following recent falls incidents and 16 staff had completed the falls training facilitated by the physiotherapist in February 2019.
- Staff told us they have received training on sepsis and continue care deteriorating patient (CCDP). The hospital had sepsis week where information on sepsis were displayed around the hospital to educate patients, visitor and staff on sepsis and trends.
- Staff were required to complete a controlled drug competency and the February 2019 team meeting showed that all staff had completed their competencies.
- In the oncology, an HCA was currently on a nursing course and supported by colleagues and clinical ward manager in their clinical practice.
- Oncology staff had attended external Macmillan study days in the last 12 months before the inspection.
- The endoscopy unit was staffed with senior scrub nurses, recovery and preceptorship nurses who were trained theatre nurses and had not received formal and additional training in endoscopy.

Multidisciplinary working

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

- The medical service multidisciplinary team (MDT) worked together and with external professionals and hospitals to improve patient care and outcomes. Doctors, nurses, pharmacists, CNS, health care assistants, physiotherapist, dietitian, and the occupational therapist (OT) supported each other and were involved in assessing, planning, and delivering patient care and treatment. We saw there was good liaison and collaborative working between the MDT which was evident in the patient notes reviewed. The service also worked closely with social services, insurance company and local NHS hospitals.
- All oncology patients were discussed at a weekly MDT meeting which was attended by the referring consultant, breast surgeon, radiologist, histopathologist, specialist nurses, physiotherapists, occupational therapists, dietician radiographers and SACT pharmacist. This MDT group discussed the care and treatment of their current cancer patients.
- MDT staff we spoke with reported good working relationships with each other and other hospital services. During inspection we saw that a medical patient on the ward had been seen and assessed by other MDT professionals such as a cardiologist, dermatologist, and vascular surgeon to plan the delivery of their care before discharge.
- There were various meeting attended by MDT staff to discuss and improve patient care such as the daily morning 'comm cell' meeting, afternoon 'safety call meeting', ward rounds, daily board round and resus meetings and antibiotics and sepsis meetings. The hospital introduced a **'**daily board round' on the ward as part of the multidisciplinary approach to patient care to ensure care needs were met and the best outcomes for the patient.
- The safety call meeting differed from the morning comm cell meetings as it was safety focused. The RMO and representative from all MDT team and departments

such as endoscopy, oncology, theatre, and IPC attended the meeting. The standard items on the safety call meeting agenda included discussion around deteriorating patient, safeguarding concerns, resus meeting, ward admission since the morning comm meeting, any surgical and endoscopy procedures after 4pm, staffing issue and need for temporary staff, incidents that had occurred or reported, expected day cases and overnight admission, equipment issues, complaints, staff accidents, on call manager and other hospital business.

- The comm cell meetings are a daily operational status meeting for the local BMI hospitals, linking Cavell and King's Oak Hospitals by telephone conferencing. During inspection we observed the meeting which was attended by 13 staff including all heads of department and service leads on both sites. Each service lead gave a rapid summary of their service status across the two hospitals on staffing, resources, access and flow and performance. Following the meeting the information brief was also sent out as an email to staff.
- The hospital also held daily resuscitation MDT meeting which was focused on safety emergencies. We observed the resuscitation meeting during inspection and noted that all seven resuscitation team members were bleeped by the switchboard. The RMO briefed each staff about their role at any potential arrest call for that day. The meeting was very brief and finished within eight minutes.
- The daily ward and board round meetings were attended by the RMO, nurses, nurse in charge, pharmacist, and physiotherapist to discuss patient care and progress and agree on discharge.
- Staff attended a daily antibiotics and sepsis ward round meeting which was introduced since October 2018. This meeting feeds into the bi-annual Commissioning for Quality and Innovation (CQUIN) antimicrobial data collection audit. The hospital attended regional pharmacy meetings where audit, trends and performance data were discussed.
- The endoscopy lead nurse attended bi-monthly national BMI endoscopy meeting for leads where the group discussed different topics usually related to JAG accreditation.
- There were receptionists on the ward that worked with other MDT staff in improving patient pathway and experience through the booking of patient appointment and porters, oversight on the clinical list, arranging ambulance and patient transport, orienting patient on the wards and sending patient discharge information to the GP.
- There was pharmacist support on the ward and they provided information to patients on their medications. The pharmacist attended the ward rounds and MDT meetings such as the oncology MDT and comm cell meetings.
- There was a dedicated fulltime physiotherapist on the ward who worked Monday to Friday, 9am to 5pm. The physiotherapists were mostly involved with the surgical patients that have undergone hips, knees, shoulders, or hand surgery. They were also involved in the pre and post-operative assessment and care. The physiotherapy team had a hand over book and received handover from their colleagues and the nurse in charge at the beginning of their shift, which helped them to prioritise discharges and patient assessments. The physiotherapists also carried out follow-up telephone calls to patient following their discharge to ensure they were recovering well and no complication.
- There was access to an on call occupational therapist (OT) and dietitian on the ward through referrals. Patients were assessed by the occupational therapist during admission with patient ordered equipment delivered before patients discharge home.

Seven-day services

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

Good

Medical care (including older people's care)

- There was 24-hour access, seven days a week to the diagnostic services such as x-ray, ultrasound, and pathology. All inpatient imaging requests were actioned within 24-hours.
- A senior nurse in charge was available as a contact point for staff, consultants and patients and was available via bleep or telephone.
- Specialist nurses supported patients who received chemotherapy Monday to Friday between 9am and 5pm. If a patient needed to be admitted overnight the specialist nurses handed over their care to the inpatient services.
- There was a dedicated endoscopy unit in the service. The unit was open Monday to Friday 8am until 8pm. There was no endoscopy service available over the weekend.

Health promotion

- Staff supported patients who accessed the medical service to live healthier lives and manage their own health, care, and wellbeing. Staff gave health promotion advice with leaflets given in line with national priorities to patients and their relatives on various topics such as smoking cessation, obesity, exercise, breast screening, prostate cancer, heart awareness, alcohol reduction and healthy eating.
- The hospital carried out a health promotion on heart awareness in February 2019 as part of the national heart month programme. The hospital reported that following the assessment 37% of patients were diagnosed with hypertension, 37% had elevated cholesterol, 15% had significant valve disease and required echo surveillance and 4% had dilated heart artery that required computerised tomography (CT) scan.
- The oncology nurses gave health promotion advice on what patients could do to improve their health and well-being such as healthy eating and exercise in chemotherapy to improve their treatment and positive thinking.
- The hospital carried out an heart awareness week in 2019 for the local population to receive an assessment of their heart and advice on loving health life.
- The hospital tobacco audit for the period of April 2017 to March 2018 showed an average of 98.4% compliance on smoking assessment and advice.
- The alcohol audit for the period of April 2017 to March 2018 showed an average of 99.7% compliance on the standard audited.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

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

- There were systems and processes to obtain consent from patients before carrying out a procedure or providing treatment. Staff understood their responsibilities regarding consent. We saw that there was an up to date consent policy for staff. The hospital data showed that staff achieved 100% compliance in their mandatory consent training.
- Staff obtained verbal and written consent from patients prior to the delivery of care and treatment. Patients we spoke to told us staff gave them enough time to ask questions and they received the verbal information needed to give informed consent. Staff explained sedation in depth before obtaining patient consent to administer the sedation. Consent to endoscopy and chemotherapy treatment were obtained by staff and documented in the patient notes we reviewed which was in line with best practice and national guidance.
- The hospital included a consent form in the 'carers and comforters folder' for patients and their relatives to give their consent when a loved ones wishes to be with the patient during diagnostic procedures such as x-ray. Patients relatives were advised of the risk involved with exposure to x-ray before they consented.
- **Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005.** They knew how to support patients experiencing mental ill health and those who lacked the capacity to make decisions about their care. There was no patient under the Deprivation of Liberty Safeguards (DoLS) when we inspected.
- When necessary, consultants assessed patient's mental capacity. They could also request a mental capacity assessment from a psychiatrist if they needed further assistance. Information about patient's mental capacity was usually captured during pre-assessment.
- Staff were able to give clear explanations of their roles and responsibilities under the Mental Capacity Act 2005 (MCA) regarding mental capacity assessments and DoLS.

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

Good

Compassionate care

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

- Patients told us, and we observed staff knocked and asked permission before entering patients' room. Patients and their relatives we spoke with told us staff called them by name, knew and remembered them which made them feel valued and respected. Patients told us they remembered the names of staff involved in their care. This was also evident in the thank you and feedback cards reviewed.
- Patients spoke positively about the care they had received, staff politeness, would recommend the service to other and their dignity had been maintained during their stay.
- Patients' privacy and dignity was respected, especially during physical or intimate care. The ward environment ensured privacy as there were only single occupancy rooms. The HCA acted as chaperone when patient were examined by the doctors and nurses, particularly post-surgery.
- We observed an endoscopy procedure and saw that staff were calm, reassured, and supported patient through their diagnostic procedure in a compassionate manner. Patient and relatives, we spoke to in endoscopy, were happy with the experience and care received by the nursing and medical staff.
- The hospital 2018 patient led assessments of the care environment (PLACE) audit showed that the hospital scored 78.5% for privacy, dignity, and wellbeing lower than the national average of 84.1%. As a result, the managers had assigned a designated quite room for patients next of kin and loved ones which will provide a place where discussion with the MDT staff could take place to maintain their privacy and dignity.
- The hospital 2018 patient satisfaction scores showed that 97.9% of patients would likely or extremely likely to recommend the service to their friends and family. The result also showed that 97% of patients had good or exceptional quality of care and 96.6% commented that their expectations were met or exceeded.
- Patients were asked to complete a questionnaire on discharge about their experience, and the results showed high satisfaction in many areas. The 2018 Hospital internal friends and family test (FFT) result showed 37.4% response rate and 98.4% of patients would recommend the service which was better than national average of 97.1%.
- FFT for period of January to February 2019 showed 97% would recommend with a response rate of 66%.
- Patients experience about the service received was positive and complimentary. Specific comments included, "staff go over and beyond expectation to provide a seamless and excellent service", "compassionate staff", "staff respect patients dignity", "happy with care received", "I am very impressed with treatment received today", "all staff are friendly, helpful and wonderful".
- During inspection, we reviewed the completed hospital feedback cards seen on the wards from January to April 2019. There were two hospital feedback forms which patients were required to complete about their experience with the consultants and the wards. There were 62 feedback cards completed on the experience of care provided by the consultants and 86% (53) patients commented it was extremely likely they would recommend the consultants, 11% (7) were likely to recommend while 3% (2) commented neither likely or likely to recommend the consultants. All patients gave positive experience about understanding their treatment, explanation received, given sufficient time during their consultation, and having confidence in the consultants.
- Specific comments seen in the hospital consultants feedback form included "made me certainly at ease", "very pleasant, experienced and knowledgeable", "kind and caring nursing staff", "good care", "very pleasant and quick to deal with my problem", "confident in care received", "staff were friendly and efficient", "excellent surgery, friendly and caring staff", "clean room and

pleasant staff", "all staff were helpful, cheerful and accommodating", "staff work hard to make sure you don't need nothing", "friendly and polite staff who showed good care".

- We reviewed 19 hospital 'in-patient feedback forms' for the same period during inspection. We noted that 84% (16) patients commented they were extremely likely to recommend the service and while 16% (3) were likely to recommend the service. Specific comments about the patient experience on the wards included, "staff were great", "excellent and comfortable care received", "clean and friendly staff", "quality of service and care was excellent", "staff are genuinely caring and polite", "excellent service from start to finish", "staff and service received are of high standard", "friendly, helpful and knowledgeable staff".

Emotional support

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

- Nursing and medical staff showed an awareness of the impact that a patient's care, treatment, or condition could have on their well-being and those close to them. Patients confirmed that all multidisciplinary team (MDT) staff had an awareness of their treatment on their well-being and they were very caring and supportive.
- All the patients and their relatives and carers we spoke with told us they felt supported throughout their journey from consultation, pre-assessment through treatment and therapies.
- Patient we spoke with told us their emotional health and mood had been discussed and assessed by staff. Patients consistently said that they had been offered emotional support and that it was available if they needed it, which have helped help them at ease and less anxious.
- Psychological, counselling and emotional support was available to patients and their relatives following diagnosis of long-term condition. A one-to-one counselling consultation was provided by a psychologist, psychiatrist, psychotherapist, specialist nurse, psychotherapeutic counsellor or consultant. The medical service also signposted patients with long term conditions to other agencies and charities such as Macmillan for additional support and counselling. Staff referred patients to a local Macmillan support centre counselling, complementary therapies as well as symptom control management in the later stages of disease progression.
- Bereavement support was also provided for the oncology patients with referrals to the community services. Where patients disease were progressing and supportive care was needed for symptom control management, patients were referred to the appropriate healthcare facility at an early stage to ensure effective management in the appropriate area and speciality including professional bereavement support and hospice.
- The service had a breast care nurse on the oncology unit that also provided on-going emotional and psychological support tailored to each patient diagnosed with breast cancer. The nurse also invited patients to a monthly patient support group where support were provided by professionals and other patients.
- Prior to starting any systemic anti-cancer treatments, patients were pre assessed and their psychological needs were addressed at this stage. Information leaflets were given to patients for local charitable organisations to access further emotional support and complementary therapies.
- The nurses within the team also attend breast and oncology clinics to support patients when they were given clinical information with regard to their initial diagnosis and ongoing treatment and follow up.
- Senior manager told us the oncology wards provided a range of anti-cancer therapies to treat a wide range of both haematological and oncological disease such as breast, bowel, bladder cancers.
- Patients were given the department phone number to use if they required and they could call staff on the wards seven days a week for support.

Understanding and involvement of patients and those close to them

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

- Patients relative we spoke told us they had been kept informed of their care and recovery of their loved ones. We saw evidence of patients and relatives been involved in the care of their loved ones in the patient notes.
- Staff spoke passionately about the importance of updating patients and their relatives about the care, recovery, and discharge process and how it impacted on patient care and experience.
- We observed patient clinical procedures and handover and noted the consultant had clear communication with patients and explained their findings and treatment plans in detail in a way they understood. We saw that staff took their time to explain information to patients and involved them in their treatment plans.
- Specific comments from the patient including feedback from the thank you and feedback cards included, “extremely knowledgeable”, “spent time explaining any questions asked”, “everything was explained to me”, “staff listened to my concerns”, “consultant gave feedback regarding my procedure after surgery”, “very efficient and discussion were straight to the point”, “excellent consultation, advice and continued follow-up”, ““not felt rushed by staff”, “very informative staff”, “Was kept informed about proceeding”, “as a family member I am happy with everything and had been kept informed”.
- The hospital 2018 patient satisfaction dashboard showed that 89.3% patient commented they were kept informed on what was happening by the physiotherapist which was a 23% increase from the previous year. The result also showed that 89.2% patient had received an information pack from the hospital which was 11% increase from the previous year. We noted that 93% of patient commented they were kept informed on what was going on during their diagnostic investigation and this was a 15% increase from the previous year. However, the result showed 40.4% of patients in the hospital had received a follow-up telephone call.

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

Good

Service delivery to meet the needs of local people

The medical service planned and delivered care in a way that met the diverse needs of the population of patients who accessed the service. Patients’ needs and preferences were considered and acted on to ensure services were delivered to meet those needs.

- The service also worked with their stakeholders such as the insurance companies and their commissioners in the planning and development of the service. The commissioners included several CCG groups such as Enfield CCG and Barnet CCG, NHS England and NHS hospitals.
- Senior managers reported good relationship with their local clinical commissioning group (CCG) in the planning and delivery of care. This was highlighted as one of the hospital strengths and achievement in the hospital 2018 business plan.
- The BMI website had an on-line query form and a life support webchat which was encrypted which patients could contact the hospital for advice and support about the service or care.
- All patients’ rooms were single en-suite and there were no restricted visiting times for patients. Patients and their relatives told us that there was good access to food and drink provisions in the hospital.
- The hospital offered inpatient medical care service and day patient facilities to medical patients on the Hadley and Ridgeway wards.
- The endoscopy unit did not have Joint Advisory Group on gastrointestinal endoscopy (JAG) accreditation and was working towards achieving this.
- The hospital had clear plans for delivering its commitments as part of the Local Cancer Alliance goals and had links with the leading cancer support charity to plan the delivery of care and treatment for patients diagnosed with cancer. The hospital had plans in expanding the oncology service and increasing the opening hours. The oncology cases were 80% breast, 5% colorectal, 5% prostate and urology, 5% haematology and 1% lung cases.
- At this inspection we saw that the hospital no longer provided an end of life service provision. The hospital had networks with local hospices and NHS hospital patients would be referred to for end of life provision. However, senior managers told us if they had an end of life cancer patients that wishes to receive end of life

treatment in the hospital and had declined referrals to hospices or local hospital. They will honour the patient wish if they decided to spend their last days in the hospital and will be cared for by the oncology team.

Meeting people's individual needs

The service took account of patients' individual needs.

- The needs and preferences of patients were considered when delivering and coordinating services, including those who were in vulnerable circumstances or had complex needs. Care and treatment were coordinated with other services and stakeholders, to ensure the needs of patients and their families were met.
- The medical ward environment was spacious with clear signage and patients felt it had a relaxed and homely feel. There was wheelchair access to the wards and the patient rooms were ensuite with accessible toilets which were suitable for people with reduced mobility. However not all rooms had showers or bath tub and patients in this rooms would use a general wet room. Staff told us these rooms would be assigned to the day cases patients that may not require the use of showers or bath.
- The service recently purchased a large wheelchair to meet the needs of bariatric patients.
- Staff told us they rarely had vulnerable patients that accessed the service and mostly see patients with mild cognitive impairment. However, they have provision in place to meet the needs of patients that are vulnerable or with complex needs. For example, the service had a dementia box, red clocks and 'this is me' for patients with dementia. As part of the hospital refurbishment plan, there were plans to design two patients rooms as a designated dementia rooms with the use of appropriate colours, toilet seats and option to cover the mirrors. The hospital also had a hearing loop recorder to support patients who are hard of hearing and text messages were used to remind patients of appointments.
- Staff we spoke with had a good understanding of meeting the needs of patients living with dementia and the hospital had policies and strategy to improve quality of care of patients living with dementia and for their relatives and carers. Staff encouraged relatives and carers to stay with a patient living with dementia to provide on-going support and help in reducing their anxiety. Patients with dementia were also encouraged to bring comforting items from home to reassure them and make them comfortable during their stay in the hospital.
- The patient led assessments of the care environment (PLACE) 2018 audit result for the dementia provision showed the hospital scored 79.6 which was better than national average of 78.9%. The hospital had introduced a mandatory e-learning dementia course for clinical staff and appointed a local dementia champions on the ward to increase awareness and improve service provision. The hospital data showed that the dementia training was 100% in all medical areas.
- In the hospital 2018 standard of care audits, the hospital scored 94.9% in the hospital responsiveness to the personal needs of its patient which was better than the national average of 69.2%.
- The pharmacy team had implemented a 'medication record card' for patients with dementia, learning disability and confused patient. This was to improve their understanding on their medicines and reduce medicines related incidents. Information on the medication record card included the drug name, useage, indication and remarks.
- Interpreter services were available for patients for whom English was not their first language if required. These were provided face-to-face or via a dedicated telephone interpreter service and staff were always able to access interpreters. Interpreting service request were booked by the receptionist. We were told translators were used when obtaining consent and when patient had their surgical or endoscopy procedure. Staff consistently told us patients relatives or loved ones were not allowed and used to interpret in accordance with their policy. We noted during inspection that staff had arranged an interpreter for a patient whose first language was not English.
- Patient had a choice of meals, which took account of their individual preferences, respecting cultural, medical, nutritional, and personal choice such as halal, diabetic and kosher meals. Patients could order food at any time and outside of set meal times. Patients could order from the menu list and were they wanted something different staff would place an order to the catering staff. Specific comments from patient about their meals included, "great tea", "great food and beverage".

- Follow up appointments were given to patients in timely manner during clinic consultation and we saw that staff accommodated patient preferences and commitments.
- Patients told us that staff responded to their call bell promptly and they were given adequate pain medication in a timely manner. Specific comment included, “staff are very attentive and come straight away when you press the bell”. During inspection we observed that staff including the administrative staff responded to patient call bell promptly.
- Consultants visited their patients daily during the ward round with the nurse in charge present, which ensured patients had opportunity to discuss their care and needs.
- The endoscopy recovery room had a three bays bed space and we saw there was no mixed gender in the unit during inspection. Staff told us endoscopy appointments were well planned to ensure there was no mixed sexes in the recovery area at any time.
- The PLACE 2018 audit result for the provision of ward food was 99% which was better than national average (91%).
- The PLACE 2018 audit result for the disability provision was 79% which was worse than the national average of 84%.

- Patients relatives were offered refreshment while they wait for the patient whilst having their treatment or procedure.
- Patients were met by the administrative staff on the ground floor who would escort and orientate them to the wards.
- Staff were able to support in arranging a funeral and chaplain for bereaved families, although families usually arranged this. There were also various leaflets for deceased families on the wards
- The inpatient service had a quiet room for breaking bad news to patients and those close to them.
- There was a separate dedicated quiet room within the oncology department for patients to sit and talk to one of the team about any concerns or worries that they have.
- Information booklets and resource packs were provided to patients in the medical areas. In the oncology unit we observed displayed leaflets on pampering therapy which include information on workshops for patients on ‘make up to feel good about themselves’ and leaflets about available support from charities such Macmillan and a Jewish community support for cancer patient. There was also information about a local charity that provided clinical and home visiting support, therapies, group activities, cancer support groups, also have various Macmillan leaflets. There was also information on the drugs patients were receiving and various booklets about their diagnosis, treatments, side effects as well as information on practical issues such as financial support, travel advice and hair care.
- The hospital did not have a scalp cooling facilities for patients but referred them to other services within their BMI network. The scalp cooling facilities such as cooling machines can help cool the scalp of patients undergoing chemotherapy so they don’t lose their hair and can be used before and during treatment. However the scalp cooling was part of their development plan to enhance the services offered within the oncology department. The hospital provided a bespoke breast prosthesis for patients with breast cancer. Patients were signposted and given information on where they to access wigs and scarves including financial help.

Access and flow

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

- The hospital had a hospital admissions policy that outlined the admission criteria that ensured suitable patients were admitted to the ward. For example, the hospital did not admit patient with acute cardiac, stroke and renal condition into the service. Medical patient admitted on the ward mostly included vascular patient and infection such as cellulitis, diverticulitis, pneumonia and other chest infections.
- Patients were admitted under the care of a named consultant following completion of a booking form. The consultants reviewed patients prior to commencement of each treatment and provided a 24 hour on call service as and when required.
- For the period of March 2018 to February 2019 the hospital Inpatient mix overnight was 49% NHS and 51% non-NHS and proportion of all-day case that stayed overnight was 24% NHS funded and 14% non-NHS patients. For the same period, the hospital reported 675

patient discharges for 18 to 74 years old and 189 discharge for patients 75 years and over. The hospital reported 2881 day case discharges for 18 to 74 years and 427 for 75 years plus.

- For the period of October 2015 to September 2016 the hospital reported 208 episodes of care carried out by consultant with practice privileges.
- From April 2018 to March 2019, there were 45 medical admissions in the service and which mostly related to chest infection, urinary tract infections and cellulitis.
- In the last months before the inspection, there were 1,656 oncology cases of which 28% were inpatients and while 72% were day cases.
- Patients repeatedly told us that they had good access to the hospital and did not experience prolonged delays to be seen.
- Following referrals to the therapists such as physiotherapist and occupational therapists, patients were seen the same day or within 24 hours. The physiotherapist saw patient same day following referral and were informed before the admission of surgical patient which ensured timely access, assessment and discharge post-surgical operation.
- All medical patients admitted on the wards and endoscopy unit were private patient and while the endoscopy patients were a combination of private and NHS patients. Patients referred by their GP for endoscopy procedure could book a convenient date and time for their appointment through NHS ‘choose and book’ electronic booking system. The private patients were mostly self-pay and insurance patients. During inspection, there were no general medical patients admitted on the inpatient wards. Staff told us they had a medical admission the previous week for chest infection. The ward had seven surgical patients admitted on the wards including one admission that morning. Staff told us two patients would be discharged later in the day.
- The hospital reported that 750 patients underwent endoscopy related procedures across both sites in the last 12 months before the inspection.
- Between April 2018 and March 2019 a total of 1,746 endoscopies were undertaken. Most patient underwent colonoscopy (32.8%), oesophago-gastro-duodenoscopy (OGD) and forceps biopsy (32.6%), OGD and colonoscopy (10.9%), flexible cystoscopies (9.1%) and diagnostic flexible sigmoidoscopy (7.7%).
- All NHS referral to treatment times (RTT) met the target rate and better than the national average of 72% for the admitted pathway.
- Bed capacity planning meetings took place weekly and representatives from each clinical area were present. This ensured that heads from all clinical areas were aware of the issues around the hospital and could offer further assistance by way of additional staff if necessary.
- For the last 12 months before inspection the average length of stay was 2.4 days. The length of stay for medical patients varied from hours to a week depending on the reason for admission and agreement with the insurance company. Staff told us the discharge process was effective and they had few cases of delayed discharge.
- To take away (TTA) medicines were stocked on the wards to dispense out of hours and prepared the day before discharge to prevent delayed discharge.
- For the period of May 2018 to April 2019, the hospital reported five cancelled endoscopy procedures. The reasons for cancellations were mostly related to clinical and safeguarding reasons such as patient feeling unwell and patient not meeting sedation criteria.
- Staff we spoke to told us they had few cancellations and reasons were related to non-compliance of patient such as nil by mouth before surgery, patient was unwell, did not attend (DNA), patient no longer require the surgery or treatment and use of aspirin before coming for surgery. Staff told us when cancellation occurred due to patient sickness the booking form were sent to the reservation team who contacted the patient when they were well. The patients would go through pre-assessment again to ensure they are safe and fit for their clinical procedure. Staff told us there were hardly any cancellations of procedures and may have an average of two cancellations in a month for the medical and surgical services.
- The hospital reported that there 47 occasions were patients did not attend (DNA) their endoscopy procedures across both hospital sites in the last 12 months before inspection. No DNA reported for the oncology service within this period.
- The oncology unit was part of the main ward and had five dedicated en-suite rooms for cancer patients. The unit was opened Monday to Friday from 8am to 5pm and with most patients finishing their treatment by 3pm.
- The endoscopy unit was opened five days a week from 8am to 8pm depending on acuity. Procedures

undertaken in the unit included gastroscopy, colonoscopy, oesophageal dilatation, prostatic biopsy and flexible cystoscopy and bronchoscopy and video capsule. During inspection, we saw that majority of patient seen in endoscopy came for diagnostic colonoscopy or flexible sigmoidoscopy.

- Staff told us there was no turnaround time between patients in endoscopy. Staff felt booking was erratic and the consultants booked procedures to suit their availability. Staff told us that sometimes the clinic can be either overbooked or under booked depending on the consultants. As a result, the clinic may finish around 9pm and sometimes staff may experience delays having their lunch break. The patents that accessed endoscopy were 50% NHS funded and 50% private patients.
- Staff did not record and monitor how long patients waited for treatment on the day of their appointment, therefore were unable to establish the extent to which services ran on time. The clinic generally ran on time in the oncology and endoscopy units. There was a 30-minute delay on a morning endoscopy clinic where the consultant arrived late. Although we noted that by midday, staff were running on time at this clinic and the initial delay did not had major impact in the access and flow of the service. The unit had three recovery bays and patients were in recovery for approximately 30 minutes and there were no delays in transfer to the wards.

Learning from complaints and concerns

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

- For the period of March 2018 to February 2019, the hospital received 50 complaints across the hospital departments. The hospital reported no referral to ombudsman or independent healthcare sector complaints adjudication service (ISCAS).
- There were processes in place to ensure complaints were dealt with effectively. Information was displayed and provided to patients on how to report concerns and make a complaint. This was an improvement from the last inspection. Patients and relatives could make a complaint verbally or written, by face to face contact, telephone calls or through the hospital website.
- We saw there were leaflets on the wards with information on how to make complaints with details on the complaint process and how to contact other agencies if patients were not pleased with the hospital response. There were patient feedback forms on the wards to capture negative feedback.
- Patients we spoke with knew that they could make a complaint if they wanted and said they were comfortable bringing up issues to staff. This was an improvement from the last inspection. There was a duty ward manager at the hospital daily who patients or visitors could speak too if they had any concerns or compliments.
- Staff understood how to handle complaints, including out of hours.
- Nurse in charge introduced themselves to patient, which ensured patients knew who they were and the point of contact to make complaints or escalate any issue they might have.
- The hospital had a regular patient satisfaction group where staff representative from each site were required to attend and meet with patients to obtain their feedback.
- We saw examples of actions being taken in response to complaints received about patients' mattress which had now been changed. The hospital had also changed 80% of the blinds on the ward bedrooms following complaints received that the blinds were not sufficient to ensure patient privacy.
- Top five hospital complaints in 2018 were communication, clinical care and treatment, billing and payment process, complaint management and professional conduct.
- We saw evidence that complaints were reviewed and discussed at various governance meetings. Feedback detailing learning outcomes from complaints and concerns was communicated to staff at hand overs and team meetings. As a result of learning from complaints the ward introduced hourly nursing rounds to provide patients with regular contact with a member of staff throughout their stay.

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

Good

Leadership

Good

Medical care (including older people's care)

The medical care service had managers at all levels with the right skills and abilities to run a service and provide high-quality, sustainable care. There was a clear management structure within the hospital and service with defined lines of responsibility and accountability, and clear lines of communication with the executives. The leaders were passionate about the service provided and knowledgeable about their risks, quality issues and priorities, understood what the challenges were and acted to address them.

- At the last inspection we had concerns about the leadership, governance process and patient engagement in the service. During this inspection we saw improvement and the concerns had been or being addressed. There was good representation of all executives at various governance meeting and changes to the leadership and governance structure.
- The leaders at every level prioritised safe, high quality, compassionate care and promoted equality and diversity. The leadership model of the service encourages cooperative and supportive relationship among staff and patients so that they felt respected, valued, and supported.
- The medical services were led by a senior management team consisting of an executive director, director of operations, director of clinical services, clinical service managers and a quality and risk manager. One of the executives was a registered practitioner with senior clinical leadership experience which ensured they were competent in their role to lead and support clinicians. There were appointed clinical service managers for the wards and pharmacy that covered both hospital sites. Consultants, resident medical officers and senior nurses supported the senior management team.
- The oncology service was led by the clinical services manager with support from the MAC representative for systemic anti-cancer therapy (SACT), senior oncology nurse, medical staff and some of the senior management team such as associate director of nursing.
- Since the last inspection, the hospital had recruited new executives such as the director of clinical service to strengthen the governance framework and leadership. The hospital introduced a new on-call rota process in April 2019 which required the presence of an on-call mangers to support staff and be present in clinical areas on Saturdays. This was an improvement since the last inspection.
- The executive director reported to the corporate regional director and had a bi-monthly one to one meeting and a bimonthly meeting of all regional executive directors.
- The executive director told us that medical staff supervision had improved since the appointment of a new MAC chair person in 2018. They said there was an issue with getting enough doctors to be part of the MAC and were trying to encourage new members. The ED said they aimed to ensure the MAC was representative of the consultant body and that they had a good range of consultants including anaesthetists and surgeons of different specialties. This was an improvement from the last inspection. However, the MAC was currently all-male staff and the ED was working to change this and two female consultants were about to join the committee. The MAC meetings now had a standing agenda and some representatives of medical staff. This was an improvement from the last inspection.
- Staff including the senior nurses and clinical service manager told us the executives were visible, accessible, and supportive, and encouraged their career progression. Staff felt the management team were interested in the medical and surgical services and attended their team meetings.
- The theater manager who covered the endoscopy unit was unavailable during inspection. Staff told us the previous endoscopy lead resigned in February 2019. In January 2019 the hospital created a new clinical services manager role in Endoscopy and recruitment was ongoing due to poor response and suitability of applicants. This was on the hospital risk register.

Vision and strategy

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

- The hospital had a five-year vision for 2015 to 2020 which was achieved through their eight strategic objectives and priorities. The objectives and priorities included patients, people, communications, growth, governance, efficiency, facilities, and information. This

was achieved through their strategies which included delivering the best clinical outcomes through best practice pathways. The strategies were also achieved by developing staff to be skilled and competent in their roles, listening and adapting staff feedback, enhance communication through better use of digital technology and apps and extend the range of services provided to meet the health care demand. The hospital also aimed at having a clear evidence of meeting standards through integrated audit results, improving patient experience, investment in new medical technology and equipment and improving the look of the hospital through refurbishment. The strategy also included improving patient management by moving to electronic records, to provide ease of key information through a new staff intranet and enhancing staff and patient connectivity with digital technology.

- The oncology department strategy was aligned to the Department of Health Improving Outcomes Cancer Strategy and the BMI national cancer strategy. The newly appointed director and associate directors of clinical services would be working on developing a local hospital strategy with support from the other BMI hospital sites to ensure consistency.
- The BMI objectives for the cancer services was to be the leading provider of cancer services in the UK, a first choice for patients, Project Management Institute (PMI) funders and NHS commissioners where appropriate. This would be achieved thorough their national cancer strategy:
- To provide a fully equipped, capable and comprehensive range of Cancer Services, promoting innovation and productivity.
- To ensure a high quality, seamless patient journey through cancer diagnosis, treatment and beyond, ensuring the best possible outcomes for BMI patients.
- To increase Cancer Services market share and revenue generation, while ensuring efficiency in delivery.
- To work in partnership with consultants who are comfortable directing patients to the BMI Cancer Alliance.
- The hospital vision was to deliver the best patient experience, in the most effective was from their comprehensive UK network of acute care hospitals. They aimed at delivering the best possible patient outcomes and experience across all groups by consistently delivering quality care and services in a cost-effective way.
- The oncology departmental vision was to continue to promote and expand the services that they currently provide and potentially have a separate purpose-built dedicated oncology unit. To improve on treatments and patient outcomes in line with current and future developments in cancer research outcomes.
- Following the inspection the provider made immediate plans to enhance the capability of its staff in dealing with the clinical management of oncology. This included additional internal and external training.
- The hospital priorities for the medical services included recruitment of nursing staff into pre-assessment and endoscopy and creating a clinical service manager post for the endoscopy services. The hospital also aimed at expanding the oncology services and to develop an end of life services in oncology.
- The six Cs nursing values which included compassion, competence, care, communication, courage, and commitment were displayed throughout the hospital to encourage staff to embrace these values to improve practice and patients experience.

Culture

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

- Staff we spoke with had a strong commitment to their job and were proud of the team working, continuity of care, service delivery, positive impact to patient care and experience, and improvements they had made to the service since the last inspection.
- Staff told us they love working with patient and were proud of the high standard of care given to patient which gave them job satisfaction.
- All staff we spoke with described good teamwork and respect within the medical service and across disciplines and gave examples of good team working on the wards between staff of different disciplines and grades. Staff felt respected and they could approach any member of staff and challenge practice or behaviour if necessary.
- Staff told us they felt supported and valued by colleagues and senior managers and there was drive for learning and progression. For example, we saw a staff that had been promoted and trained from a porter to a health care assistant and an administrative lead had progressed from a receptionist role.

Good

Medical care (including older people's care)

- The hospital celebrated staff and team success through various star awards and displaying of team success. Staff success were also celebrated at the daily communication meeting and hospital newsletter. The hospital newsletter also highlighted and celebrated staff that were newly recruited, or maternity leave or retired.
- There was good staff turnover and some staff had been working at the hospital for several years and reported good job satisfaction and progression. For example, we saw staff that had been working in the hospital for 15 and 17 years.
- Staff spoke positively about the culture and support from their colleagues and managers. Specific comments included, "real team here who are passionate about patient care", "good and supportive team in oncology who supported each other", "no bullying and harassment", "we work and get well together as a team", "good team environment", "love working here", "amazing support from colleagues and managers".
- Staff told us there was a no blame culture when incidents happened, and the team supported each other. Staff were able to raise concerns when needed. The duty of candour was implemented in the service and we saw that cases that met the duty of candour were reviewed and monitored at the governance.
- The hospital had a freedom to speak up guardian. Senior managers told us the service was committed to continuously improving patient safety and staff experience by ensuring that all staff could speak openly about things that went wrong or the things that worried them. Staff we spoke told us they were able to raise concerns and knew who their speak up guardian was.
- There was a high level of staff satisfaction across all disciplines and equality groups. Staff reported good morale and support on the wards and oncology unit however there was low morale among some staff in the endoscopy as there was a temporary gap in leadership and due to not having sufficient lunch break when clinics were overbooked by some consultants.

Governance

The service systematically improved service quality and safeguarded high standards of care by creating an environment for excellent clinical care to flourish.

- The service gained assurance through various governance meetings such as the clinical governance committee, health and safety committee, MAC meeting, senior management meeting, infection prevention control (IPC) meeting and the cross site departmental meeting.
- The hospital governance meeting was held regularly to review all incidents, significant events, audits, complaints, compliments, patient satisfaction and practice privilege.
- The clinical governance committee meeting was a cross site meetings and held monthly. This meeting was attended by all hospital departmental leads and executive director, director of clinical services and pharmacists. Agenda included the CQC action plan, update from the local hospital clinical governance reports, update from the hospital quality and risk management report, incidents case reviews and learning, pre-assessment, medicines management, staffing, policies, health promotion, clinical bulletin, national safety alerts, dashboards, complaints, risk register, patient satisfaction and unplanned transfers. In the February 2019 meeting minutes, we saw that local policies and some clinical guidance were reviewed by the committee.
- The monthly cross site departmental team meeting was attended by staff and the clinical service manager to review staffing, risk register, finance, audits, risk assessments. Other items on the agenda included journey to outstanding, key messages, IPC, patient satisfaction and complaints, training, clinical governance, policies, and procedures. We noted that the February 2019 minutes highlighted that the new blood transfusion audit and pathway were in progress across the hospital. Action plans were developed at the end of each meeting and assigned to staff.
- Other governance committees included head of department committee, senior management committee, hospital governance committee and hospital health and safety committee.
- The hospital governance meeting was held regularly and included discussion on incidents, significant events, audits, complaints, compliments, patient satisfaction and practice privilege.
- The senior management committee meeting was held monthly and attended by the hospital executive teams such as executive director, director of operation and quality and risk manager. The meeting's agenda included review of action from previous meetings, complaints, review of practice privilege, finance, new

legislation and corporate policies, significant events, executive monthly reports, facilities and estates, audits result, business development and key projects. In the February 2019 meeting minutes, we saw there was a discussion plan on merging patient medical record into one number which would be discussed with stakeholders to prevent missing files.

- The medical advisory committees (MAC) meetings were held quarterly and oversaw the renewing of consultants' practicing privileges, clinical governance issues, key policies and guidance and monitored patient outcomes. This was a cross site meeting and attended by executive team, MAC chairman, consultants in various department, quality and risk manager and GPs. There was representation from the medical services for example the consultant haematologist and urologist attended the February 2019 meetings. This was an improvement from the last inspection. We saw that younger consultants were encouraged to join the MAC committee and staff were encouraged to complete consent forms. Discussion also include scope of practice, executive directors report, hospital improvement, medicines, reports from clinical governance, updated policies, accreditation and booking forms. Practice privileges were granted after submitting a curriculum vitae (CV) and two referees to the general manager who then interviews along with the chairman of the MAC. Privileges were reviewed and renewed annually according to evidence of appraisal, revalidation, General Medical Council (GMC) membership, mandatory training completion, and sufficient evidence of good conduct.
- The oncology services reported on their performance and outcomes at various governance meeting such as the MAC meeting, cancer strategy group, clinical governance meetings, cancer clinical development group and cancer services cluster meetings. The oncology department had five consultants with specialities in areas such as haematology, prostrate, gastroenterology, lung and breast cancers that participated in various multi-disciplinary team and governance meetings in the hospital and other NHS hospitals in their region.
- The administrative leads also attended the monthly administrative leads cross site meetings where issues around staffing, work and patient's pathway were discussed.
- The hospital also held regular radiation protection and medical exposures committee meeting which were attended by MDT staff and department including endoscopy, consultants, risk manager and executive director. Discussion included audits, clinical bulletin, reporting turnaround time, information governance, risk assessments, incidents, Ionising Radiation Medical Exposure Regulations (IRMER) updates, training, laser, and radiation protection update.
- The infection prevention and control (IPC) committee meeting were attended by executives and representative from various MDT staff and department such as head porter, microbiologist, physiotherapist, nurses, and doctors. Standard agenda included water safety committee feedback, surveillance reports, progress on IPC annual work plan, mandatory training, waste, link practitioners, decontamination, risk register, projects, antimicrobial stewardship, occupation health and actions from previous meeting. The January 2019 meeting minutes included educating staff on flu jabs, BMI learn package to cleaning standards. since the last inspection, an IPC link staff were appointed in each department and cleaning staff had been trained for all scenarios including resistant organism such as C.difficile as part of the 2018 annual plan and knew appropriate products to use. There was a water safety group to ensure compliance with legionella and pseudomonas guidelines and staff such as head porters, executive director and lead engineers had received appropriate training. There was a standard operating procedure (SOP) for dealing with blood or body fluid spillage and staff had received training.
- There was a clinical governance and quality and risk bulletin which was shared to staff and included lessons learnt from incidents and complaints. We reviewed the January 2019 bulletin and saw that items in the bulletin including key learning from other BMI hospitals, linking of patient records to prevent duplication, incidents reporting, latest NICE guidance, policy statements, update on the withdrawal of NMC guidelines for administration of medicine, policy update reminder, clinical service contact details and safety alerts on patient safety, medical devices, field safety, drugs alerts.
- We reviewed the draft out of hours draft standard operating procedure (SOP) for the oncology patients which was written by the lead oncology nurse and waiting for the approval by the clinical governance committees. We noted their was lack of involvement of

the medical advisory committee in developing the oncology SOP which meant the service had not sought professional and expert advice as needed to identify and make improvements. At the time of the inspection there was no finalised local oncology SOP and staff had no clear protocol to guide them in caring for oncology patients.

Managing risks, issues, and performance

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

- The service had clear risk processes and systems for managing performance and identifying and mitigating risks.
- Incidents were reviewed at various governance meeting and minutes of governance meetings we reviewed showed that serious incidents, complaints, and quality audit updates were discussed and shared with staff. Actions taken to reduce recurrence and improve service provision were detailed and any potential serious incidents were escalated appropriately.
- The service had arrangements for identifying, recording and managing risks. The divisional and hospital risk register included a description of each risk, with mitigating actions and assurances in place.
- We reviewed the hospital wide risk register which contained clinical and non-clinical risks. The risk register contained risks that also related to the medical service which included preventable death or injury through no portable ventilator, facilities (heating and water risk), environment, medical gases, carpets, records, recruitment and retention in endoscopy and failure to meet legislative requirement from their regulators. The risk register also included a risk about the current defibrillator which had come to its end of life and the spare parts including the batteries were no longer available from the manufacturers. There was a plan to change the hospital heating system. The risks were reviewed regularly with update of each review documented on the risk register. Staff were aware of the risks on the register and the top hospital five risks were displayed on the wards.

Managing information

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

- During inspection we observed staff treated patient identifiable information in line with the General Data Protection Regulations (GDPR).
- The hospital had effective arrangement to ensure data and notification were submitted and in compliant with the external bodies such as the NHS Health and Social Care Information Centre (HSCIC) and NHS Digital Information Governance Statement of Compliance – information governance toolkit. The hospital reported that their records were in line with data security standards such as the code of practice for information security management.
- Information technology systems were used effectively to monitor and improve the quality of care. For example, the corporate risk and incident recording system provided the hospital with a platform to monitor and assess risks and assess trends.

Engagement

The service engaged well with patients, staff, stakeholders, the public and local organisations to plan and manage appropriate services, and collaborated with partner organisations effectively.
The service obtained and acted on people's views and experiences to shape and improve the services and patient experience. Patient feedback was sought to inform changes and improvements to service provision.

- The service obtained patients feedback through various forms such as social media, NHS choices, BMI website, feedback forms, and the patient satisfaction group. The monthly patient satisfaction meeting was a cross site meeting were staff representative from each site were required to attend and meet with patients to discuss patient feedback trends.
- Patient feedback were also monitored and reported monthly through the patient satisfaction dashboard and discussed at monthly management meetings.
- The hospital participated in various national campaign awareness days in 2018 such as the 'Hand hygiene day' and 'Antibiotic awareness week'. The service engaged with staff through quizzes and patients using variety of displayed posters during the awareness week.

- The service engaged well with staff through various initiatives such as monthly staff forums, executive's walkabout rounds, staff awards, staff surveys, team meetings and you said we did. Staff told us they had a summer ball last year.
- The staff meeting was attended by MDT staff including the RMOs, nurses and administrative staff. Staff we spoke to felt listened to by their managers and executives.
- The 2018 staff survey showed 50% response rate and 88.2%of staff would recommend the service which was better than national average of 73.2%. As a response, the hospital introduced a 'wow day' which was a weekly work out initiative that required head of department to spend time working in another department. The hospital also launched a staff newsletter in 2017 which staff were encouraged to contribute to its content.

Learning, continuous improvement and innovation

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

- The pharmacist had developed and implemented medication record cards for patients living with dementia or those concerned about remembering to take their medications when discharged home.
- The hospital introduced a learning, educating and adapting to falls (LEAF) group in 2016 and the multidisciplinary team met quarterly to asses, plan, discuss potential falls and how to mitigate risk and manage falls.
- The hospital introduced a 'daily board round' on the ward as part of the multidisciplinary approach to patient care to ensure care needs are met & the best outcomes for the patient.

Good

Surgery

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

Mandatory training

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

- The hospital set a target of 90% for completion of all mandatory training courses. Overall, mandatory training completion rates were 95% for ward staff and 91% for theatre and recovery staff at BMI The Cavell Hospital. Completion rates of mandatory training improved from our last inspection at this location. The hospital mandatory training programme included equality and diversity, fire safety training, immediate life support (ILS), infection prevention and control, consent, dementia awareness, waste management, safeguarding and other topics which related to working safely at work.
- Staff completed mandatory training through the BMI online training system and in face-to-face sessions. Staff said the quality of training was good and easily accessible. Staff were aware when their mandatory training was due for refresher training and received emails six months in advance to remind them of its due date. Yearly mandatory training was due at the time of each staff members' annual appraisal.
- Training was primarily delivered by e-learning modules. Face-to-face training was done for some courses, such as for basic life support. Staff confirmed the quality of training was good and that there was enough time to complete modules.
- Temporary and locum staff were required to provide evidence of mandatory training compliance from their employers.
- Consultants and clinicians with practising privileges were not required to complete training via the hospital system but assurance of mandatory training was checked by the medical advisory committee.
- The resident medical officers (RMOs) were managed via an agency and received mandatory training via their agency and had access to the hospital on-line training system.

Safeguarding

- **Staff understood how to protect patients from abuse and the service worked well with other agencies to do so.** Staff had training on how to recognise and report abuse and they knew how to apply it.
- Staff across theatres, recovery, wards and pre-assessment were aware of their responsibilities for safeguarding vulnerable adults and children. The Director of Clinical Services was the location lead for adult safeguarding and staff were aware of who to report safeguarding concerns to and felt comfortable doing so. Staff had good understanding on safeguarding including modern day slavery, human trafficking and female genital mutilation (FGM) and knew how to raise or report safeguarding concerns.
- All staff were required to complete safeguarding vulnerable adults levels 1 and 2 and safeguarding children levels 1 and 2. 97% of staff completed safeguarding vulnerable adults (levels 1 and 2) and 97% of staff completed safeguarding children training (levels 1 and 2). The hospital target for safeguarding training was 90%.

- For the period of 2017/18, the hospital reported zero safeguarding incidents across the hospital department.

Cleanliness, infection control and hygiene

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

- We found all clinical areas to be visibly clean and tidy. We observed thorough cleaning of theatres between patients. We saw evidence that staffed signed off on daily cleaning of the theatres and the recovery environment.
- The service reported surgical site infections in line with Public Health England national mandatory surgical site infection (SSI) surveillance in order to identify trends, From March 2018 to February 2019, the service undertook 156 hip arthroplasty procedures which resulted in one surgical site infection (0.6%) and undertook 446 knee arthroplasty procedures which resulted in no surgical site infections. SSI rates at BMI The Cavell were better when compared to other hospitals nationally.
- There were no hospital-acquired infections from March 2018 to February 2019.
- The hospital used an outside provider for the decontamination of surgical instruments. Staff found the service good and there were no significant issues.
- Throughout surgical services, there was adequate personal protective equipment (PPE) such as gloves and aprons. There were hand sanitisers on the walls at the entrance and throughout the department.
- We observed good adherence by staff to infection prevention control and improved compliance of staff in clinical areas being bare below the elbows. Staff in clinical areas practiced good hand hygiene.
- The service provided a hand hygiene audit for November 2018. Compliance was overall 89% in theatres and 87% compliance on the ward. We saw evidence that infection prevention and control, including hand hygiene was discussed at quarterly IPC meetings. Where there were gaps in hand hygiene facilities, an action plan was in place to address short and long term hand hygiene facilities. The December 2018 IPC hand hygiene audit showed an overall 100% compliance on the 31 standards audited.
- The service had an infection prevention and control (IPC) link nurse who worked with the IPC lead nurse. There were monthly IPC link meetings between the sister hospitals in order to strengthen the link nurse group and provide a forum for training and guidance.
- We observed clinical waste disposed of appropriately. All clinical, non-clinical and offensive waste was segregated and disposed of in the correct waste stream. We observed the correct colour coding system used throughout the theatre and in patient’s recovery areas.
- The hospital took part in the 2018 patient led assessments of the care environment (PLACE) audit. The hospital scored 98.2% for cleanliness which was similar to the national average of 98.5%. The hospital scored and 90.7% for condition, appearance and maintenance which was below the national average of 94.3%.
- There was improvement in the environment since our last inspection, which directly impacted infection prevention and control in clinical areas. The hospital had an on-going refurbishment plan to improve the hospital environment, which included bedroom decoration and replacement of carpet with flooring, installation of compliant clinical handwashing sinks and replacement of blinds in the patient bedroom.
- Cleaning of the ward areas was scheduled daily and in between patient discharge or transfer. Staff requested the deep cleaning of rooms or bed areas if a patient had Methicillin-resistant Staphylococcus aureus (MRSA) or an infected wound. Patients’ operations with a known history of MRSA were done at the end of theatre lists to ensure the room could be cleaned properly for the next patient.
- Disposable curtains with an antibacterial covering were used in all recovery bays and were clearly labelled with the date of when they were last changed.
- Sharps bins were easily accessible in theatres, recovery and the ward. They were sealed and dated, and none were found to be overfull. There were arrangements in place to safely manage waste and clinical specimens. Waste was handled appropriately with separate colour-coded arrangements for general waste, clinical waste and sharps.

Environment and equipment

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

- There was good security of the theatres and recovery area. The service was secured through employee badge electronic access.
- The service had two theatre suites covering a variety of specialities including orthopaedics, cosmetic surgery, ophthalmic, pain management and gynaecology. One of the theatres was equipped with laminar flow which safely filtered air away from the theatre and prevented any bacterial contamination from being recirculated. All orthopaedic procedures were done in the theatre with laminar flow to help prevent surgical site infections.
- The anaesthetic room was tidy, organised and uncluttered. From January 2019 to the day of our inspection, there were no gaps in the anaesthetic machine daily log book. The machine was checked daily by staff and if it was not in use on a particular day, staff marked that theatres were 'closed'.
- Staff tested the defibrillator on the resuscitation trolley in theatres and recovery daily and we saw records that indicated this. The service had an easily accessible difficult airway trolley which was checked regularly and was well-stocked.
- There was appropriate emergency equipment on the ward including resuscitation equipment, fire extinguisher cylinders, fire blankets, defibrillator, emergency eye wash and oxygen cylinders. We checked a range of consumable items from the resuscitation trolley, including syringes, airways and naso-gastric tubes and emergency medicines and noted they were all were in-date. All resuscitation trolley drawers seen were secured with a tamper evident tag.
- We found one observation machine in pre-assessment was overdue for its engineering testing by two months.
- The service had four recovery bays which were spacious and there was enough room between bays to carry out emergency resuscitation if necessary. Equipment in the recovery area could provide good monitoring of patients post- procedure and there was access to CO2 monitoring.
- Staff could access all equipment as they needed it. We observed a well-stocked store room with intact sterilised trays. There was clear signage for staff to identify the contents of the trays.
- The hospital had an on-going refurbishment programme which included the removal of carpets from clinical areas and installation of hand hygiene sinks. We noted an improvement on the ward where some sinks had been installed in a number of the patient bedrooms.
- The theatre department had an implant register in each theatre where details of each implant used were recorded. Implant item stickers were attached to the register book alongside patient details, site of surgery, date of surgery and the names of the scrub practitioner and circulating staff member. When theatres were not in use, staff stored registers in a locked cupboard.

Assessing and responding to patient risk

Staff completed and updated risk assessments for each patient. They kept clear records and asked for support when necessary.

- Following a serious incident involving the late detection of sepsis at BMI The Cavell hospital, the hospital and its sister hospital rolled out sepsis training to all clinical staff. Staff of all grades were aware of the serious incident and the learning from it. Staff carried early detection of sepsis reference cards which they could refer to if patients' observations were outside of a normal range.
- Staff received training on sepsis and we saw posters of sepsis six (management of sepsis that usually involves three treatments and three tests) and escalation using the internal emergency service during inspection. There was information on the wards that had contact details for emergencies that staff could call where there concerns including out of hours. Staff used the situation, background, assessment and recommendation (SBAR) tool for escalation.
- In theatres, we observed good adherence and consistency to following the World Health Organisation (WHO) surgical safety checklist and '5 steps to safer surgery'. Staff were fully engaged with the process and were paying attention during checklist.
- In theatres, recovery and the ward, the service conducted regular emergency response scenarios for training purpose. A cardiac simulation was done once a month and a major haemorrhage scenario was done quarterly. There were regular fire drills across theatres, recovery, the ward and pre-operative assessment.

- Staff in theatres and recovery had access to the urgent provision of blood in cases of life-threatening haemorrhage. There was a blood refrigerator within the surgery department.
- Prior to accepting a case, the service used tools to risk assess the safety of a surgery. Patients were pre-operatively assessed in a nurse-led clinic prior to surgery or by a telephone pre-operative assessment depending on if they met certain criteria. For example, staff considered patients' past medical history and American Society of Anaesthesiologists (ASA) physical status classification (a system used to assess the fitness of patients before surgery). The service had strict admission criteria and did not admit patients with complex co-morbidities or bariatric patients (body mass index (BMI) 40 or greater).
- Staff used a traffic light system during patients' pre-operative assessment appointments. This meant staff used national best practice guidance when deciding which routine pre-operative tests were performed prior to an elective surgery.
- We saw evidence that patients had risk assessments completed, for example a fall risk assessment, moving and handling assessment, malnutrition risk assessment and pressure ulcer risk assessment. Staff completed a venous thromboembolism (VTE) risk assessment for all patients. The hospital reported 100% of inpatients admitted had a VTE risk assessment completed; this was an improvement from our last inspection.
- The service followed National Institute for Health and Care Excellence (NICE) recommendations for pre-operative testing. This meant that the service considered the patient's risk factors when evaluating and preparing the patient for elective surgeries.
- Staff we spoke to told us they carried out regular clinical observations, such as vital signs post-surgical procedure every 30 minutes to ensure patient safety and recovery.
- The service used the National Early Warning Score (NEWS), designed to allow early recognition and deterioration in patient by monitoring physical parameters, such as blood pressure, heart rate and temperature. During inspection we observed that nursing staff used the NEWS and knew the threshold for escalation to the registered medical officer (RMO). The RMO were available on the wards and ensured prompt identification and managing of deteriorating patients. Staff also carried out further investigations such as blood tests as required. Staff told us there have been improvement in staff competency on NEWS score and managing deteriorating patient. All records we reviewed on the ward showed staff monitored patient's observations using the national early warning score tool (NEWS).
- The hospital December 2018 NEWS audit showed 93% compliance on the standard audited. We noted there was an action plan in place to address the areas of low compliance. During inspection we observed posters which prompted staff to ensure the NEWS score were completed and calculated accurately.
- There continued to be no formal on-call anaesthetic rota. There was an informal agreement that anaesthetists in charge of the list were responsible for patients up to 48 hours post-operatively. The RMO told us they hadn't had problems getting in touch with the consultant surgeon or anaesthetist when they needed them. There was an on-call theatre staff list. Consultants were required to be within a 30-minute commute to the hospital in case of an emergent return to theatre. From January 2018 to December 2018, the service had no unplanned returns to theatre and eight unplanned transfers of patients to a higher level of care.
- Staff we spoke to told us that consultants mostly responded immediately or within few minutes in 90% of time they had been contacted during emergencies. The 10% were potentially delayed for several hours. In these situations, staff would call the relevant anaesthetist whose mobile number was usually in the notes before contacting the duty manager if the consultants could not be reached. For medical emergencies affecting surgical patients, such as possible pulmonary embolism, staff would call the consultants or physician to obtain advice or instruction for possible patient transfer to another hospital for a higher level of care. Staff told us patient transfers were rare and have used local NHS hospitals in the past.

Nursing and support staffing

Although the service did not always have enough permanent nursing staff, nursing staff had the right mix of qualification and skills, to keep patients safe and provide the right care and treatment.

- On the wards, a corporate nursing staffing planner tool was used to determine staffing levels. The normal staff to patient ratio was 1:6. Senior staff used the tool to allocate staff in advance based on pre-determined

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

- During our inspection, in pre-assessment there was one permanent qualified nurse allocated to the department. Two healthcare assistants (HCAs) were trained in pre-assessment and, at times, nurses from the outpatient department filled in vacancies. However, we were told it was one health care assistant's last week and another was on extended leave. While staff were promised two new staff members to start early in 2019, this had not happened and staff were not clear when they would receive additional help.
- From March 2018 to February 2019, the ratio of nurses to operating department practitioners (ODPs) and health care assistants (HCAs) in theatres was 1 to 2.3 and the staffing ratio of nurses to HCAs on wards was 3.3 to 1. The service in theatres and recovery was reliant on bank and agency staff to fill gaps in skill mix. From March 2018 to February 2019, theatres used bank and agency nursing staff for 1579 hours and used bank and agency ODPs and HCAs for 597 hours. For inpatient wards during the same time, bank and agency nursing staff filled 7.5% of shifts and bank and agency HCAs filled 40% of shifts. From March 2018 to February 2019, in theatres and recovery the ratio of bank to agency nursing staff was 1.4 to 1 and the ratio of bank to agency ODPs and HCAs was 2.6 to 1.
- The service reported that as of February 2019, the vacancy rates in theatres were 19.58% for ODPs and HCAs (2.8 FTE) and 16.67% for theatre nurses (1 FTE).
- There were no reported unfilled shifts for theatres from December 2018 to February 2019. On the day of inspection, we saw staffing levels were safe and there was enough staff allocated to theatres and recovery. The service undertook elective surgeries and was able to plan staff accordingly. If a staff member called in sick, staff were supported to use bank and agency staff to fill the shift.
- Nursing staff used the situation, background, assessment and recommendation (SBAR) technique for handovers. Handovers took place twice daily between staff for patients staying on the ward.
- There was a dedicated full-time physiotherapist on the ward who worked Monday to Friday, 9am to 5pm. The hospital also had a part time physiotherapist that covered weekend shifts.
- The hospital also had six administrative staff receptionists that covered the inpatient wards on both hospital sites.

Medical staffing

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

- Consultants worked under practising privileges agreements in the service. Under practising privileges, a medical practitioner is granted permission to work within an independent hospital. The medical advisory committee (MAC) was responsible for granting practice privileges and was overseen by the medical director. Consultants with practicing privileges had their appraisal and revalidation undertaken by their respective NHS trusts. Staff we spoke to told us the process for managing practice privileges and consultant's' scope of practice was robust.
- The service had anaesthetists that covered the wards and procedures in theatre. There was no formal rota for on call consultant surgeons or physicians. The relevant staff would be contacted directly by staff when needed. Staff told us this arrangement worked and no concerns identified.
- While consultant surgeons had patients under their care in hospital, they were required to be within 30 minutes journey to the hospital or to have suitable stand-in to provide cover. This was in line with best practice for emergency surgery standards.
- From March 2018 to February 2019, there were 320 doctors or dentists with practicing privileges for more than six months at the hospital and its sister hospital. During the same time, the hospital reported three cases of suspended practicing privileges of medical staff.
- The RMOs were provided under contract with an external agency that provided training and support. The RMOs provided 24-hour 7 day a week service on a two-week rotational basis. Senior staff told us that the RMOs were selected specifically to enable them to manage a varied patient caseload and requirements. The hospital had two inpatient RMOs who rotated for at least six months to ensure continuity of care. The

resident medical officer (RMO) provided day to day medical service and dealt with any routine and emergency situations in consultation with the relevant consultant. Out of hours, consultants provided either telephone advice or attended in person.

Records

Although staff kept detailed records of most patients' care and treatment, some records were not always available, clear or up-to-date.

- The hospital used a paper and electronic system to record patient needs and care plans, medical decision-making, reviews and risk assessments. The hospital kept and maintained health records for both NHS and private patients.
- Consultants in the service would send a letter to the patient's GP with information and the outcome of a consultation. All patients admitted to the service would have a discharge summary sent from the hospital and consultant to the patient's GP
- Staff told us all patient notes were kept securely in the hospital following discharge and doctors could have copies of the patient discharge letters. This was an improvement from our last inspection where there were times when consultants would keep patient records.
- Staff had access to the BMI clinician app through a remote log in that allowed real time information to the clinic list, theatre list, booking request and individual patient information. Although staff told us they had timely access to patients record on the wards and theatres, there were issues with missing records when patients arrived at pre-operative assessment.
- Missing records were a problem for pre-operative assessment. Staff told us that on a regular basis they received records with less than 50% completeness and about 60% of patients arrive to pre-assessment with a blank pack. This was a problem because sometimes patients' appointment were not long enough to fully complete the packs and patients did not always remember their medical or surgical history and all of their medications on the day of pre-assessment. Staff felt rushed to complete the entire record and complete a physical assessment. When there were gaps in history or medication it meant that the patient may be cancelled on the day of surgery.
- Pre-operative assessments were completed by nursing staff. Pre-assessment records included the patient's history and medications, allergies, patient's understanding of their procedure, fasting instructions for the day of the procedure, where to go on the day of the procedure and discharge instructions.
- We saw evidence that patients had risk assessments completed, for example a fall risk assessment, moving and handling assessment, malnutrition risk assessment and pressure ulcer risk assessment.
- Staff told us there continued to be some gaps with consultants not adding to records. Leaders in the hospital told us that most issues were resolved where consultants kept their patient records with them. Hospital policy was that all records were to be retained by the hospital and consultants who wished to view the hospital's patient notes were asked to do so within the hospital and in accordance with data protection legislation and the Caldicott Principles.
- We reviewed 10 sets of patient records. We observed that records were of good quality, national early warning system (NEWS) observations were completed, venous thromboembolism (VTE) risk assessments were completed and prevention was signed off for by the consultant. Most medication charts we reviewed were filled out completely and allergies were noted. We saw evidence in patients' records that staff completed the safety checks undertaken during procedures using the World Health Organisation (WHO) 'Five Steps to Safer Surgery.
- However, we continued to find records issues from our last inspection. In one of the surgical patient's record we reviewed, it was only noted in the booking form and pre-op assessment that he had a total knee replacement. There was no consultant letter, or GP letter to explain the symptoms or to validate the rationale for the procedure in the same notes. Also in this chart, the prescription for morphine was not legible.
- The hospital undertook monthly audits of patients' health records, which included monitoring of risk assessments such as falls and pressure areas. The health record documentation December audit in 2018 audit showed an overall 85% compliance on the four standards audited. Staff achieved 100% compliance on the WHO checklists, 82% on the general standards, 89% on the clinical risk assessments and 95% on the pharmacy prescription chart on allergies and weight standard.

- We saw that staff stored patient records securely, and when electronic records were not in use staff logged off their computer.

Medicines

The service followed best practice when prescribing, giving, storing and recording medicines. Observations during the inspection showed that patients received the right medication at the right dose at the right time.

- The service had robust systems in place for the management and reconciling of medicines in line with national standards and guidelines. The service carried out several audits of medicines to identify and address safety issues, improve patient outcomes and to offer support to staff.
- All clinical staff we spoke with were clear about the arrangements in place for safely managing medicines, including controlled drugs (CDs). CDs are medicines which require additional security. The arrangements were set out in policies and procedures for ordering, recording, storing, dispensing, administering and disposing of medicines.
- A controlled drug audit performed in theatres in January 2019 showed 100% compliance of staff following standards when prescribing storing and administering controlled drugs. We observed this in practice. Staff accurately filled in the controlled drug (CD) register in theatres and recovery and it was signed for by the anaesthetist. The hospital December 2018 controlled audits showed 100% compliance on the wards.
- In theatres, recovery and the wards, we observed staff followed best practice when administering medications.
- The drug fridge log book in theatres and recovery was neatly filed out and there were no gaps for April 2019. Staff daily checked temperature of the fluid warming cabinet in theatres. Fluids in the warming cabinet were all in date and labelled.
- On the ward, fridge temperatures and clinical room ambient temperatures were monitored and recorded daily. During inspection we saw that all fridge and room ambient temperatures were within the expected range. We observed all medicines stocked on the wards were managed safely. There was a system in place to alert staff through a red flashing light signal when the medicines room was opened and unsecured.
- We found one intravenous medication was stored with other intravenous fluids. Because the intravenous fluid was in a similar packaging as the intravenous fluids, there was a risk that patients could receive the wrong medication.
- We found improvements since our last inspection where we had concerns around the governance of authorised signatories of staff that could order medicines and the lack of antimicrobial stewardship and controlled drug audits. A list of authorised signatories of staff that can order medicines were kept by the hospital pharmacy team, so that staff who undertook this responsibility could be identified. We reviewed the lists held in the pharmacy department and noted these were complete and in date.
- The hospital had a new pharmacy manager that had recommenced the bi-monthly medicines meeting where all medications incidents and action were reviewed. Staff found the pharmacy team to be visible, accessible and a valuable resource. Pharmacy staff double checked prescriptions and explained medicines information to patients and counselled patients on how to take their medicines at discharge.
- There were effective arrangements in place to facilitate medicines supplies and advice out of hours. Clinical pharmacy services were available every day from 9am to 5pm and the registered medical officers (RMOs) had permission to access the pharmacy out of hours to obtain any medicines which wards ran out of. There were also labelled packs of to take away (TTA) medicines on the ward which were dispensed by the nurses and checked by RMO during out of pharmacy hours. Nursing and medical staff were required to complete patient details and name of the medicines dispensed in the TTA book on the wards which would be reviewed by the pharmacist the next day.
- There was an up to date antibiotic protocol which included first and second choice medicines to use, the dosage, and duration of treatment. The March 2019 antibiotics audit showed that 100% prescription were compliant with the local policy and had an allergy status indicated. Although none of the infections were hospital acquired, the clinical indication was documented, and prescribers were contactable when needed. However, across The Cavell Hospital and its sister hospital 20% antibiotics were prescribed according to antimicrobial sensitivity and only 30% of prescription stated the duration or review date of the antibiotics prescribed.

Good

Surgery

The recommendation for prescribers was to clearly indicate the treatment duration and review date of antibiotics and to undertake antimicrobial sensitivity prescribing rather than empirical treatment to be increased.

Incidents

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

- The service reported no never events or serious incidents in surgery from January 2018 to December 2018. A never event is a serious incident that is wholly preventable as guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and should have been implemented by all healthcare providers.
- Between January 2018 to December 2018, the hospital reported 14 incidents in surgery or inpatient wards.
- We found some improvements in incident reporting since our last inspection. A new electronic system which was introduced in December 2016 so that all staff could report incidents. Though staff knew how to use the system, several said they would ask their manager to fill out the incident report for them because they did not have enough time during their shift. This meant incidents were not always reported to the hospital, for example when patients had extended wait times at appointments or when there were missing notes.
- Staff on the ward told us they were encouraged to report incidents by their managers and felt confident to do so. Staff knew how to report incidents and most staff we spoke with had reported incidents before. Senior managers had oversight of reported incidents and gave feedback and learning to staff.
- Staff demonstrated learning from incidents. The hospital rolled out sepsis learning to all staff following an incident where there was late identification of a patient who developed sepsis. All levels of staff, from healthcare assistants to the resident medical officer, demonstrated understanding on early identification of sepsis and use of sepsis tools.
- In line with BMI's incident management policy, staff received feedback and learning from incidents across surgery at The Cavell Hospital, as well as from their sister hospital and from across the BMI network. We saw evidence learning from incidents was discussed at staff meetings.
- Staff had a good understanding of the Duty of Candour requirement. Staff apologised when things went wrong and aimed to resolve any issues with patients before the end of their hospital stay. The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain 'notifiable safety incidents and provide reasonable support to that person, under Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.
- The hospital had a monthly lessons learned workshop that was chaired by the risk and quality assurance team and where all MDT staff including housekeepers attended. Learning from incidents, risks and complaints were discussed and shared with staff.

Safety Thermometer

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

- The safety thermometer is used to record the prevalence of patient harm and to provide immediate information and analysis for frontline teams to monitor their performance in delivering harm free care. It measured the proportion of patients that experienced 'harm free' days from pressure ulcers, falls, urinary tract infections in patients with a catheter and venous thromboembolism (VTE). Staff were aware of their duty to report and reduce incidents of pressure ulcers, falls, urinary tract infections in patients with catheters and VTE.
- We observed that safety thermometer data were displayed in hospital areas which showed information about incidents and patient satisfaction.
- The service gathered patient information, for example in hospital-acquired infections, falls and venous thromboembolism (VTE) and discussed these at the hospital's clinical governance meetings. In the reporting period of January 2018 to December 2018, there were

no reported incidents of hospital-acquired Meticillin-resistant Staphylococcus aureus (MRSA), Meticillin-sensitive staphylococcus aureus (MSSA), Clostridium difficile (c.diff) or E-Coli.

- Patients were risk assessed for venous thromboembolism (VTE) at the time of their admission to the hospital. The clinical quality dashboard showed that 100% of patients received a VTE risk assessment. The service had a target rate of 95% screening for VTE risk assessments.
- We reviewed meeting minutes from the hospital's monthly clinical governance meetings where staff discussed the clinical quality dashboard. Staff reviewed quality and safety measures which indicated performance was within or better than safety performance targets. Areas such as falls and incidents for example were monitored.

Are surgery services effective?

Good

Evidence-based care and treatment

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

- We reviewed ten policies including hand hygiene, critical care of adults, resuscitation, induction, pre-operative assessment, complaints, incident management and complaints. All polices were in date and showed recent review by the clinical governance team. Policies were developed in line with national guidelines, such as the Health and Safety Executive, National Institute for Health and Care Excellence (NICE) and the association of surgeons of Great Britain and Ireland.
- Policies were reviewed in line with NICE guidance. For example, the critical care policy was developed following NICE guideline CG50: Implementing the 'acutely ill patient in hospital'. Staff used the National Early Warning Score (NEWS) for the early detection and treatment of the deteriorating patient. Additionally, the critical care policy was developed with NICE guidelines CG83 which meant that staff took a multidisciplinary approach to help improve outcomes in the acutely ill patient.
- The service audited adherence to national guidelines, for example of completion of NEWS and the World Health Organisation (WHO) checklist for safer surgery. The service provided a NEWS audit from December 2018 of patients on the ward where the compliance average was 99%. A WHO observational audit from March 2019 in theatres showed 99% compliance with standards.
- Patient documentation, such as treatment plans, risk assessments and observational charts was developed in line with national guidance such as the Royal College for Nursing standards. Local policies and procedures were developed in line with national guidelines to ensure staff used evidence based systems to deliver care. This ensured staff delivered appropriate interventions and prescribed care.
- Theatre and recovery staff were kept informed of updates to best practice and changes in the hospital's policies in procedures regularly at theatre meetings. New policies were updated on the hospital's elearning system which you had to read through before continuing onto other training.

Nutrition and hydration

Staff gave patients enough food and drink to meet their needs and improve their health. They used special feeding and hydration techniques when necessary. The service made adjustments for patients' religious, cultural and other preferences.

- Staff screened and assessed patients' nutrition and hydration on admission, taking their cultural, dietary and religious need in consideration, to ensure they were not at risk of malnutrition. Staff used the malnutrition universal screening tool (MUST) for assessing patients' nutrition. MUST was a nationally recognised method used to identify the risk level of each patient and this was documented in the set of notes we reviewed. We saw that were risks were identified staff referred patients to the dietitian service.
- Staff gave advice and followed up patients where nutrition and hydration concerns were identified through their weight, blood result such as urea or appeared dehydrated. Where severe dehydration was identified the nurses liaised with the medical staff to prescribe intravenous (IV) fluids.
- Fluid and food charts were used to monitor patient input and output particularly following a surgical procedure.

- Patients had timely access to dietitians following referrals by medical or nursing staff.
- Patients' dietary requirement were communicated to staff including catering staff during handover and using signs in patients' rooms and yellow jugs on the ward. this ensured staff were aware of patients on restricted drinks or food or required assistance with feeding.
- Patients were given fasting instructions at pre-assessment. Nursing staff tested patients' knowledge on their fasting times and gave them reminders when needed. Patients were asked if they had any special dietary requirements during their pre-operative assessment.
- The hospital food was outsourced to a catering company. The 2018 Patient-led assessments of the care environment (PLACE) showed that the hospital scored 98.9% for the ward food which was better than the national average of 90.5%.
- Patients told us they were given adequate food and water regularly. Patients were offered a choice of menu before their surgery. Once the patient recovered and was ready to eat, staff checked to see if their original option was preferred or provided available alternatives. Patients we spoke with were very positive about the food choices and said the quality was good.

Pain relief

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

- The hospital completed pain management audits. The audit form the hospital provided to us for November 2018 was completed at ward level. 70% of patients were prescribed regular pain relief medication and 70% of patients were prescribed as needed pain relief medication. Patients pain levels were follow up post-pain relief medication only 25% of the time. However, the patient satisfaction survey from February 2019 showed 94.6% of patients felt staff did everything to help control pain.
- Pre-operative assessments for post-operative pain relief were completed by staff in pre-assessment. Patients used a scale from zero to three, where zero was no pain and three was the worst pain to indicate the severity of their pain level. Although audit data from November 2018 showed 45% of patients were advised or prepared for their post-operative pain management at pre-assessment, the patient satisfaction survey from February 2019 showed 97.6% of patients felt the likelihood of post-operative pain was explained to them.
- Patients were assessed for pain at regular intervals throughout their care journey and records reflected pain relief was given when needed. Patients we spoke with said that their pain was well controlled and staff responded quickly to giving pain relief support. The pain management audit from November 2018 showed 95% of patients had pain relief medication planned for discharge.
- Pharmacy staff supported pain management at ward level and provided advice and support to patients and clinical teams. Medications prescribed at discharge were communicated to the patient's GP through the discharge letter.
- The service used patient feedback forms to gather information on how well pain was controlled in the hospital.

Patient outcomes

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

- Patient outcomes were audited and reports showing trend analysis were reviewed through the internal governance structure. This included key performance indicators such as unplanned readmissions, unplanned returns to theatre, unplanned transfers out of the service, healthcare associated infections and significant incidents.
- From January 2018 to December 2018, there were 864 inpatient admissions for surgical patients. During that time, there were eight unplanned transfers of patients to higher level of care hospitals, seven unplanned readmissions within 28 days of discharge and no unplanned returns to theatre.
- The surgical service participated in several audit programs. These included the national joint registry (NJR) which collects relevant data about joint replacement surgery to provide an early warning of issues relating to patient safety. They also participated in patient reportable outcome measures (PROMs) for hip

and knee replacement surgery and cataract surgery, as well as reporting to Public Health England (PHE) and participate in patient led assessment of the clinical environment (PLACE) audits.

- Patient Reported Outcome Measures (PROMs) are a means of collecting information on the effectiveness of care delivered to NHS patients as perceived by the patients themselves. During the reporting period from April 2016 to March 2017, there was too small of a sample size to compare adjusted health gains for patients undergoing hip and knee replacements to both the BMI Healthcare average and the national average.
- The service followed the Royal College of Surgeons (RCS) standards for unscheduled care. For example, we saw evidence of this in the hospital's policy to have consultants be within 30 minutes journey to the hospital in case of an unplanned emergent return to theatre.
- The hospital submitted data to the Private Healthcare Information Network (PHIN). PHIN is an independent patient information network that informs and empowers patients to make informed choices about their care provider.

Competent staff

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

- New staff were required to complete BMI competencies prior to working independently. Competencies were specific to job roles and were signed off by senior members of staff.
- When staff in pre-assessment began in their role, a senior manager met with them after the first and second month they were there. This was to ensure things were going well and to evaluate competency checklists.
- Staff had annual appraisals and were notified when their appraisal time was coming up six months before. They were then notified on a monthly basis to complete yearly mandatory training in preparation for their appraisal. The service reported 70% of theatre staff completed an annual appraisal. On the ward, 76% of nursing staff completed an annual appraisal. Annual appraisal rates for healthcare assistants was 60% on the ward. Following the inspection the hospital told us the appraisal completion was on-going completion and all outstanding appraisals would be completed by the end of June 2019. We noted that the nurse in charge and the senior nurses completed the appraisals of the HCAs.
- The RMOs were supported by an allocated medical staffing manager assigned by their agency that provided mentoring and carried out their annual appraisals.
- Medical staff had attended an orthopaedic conference for GP's and a monthly GP education event. We noted this was highlighted as one of the hospital 2018 key successes.
- Staff had access to additional training they were interested in and could sign up with their manager's approval. Although we were told there was a large variety of good courses, some staff were not sure they could go due to staffing numbers. Nursing staff told us that the hospital helps them with revalidation of their nursing registration.
- The pharmacy team updated their skills and competency through evidence based practice and best practice. We saw that the pharmacy staff kept up to date with latest medicines guidance, trends through the pharmacy journal which were shared with colleagues and other MDT staff. For example the pharmacy discussed and shared a recent article by the NHS Improvement on medication errors.
- The pharmacy manager was on a Chartered Management Institute (CMI) level 5 course which was funded by the hospital. The manager reported good support with the training from the executive director.
- The IPC link practitioner had attended an ANTT conference in December and BMI were looking at achieving a gold accreditation in 2020 to improve patient outcome.
- Staff on the ward received a falls refresher following recent falls incidents.16 staff completed the falls training facilitated by the physiotherapist in February 2019.
- There was a BMI policy for practising privileges. This set out that practising privileges were only granted to doctors who were licenced and registered with the General Medical Council (GMC), held a substantive post within the NHS in the past five years or could demonstrate independent practise over a sustained period, and had clinical experience relevant to practise. Each application for practising privileges was assessed by the Medical Advisory Committee (MAC) and we saw evidence of this in the MAC minutes we reviewed.

- A weekly report was exported from a consultant database to check that documentation such as indemnity insurance and registration with the GMC was up to date, and consultants were contacted where these were due to expire with a set deadline to produce new documents.

Multidisciplinary working

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

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

Seven-day services

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

Health promotion

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

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

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

- We saw consent forms were completed in patients' records in line with the BMI policy 'consent for examination or treatment'. Consents were generally completed the morning of surgery and confirmed with patients in theatre prior to anaesthetisation. We saw evidence that consents addressed the diagnosis, potential risks and benefits, the treatment team and patients' rights. The service provided data from a documentation audit from December 2018 and April 2019 which showed evidence that 100% of patients from 40 records had documented informed consent.
- Staff received training on the Mental Capacity Act (2005) as part of their mandatory training. The BMI consent policy was created with current legislation for patients who lack mental capacity. Staff were able to give clear explanations of their roles and responsibilities under the Mental Capacity Act 2005 (MCA) regarding mental capacity assessments and DoLS. Due to the service provision and admission criteria the service did not have patient under MCA.
- The service undertook regular audits for completion of consent forms as part of their health documentation audit. The service completed these audits quarterly.
- The service reported no breeches in the two-week cooling off period required for cosmetic surgeries in the 12 months prior to our inspection.

Are surgery services caring?

Good

Compassionate care

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

- In theatres and the recovery area, staff were consistently friendly and caring to patients. Staff explained steps as they went along, and patients told us they felt well-informed of their care and included in decision making.
- Friends and family test scores were consistently high. From September 2018 to February 2019, FFT scores ranged from 95% to 99% with the average overall response rate during that time of 53%.
- Patients we spoke with were mostly very positive about their experience in the service. Many patients told us they used the service on more than one occasion and recommended other friends and family members to use the service. Specific comments about the patient experience on the wards included, "staff were great", "excellent and comfortable care received", "clean and friendly staff".
- One patient we spoke with said that this was not their first visit to the service as a patient. Although their first time using the service was very good they had not had

the best experience during this hospital stay and found it "a bit potluck about nursing care," which was "very clinical and very cold". However, they would still overall recommend the service to friends and family.

- The hospital 2018 PLACE audit showed the hospital scored 78.5% for privacy, dignity and wellbeing. This was worse than the national average of 84.2%. As a result, managers assigned a designated quiet room for patients, family and carers to provide a place where discussion with the multidisciplinary team could take place to maintain their privacy and dignity. Patients we spoke with said their privacy and dignity was respected, especially during physical or intimate care. All patient rooms on the ward were private and chaperones were used when necessary.
- Feedback from patients in surgery included, "from consultation through pre and post-operative care, it cannot be faulted as every member of staff were lovely including the physiotherapist and the kitchen staff were very helpful and caring".

Emotional support

Staff provided emotional support to patients to minimise their distress.

- Staff told us they had time to spend with patients to reassure them and provide emotional support. In theatres, staff were calm and reassuring to patients, especially those who were nervous or anxious. Patients on the ward told us their emotional health and mood had been discussed and assessed by staff. We saw staff provided emotional support to patients and always reassured and encouraged patients to achieve their goals.
- All patients and their relatives and carers we spoke with told us they felt supported throughout their journey from consultation, pre-assessment through treatment and therapies.
- Patients consistently said that they had been offered emotional support and that it was available if they needed it. Patients could call staff on the wards seven days a week for support, even after discharge.

Understanding and involvement of patients and those close to them

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

- Patients told us that staff introduced themselves and they knew who their nursing staff were during each shift. Patients knew who their consultants were.
- Patients felt that conversations about finances were handled sensitively. We heard from patients and staff that NHS and non-NHS patients were not treated differently in any way.
- During our inspection we saw evidence that staff involved and discussed with patients and their loved ones on the choices of their care and treatment. All the patients we spoke with were aware of what to do if they felt unwell during admission and when discharged home.
- We observed patient clinical procedures and handover and noted the consultant had clear communication with patients on the ward. After surgery, consultants explained their findings and treatment plans in detail in a way patients understood. We saw that staff took their time to explain information to patients and involved them in their treatment plans.
- Most patient feedback we reviewed was positive. Specific patient comments included, "consultant gave feedback regarding my procedure after surgery", "I have good access to medical staff", and "excellent consultation, advice and continued follow-up". Although one comment from feedback cards included, "it would be good to talk to a consultant after their surgery".
- The 2018/19 hospital satisfaction score was displayed on the ward which showed improvement in hospital performance from the previous year. The results showed 89.2% of patients received an information pack from the hospital (an 11% increase) and 89.3% of patients were kept informed on what was happening by the physiotherapist (a 23% increase). The results also showed that only 40.4% of patients received a follow up telephone call.

Are surgery services responsive?

Good

Service delivery to meet the needs of local people

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

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

Meeting people's individual needs

The service took account of patients' individual needs.

- Staff had access to a new interpreting service, although while this was advertised in the theatres, most staff had not used it. The interpreting service provided British Sign Language interpreters and spoken language interpreters of over 200 languages and dialects. The need for an interpreter was normally identified at the time of referral to pre-assessment and the service could arrange for an interpreter to be booked in person for their appointments.
- The service worked to meet patients' individual needs. One example we saw of this was when a female patient requested a female doctor and the service was able to arrange it.
- Leaflets on the wards were in English, but we were told they could obtain them in languages other than English.
- Nursing staff discussed discharge planning with patients at pre-assessment, including expected discharge day, planning transport arrangements to get home and if patients would need assistance once home, for example from a friend or family member.
- Physiotherapy was involved in patient care. Nursing staff in pre-assessment could make referrals to physiotherapy and occupational therapy.
- Patients who underwent total hip or knee replacement were seen on the ward by physiotherapy and nursing team members. They were given patient-specific instructions and education on basic bed mobility, gait re-educated using walking aids, stair training and home exercise plans. On discharge, all patients were given a pre-booked post-operative outpatient appointment with physiotherapy.
- During our inspection, we saw that staff promptly answered patients' call bells and responded to their individual needs. Most patients told us their care felt individualised to them.
- The service did not often admit patients living with dementia or learning disabilities, however this would be identified in the pre-operative assessment. Staff would ensure that the patients' family or carers were involved with the care plan.
- Staff catered to patients' individual dietary needs. Dietary preferences would be assessed during the pre-operative assessment and catered for during the patient's stay. Patients told us there was a good variety of food and that the quality was good.
- The service continued to implement intentional hourly rounding. Patients sometimes felt isolated because they were all in private rooms. Staff rounded on patients hourly to ensure their pain was well-controlled, personal items were within reach, aid the patient if they needed to use the toilet, and ensure that they were in a comfortable position.
- Follow-up appointments were given to patients in a timely manner during clinic consultation and we saw that staff accommodated patient preferences and commitments.
- Physiotherapy was involved in patient care. Nursing staff in pre-assessment could make referrals to physiotherapy and occupational therapy.

Access and flow

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

- We spoke with patients who attended the service for several years and who had family or friends who had attended the service for several years. We also spoke with patients where it was their first visit to the service. All said that they waited only for a short time for their procedure.
- Patients were pre-operatively assessed in a nurse-led clinic prior to surgery or by a telephone pre-operative assessment depending on if they met certain criteria. The National Institute of Health and Care Excellence (NICE) guidelines were used to assess patient's anaesthetic risk in the clinic. The service had strict admission criteria and did not admit patients with complex co-morbidity or bariatric patients. Discharge planning was addressed at time of pre-assessment so any specific needs could be met and planned for.
- Theatre staff remained on site until the patient was appropriately recovered and ready to return to the ward. There were enough beds on the ward for patients that unexpectedly needed to stay the night, for example for patients undergoing a day case surgery.
- The service maintained an on-call theatre team in case of emergencies. Consultant surgeons were required to be within 30 minutes transportation to the hospital. Although there was no service level agreement (SLA) in place with a local NHS trust, the service did not have difficulties transferring out patients in need of more complex care and treatment. The registered medical officer (RMO) said they felt well-supported by consultants when they needed to escalate care.
- The referral to treatment (RTT) standard for NHS-funded patients was within 18 weeks (admitted pathway) of referral. The overall average of NHS-funded patients meeting the target 18-week RTT from April 2018 to February 2019 was 91.4%. This was better than the national average of 72% of patients meeting the 18-week RTT.
- The service held a weekly planning meeting to discuss staggered admission times for morning and evening surgery lists. Patients were informed on admission the order of the theatre lists and waiting times. Most patients told us they felt well-informed of waiting times once admitted.
- There were a total of 86 cancelled procedures for non-clinical reasons from March 2018 to February 2019. Of these, 36% of patients were offered another appointment within 28 days of the cancelled appointment. Some non-clinical cancellated were cancellations requested by the patient and did not want to reschedule.
- Bed capacity planning meetings took place weekly and representatives from each clinical area were present. This ensured that heads from all clinical areas were aware of the issues around the hospital and could offer further assistance by way of additional staff if need be.
- A surgical patient we spoke with commented they had experienced long delays before their surgery. Staff did not record and monitor how long patients waited for treatment on the day of their appointment, therefore were unable to establish the extent to which services ran on time.
- Staff told us the discharge process was effective and they had few cases of delayed discharges. To take away (TTA) medicines were stocked on the wards to dispense out of hours and prepared the day before discharge to prevent delayed discharge. The length of stay for surgical and orthopaedic patients such as hip or knee replacement procedures was three days. Staff told us orthopaedic patients were now discharged quicker on day three. Staff in the service were passionate about safe discharges.
- Leaders worked on consolidating services across the two hospital sites (BMI The Cavell Hospital and its sister hospital). For example, theatre utilisation was about 50% across the two sites and the services were considering consolidating day case surgeries at one location and inpatient surgeries at another location with the aim to use resources more effectively.

Learning from complaints and concerns

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

- Patients were provided with information on how to make complaints. There were leaflets and posters available on the ward on the process of making complaints and providing feedback.
- Complaint trends were discussed at the clinical governance meetings and at theatre and ward meetings.

Good

Surgery

- From September 2018 to February 2019, there were 21 complaints reported at BMI Cavell Hospital which were all resolved at hospital level. The top trends identified for complaints during that time were around communication and clinical care/treatment. The service kept a log of planned dates for responding to complaints, lessons learned and if the complaint was resolved. We saw evidence that complaints were investigated and that staff apologised when something went wrong.
- Most patients we spoke with were aware of how they could make a complaint and felt that they could bring up complaints with staff if necessary. Staff aimed to address and resolve complaints each shift or before patients' discharge.
- The service encouraged patients to complete patient satisfaction questionnaires.

Are surgery services well-led?

Good

Leadership

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

- The hospital was led by a senior management team consisting of an executive director (ED), director of operations, director of clinical services and a quality and risk manager. Surgical services had a theatre manager and ward manager who worked across sites with the sister hospital. The hospital had a local deputy theatre manager. At the time of our inspection, the theatre manager was absent due to sickness and the deputy theatre manager provided cover.
- The executive director reported to the corporate regional director. They had a bimonthly one to one meeting and a bimonthly meeting of all regional executive directors.
- Leaders prioritised safe, high quality, compassionate care and promoted equality and diversity. The leadership model of the service encourages cooperative and supportive relationship among staff and patients so that they felt respected, valued and supported.
- Since the last inspection, the hospital had recruited new executives such as a quality and risk manager and director of clinical service to strengthen the governance framework and leadership. The hospital introduced an on-call rota in April 2019 for the hospital mangers to support staff and be present in clinical areas on Saturdays. This was an improvement since the last inspection.
- The executive director told us that medical supervision had improved since the appointment of a new MAC chair person in 2018. They were a senior consultant at a local NHS trust. They said there was an issue with getting enough doctors to be part of the MAC and were trying to encourage new members. The ED said they aimed to ensure the MAC was representative of the consultant body and that they had a good range of consultants including anaesthetists and surgeons of different specialties. However, the MAC was currently all-male. The ED said they were working to change this and two female consultants were about to join.

Vision and strategy

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

- The hospital had a five-year vision for 2015 to 2020 which was achieved through their eight strategic objectives and priorities. The objectives and priorities included patients, people, communications, growth, governance, efficiency, facilities and information. This was achieved through their strategies which included delivering the best clinical outcomes through best practice pathways. The hospital aimed at having a clear evidence of meeting standards through integrated audit results, improving patient experience, investment in new medical technology and equipment and improving the look of the hospital through refurbishment.
- Staff throughout the surgery department could tell us about future visions for the hospital and sister hospital, such as for plans for a high dependency unit (HDU). Having a HDU meant the hospital could take on more complex surgeries.
- Staff throughout the surgery department could tell us about plans for the hospital and sister hospital, such as for plans for a high dependency unit (HDU).
- Senior leaders shared the hospital vision to staff through monthly staff forums chaired by executive director

leads. Staff forums were an opportunity for staff to get information on the hospital's and company's performance and key issues. It was also an opportunity for staff to voice concerns and raise issues.

- There was a monthly staff newsletter delivered by email to staff across both of the BMI hospital sites where the service's vision was shared. As well, staff newsletters were printed and displayed in staff rooms.

Culture

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

- The executive director (ED) told us that the recent staff survey results showed that bullying and harassment was still an issue across the two hospitals. The results were not broken down by staff site or speciality so they were unable to identify if the issue was localised. The ED said they planned to work with staff to address the issue, and that it had improved slightly since the last survey.
- In the recent staff survey, the number of staff who responded to say they would recommend the hospitals to family and friends as both a place to work and for treatment had increased.
- Theatre and recovery staff spoke highly about the senior nurses in the service. Staff said there was good local leadership who had high standards and could challenge consultants. However, staff did not feel that the manager for the service was visible.
- We spoke to 11 staff across theatres and recovery. All staff were complimentary of the service they provided and proud to work in the department. Staff felt well-supported and there was a collective dedication to a culture of providing safe surgery. Staff felt that they worked together well across theatres, recovery and the ward.
- Staff on the ward told us they felt supported and valued by colleagues and senior managers. There was a drive for learning and progression. For example, we saw a staff member was promoted and trained from a porter to a health care assistant and an administrative lead progressed from a receptionist role.
- On the ward, staff we spoke with had a strong commitment to their job and were proud of the team working, continuity of care, service delivery, positive impact to patient care and experience, and improvements they had made to the service since the last inspection.
- The hospital celebrated staff and team success through various star awards and displaying of team success. Staff success were also celebrated at the daily communication meeting and hospital newsletter. The hospital newsletter also highlighted and celebrated staff that were newly recruited, or maternity leave or retired.
- Staff told us there was a no blame culture when incidents happened and the team supported each other. Staff were able to raise concerns when needed. The duty of candour was implemented in the service and we saw that cases that met the duty of candour were reviewed and monitored at the governance.
- BMI The Cavell participated in a survey for the BMI Healthcare Limited organisation which looked at workforce race equality standards (WRES). The results for the BMI Healthcare Limited organisation in 2017/18 showed that 14.5% of staff identified as black and minority ethnic (BME), 76.3% identified as white and 8.2% identified as unknown or did not answer. Across the organisation, 91.9% of board members were white and 9.1% were BME. Across all BMI sites, 65% of white staff and 55% of BME staff thought there was equal opportunity for career progression or promotion, 13% of white staff and 20% of BME staff said they experienced bullying, harassment or abuse from staff in the 12 months prior to the survey, and 9% of white staff and 17% of BME staff said they personally experienced discrimination at work from their manager/team leader or other colleague.

Governance

The service systematically improved service quality and safeguarded high standards of care by creating an environment for excellent clinical care to flourish.

- The service gained assurance through various governance meetings such as the clinical governance committee, health and safety committee, medical advisory committee (MAC) meeting, senior management meeting, infection prevention control (IPC) meeting and the cross site departmental meeting.

- Hospital governance meetings were held regularly to review all incidents, significant events, audits, complaints, compliments, patient satisfaction and practice privilege.
- The clinical governance committee meeting: was a cross site meetings and held monthly. This meeting was attended by all hospital departmental leads and executive directors, director of clinical services and pharmacists. The agenda included the CQC action plan, updates from the local hospital clinical governance reports, updates from the hospital quality and risk management report, incidents case reviews and learning, pre-assessment, medicines management, staffing, policies, health promotion, clinical bulletin, national safety alerts, dashboards, complaints, risk register, patient satisfaction and unplanned transfers. In the February 2019 meeting minutes, we saw that local policies and some NICE guidance were reviewed by the committee.
- The monthly cross-site departmental team meeting was attended by staff and the clinical service manager to review staffing, risk register, finance, audits, risk assessments. Other items on the agenda included journey to outstanding, key messages, IPC, patient satisfaction and complaints, training, clinical governance, policies and procedures. We noted that the February 2019 minutes highlighted that the new blood transfusion audit and pathway were in progress across the hospital.
- The medical advisory committee (MAC) was held quarterly and oversaw the renewing of consultants' practicing privileges, clinical governance issues, key policies and guidance and monitored patient outcomes.
- Practicing privileges were granted after submitting a CV and two references to the general manager who then interviews along with the chairman of the MAC. Privileges were reviewed and renewed annually according to evidence of appraisal, revalidation, GMC membership, mandatory training completion, and enough evidence of good conduct.

Managing risks, issues and performance

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

- There were three risks on the hospital risk register that were specific to issues in theatres and the wards. Mostly, we found that the risks on the risk register matched the risks that we observed on inspection. Senior staff could explain what was on the risk register, who took oversight and what actions were in place to mitigate risks.
- Senior leaders of the service, including the executive director, ward manager, theatre manager and infection prevention control lead nurse attended clinical governance committee meetings monthly. We saw that risks were discussed regularly at clinical governance committee meetings. Outstanding actions and updates were regularly addressed at these meetings and leaders had good oversight of the risks within the service.
- Staff were able to enter potential risks within the service on the electronic reporting system. Initially the ward manager or theatre manager would review the risk and investigate if they needed to be escalated to the head of the department and quality and risk manager. This meant that staff could directly be part of risk management within the organisation.

Managing information

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

- During inspection we observed staff treated patient identifiable information in line with the General Data Protection Regulations (GDPR).
- All designated staff had access to patients' medical records which included assessments, tests results, current medicines, referral letters, consent forms, clinic notes, pre- and post-operative records.
- As well as having access to the hospital intranet for all up-to-date policies, staff were aware that policies and pathway information was kept in paper format on the wards.
- Information technology systems were used effectively to monitor and improve the quality of care. For example, the corporate risk and incident recording system provided the hospital with a platform to monitor and assess risks and assess trends.

Engagement

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

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

Learning, continuous improvement and innovation

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

- In pre-assessment, a senior nurse was supported by management to work on a project to help streamline the admissions process for patients. The project entailed making procedure pathways for specific procedures within specialities, for example a total knee replacement. Procedure pathways meant there could be a standardised for patients, for example medicine management guidelines based on the proposed procedure. This meant that there would be agreed practices and could help prevent clinical cancellations of appointments. The senior nurse created the procedure pathways in accordance with current best practice, they would be checked by pharmacy staff and signed off and agreed on by consultants and anaesthetists working at the hospital.
- Pharmacy staff developed and implemented medication record cards for patients who may be living with dementia or were concerned about remembering to take their medications when discharged home. Medication record cards listed the drug name and strength, dose, times to take medication, indication (for example for pain or prevention of deep vein thrombosis) and remarks (such as to take medication only as required or to take medication with a meal).
- Staff from the hospital and sister hospital started a group for learning, educating, and adapting to falls (LEAF) which met quarterly to assess, plan and discussed potential falls and how to manage them. In October 2017, the hospitals worked with the GP liaison officer and the Chartered Society of Physiotherapists (CSP) to hold the 'older people day and LEAF' GP evening where 15 GPs attended the event. A geriatric consultant and the physiotherapy manager gave a falls presents and discussed referral pathways along with a leaflet to demonstrate how to quickly make referrals.

This helped to ensure there was a clear pathway for patients at risk for falls and understanding when further referrals were needed for occupational therapy or physiotherapy.

Good

Outpatients

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

Are outpatients services safe?

Good

Mandatory training

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

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

Safeguarding

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

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

Cleanliness, infection control and hygiene

Staff used control measures to prevent the spread of infection. Staff kept themselves, equipment and the premises clean.

- There was an infection prevention and control (IPC) nurse who covered both Cavell and Kings Oak Hospitals. Part of the role was to conduct regular walk arounds on wards and in outpatient areas to check on standards. There was a link nurse for IPC in outpatients. They attended infection control meetings and carried out audits on personal protective equipment, environment and hand hygiene. They had induction with the infection control lead nurse for this role.
- All staff had aseptic non touch technique (ANTT) competencies which were also covered by the IPC nurse. We were provided with a consulting rooms hygiene audit dated 21 March 2019. It focussed on supply of personal protective equipment, hand hygiene

and the use and disposal of sharps. It showed 100% compliance with all items. We were also provided with a hand hygiene audit dated 21 March 2019 which showed a compliance rate of 88%.

- On checking with the infection prevention and control lead nurse, we were told that curtains should be changed every six months. In the rooms we checked there were some curtains that had no expiry date stated, some were out of date and some were within date.
- Hand gels were available in corridors and by toilets. All were in working order. There was a daily cleaning schedule in the toilets by reception which stated the toilets were cleaned once a day. Toilets were clean and hygienic with hand soap, hot water and dryer available. There were no cleaning schedules available in other public areas. However, it was confirmed with cleaning staff that their own schedule meant they cleaned the waiting areas and toilets at least three times a day.
- There were no individual cleaning schedules in consulting rooms or on trolleys. The treatment and consultation rooms we saw were clean and orderly. Trolleys were also orderly and clean. We were provided with hygiene audits for March 2019; one for consulting rooms and one for hand hygiene which showed 100% and 88% compliance respectively.

Environment and equipment

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

- Outpatients had a separate entrance to the main hospital. The reception desk and waiting area were located directly inside the entrance. The waiting area had approximately 30 seats and was spacious enough for all patients to be seated. It was visibly tidy and the department was fully wheelchair accessible. Treatment and consultation rooms were located in close proximity to the main waiting area.
- There was an online reporting system for logging maintenance work. A maintenance team were based on site and we were told they provided a responsive service, usually responding to maintenance requests on the day.
- Daily checks on the resuscitation trolley were taking place. Drawers containing equipment were sealed appropriately. There was a note attached to the defibrillator dated 8 April that stated that a new defibrillator pad was on order as the current one was not fit for purpose. Servicing was in date.
- In the consultation and treatment rooms we saw trolleys containing items for use were orderly. Storage cupboards in treatment rooms were well organised and did not contain temperature monitored fluids or dressings. The dirty utility was well organised with all equipment up to date. However, the electrical equipment testing was out of date.

Assessing and responding to patient risk

Staff completed and updated risk assessments for each patient. They kept clear records and asked for support when necessary.

- We reviewed eight sets of notes, pulled at random from medical records and the bookings team room. Notes and files we reviewed contained basic patient information and assessments. There were outpatient outcome forms that included referral for further assessment, medication management, physiotherapy and for referring back to the patient’s GP.
- The patient clinical summary assessment included past medical history, allergies, medication, family history and test results. There was a patient booking form that included a clinical coding form for cardiac, respiratory, renal, endocrine, neurological, orthopaedic and sensory assessment. For new NHS patients, there was also NHS tracker information.
- We followed the pathway for one patient who had their first appointment and required funding for surgery. There were flags on notes for dementia and a stamp on the front of the notes folder for MRSA and infection screening. Patients signed the back of the registration forms that the demographic details were all correct such as address, next of kin and contact details. Referrals went to a central referral service for triage.
- All referrals in to the service were triaged before being accepted for a first appointment. Triage was carried out by senior nurses including the quality and risk manager, outpatients manager, infection control lead, paediatric lead and ward manager. The referral criteria included a BMI of under 40 and no co morbidities such as asthma or COPD. Following the triage process, the medical notes were located in the online notes system for consultants to check against the proposed procedure. If

the patient was judged to not be eligible at any stage of the process, they were referred back to their GP. If they were accepted the consultant carried out further assessment and completed the booking form during the consultation and authorised for surgery.

- There were daily briefs at 9.30am and 3.00pm. these took the form of both teleconference and face to face meetings involving senior managers and clinicians from both Cavell and Kings Oak sites. They covered deteriorating patients, incidents, equipment issues, IT issues and any concerns or reportable events. They were forums for information sharing and making decisions to take action. They were minuted in real time and emailed to all staff. We were told this was an effective means of communication and given examples of how rapidly information discussed had become common knowledge.
- All staff were trained in using the national early warning scores (NEWS) for deteriorating of patients.

Nursing staffing

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

- We were told that across BMI Healthcare, the BMI Healthcare Nursing Dependency and Skill Mix Planning Tool was used. This was introduced in 2015 as a guide to assist trained professionals exercise their judgement to ensure the right members of staff are on duty at the right time and with the right skills, to respond to patient acuity and therefore ensure good patient care. We were told this was populated in advance so that staff levels can be reviewed and planned in a timely manner.
- In information provided prior to our inspection visit we were told that as at 1 February 2019, there was a staffing establishment in outpatients of four nurses and four healthcare assistants. They were currently filled to 2.2 and 1.64 whole time equivalent (WTE) respectively. Staff turnover for both groups of staff between March 2018 and February 2019 was stated as 0%. The use of bank staff in outpatients was stated as (between September 2018 and February 2019) an average of 2% for nursing and HCA staff. We were told that between December 2018 and February 2019 there were zero unfilled shifts. Agency staff were not used.
- Staff sickness rates in outpatients were given for March 2018 to February 2019. There was a 19% rate in March 2018, 24% in October 2018, 40% in November 2018 and 30% in December 2018. Other months averaged between 4 and 10%.
- On site we found that the outpatients' sister organised the staff roster four weeks in advance. This was then forwarded to the outpatients' manager for verification of the correct skill mix and for signing off.
- We found the service was organised for there to be two nurses and one to two healthcare assistants on duty depending on the number of clinics running each day. Shifts ran from 7.30 am to 3.30 pm, and from 1 pm to the end of the day which could vary in time depending on the late running of clinics.
- The service had four vacancies; two nurses and two healthcare assistants and was currently organised by utilising three substantive nurses and three substantive healthcare assistants for use across both Kings Oak and Cavell sites. There were currently three bank nurses for the service to call upon and we were told they tried to use the same bank staff for consistency. All bank staff had induction, completed mandatory training, had access to emails and the incident reporting system just as substantive staff. Agency nurses were not used.

Medical staffing

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

- In information provided prior to our inspection visit we were told that consultants and anaesthetists were engaged under BMI practicing privileges which were also available for their own patients. Consultants and anaesthetists were required to confirm suitable cover arrangements if they were unavailable or on annual leave.
- New Consultants enquiring about practicing privileges were directed to the central executive team and an application pack forwarded for completion which included demonstration of all relevant clinical experience relating to the practice which they wish to bring into the hospital. They were expected to provide a number of supporting documents including; curriculum vitae, certificates of qualification, annual appraisal, GMC specialist register registration, medical indemnity certificate, and ICO certificate evidencing registration as a data controller with the Information Commissioners

Office. References and immunisation status were also requested and an enhanced DBS check took place. The application was scrutinised by the hospital's Medical Advisory Committee (MAC) for it to be fully ratified. Consultants were required to provide updated documentation annually. We were told failure to provide or renew documentation prior to expiry may lead to temporary suspension or withdrawal of practising privileges.

Records

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

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

Medicines

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

- We were told that pharmacy staff pro-actively supported the clinical teams. All medications given on discharge were communicated to the GP on the discharge letter. The pharmacy was open until 5pm from Monday to Friday with no Saturday service. Prescription pads were provided by pharmacy and FP10s were not used. Out of hours, the local community pharmacy could be accessed for private and self pay prescriptions but not NHS. NHS patients had to return to pharmacy within working hours to obtain their prescription medications. Two week prescriptions were given to patients. Prescriptions were tracked by the pharmacy team. There were no controlled drugs stored in outpatients.
- Resuscitation trolleys were not temperature monitored which was confirmed with the pharmacist. However, we were told that BMI had requested that the trolleys were kept in temperature controlled areas or moved away from radiators due to the storage of medicines on them. This was the responsibility of the lead for each department. The drugs stored on the resuscitation trolley were not temperature monitored. The trolley was not located near a radiator but was not in a temperature controlled area as advised by the pharmacist.
- Sachets of fluids were found on nurse trolleys kept in treatment rooms that were not temperature controlled. However, daily checks on room temperatures and fridge temperatures had been signed and dated in the minor operations room, treatment room, and both clean and dirty utility rooms.

Incidents/Incident reporting, learning and improvement

Good

Outpatients

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

- In information provided prior to our inspection visit we were told that in outpatients and diagnostic imaging, there were zero never events in the last 12 months and 14 clinical incidents. We were told that the hospital actively encouraged incidents to be reported and that the number of reported incidences had increased as staff confidence in a culture of openness had improved. We were told that all incidents were investigated, with Route Cause Analysis (RCA) being completed as appropriate.
- On site we found incident investigations were allocated to the head of department aligned to the department of origin. We were told that any investigation involved speaking to those directly involved. Any investigation report went to senior management who sent feedback that may advise on further action depending on context and circumstances.
- There was a hospital wide lessons learnt meeting attended by staff of different grades, and coordinated by the quality and risk manager. Learning was shared throughout the hospital and other departments within the Kings Oak and Cavell collective. The most recent reportable incident in outpatients related to communication and minor harm regarding a patient who had been seen at both sites. We were told that duty of candour was observed and the patient apologised to and given an explanation.
- There was an outpatient departmental meeting on the last Tuesday of each month where the service tried to block the time out for 50% of nursing and healthcare assistant staff to attend. This included a 'lessons learnt' briefing.
- There was an online incident reporting system used. This broke down all incidents so that what might be attributable to outpatients could be identified. Monthly clinical governance meetings reviewed incidents reported by both hospital sites, broken down by type of incident rather than by department. We were told that a supplementary report was also presented at clinical governance meetings which further examined incidents at a team level, such as outpatients.
- All staff had an individual log in to the reporting system and it was everyone's responsibility to report incidents. The system also reported on risks and anyone could add a risk but staff were encouraged to discuss risks so they can be correctly categorised. All staff were trained in its use but we were told responsibility to report was usually left to the lead nurse to put it on the system.
- We questioned why there were hand mirrors in the consulting rooms and were told there had been an incident involving wrong site surgery. As part of lessons learnt, mirrors were placed in consultant rooms where patients confirm the correct excision, patients then marked for procedure and consent taken.

Safety thermometer

The service used safety monitoring to improve the service.

- The patient safety thermometer is a national tool to record the prevalence of patient harms and to provide immediate information and analysis for frontline teams to monitor their performance in delivering 'harm free' care. This information is intended to help staff focus their attention on reducing patient harm and improve the safety of the care they provide.
- The safety thermometer tool was not used in outpatients at the hospital as it was not suitable for an outpatient setting. However, we were told that there were a number of arrangements to promote harm free care. The service had signed up for sepsis prevention and all staff knew how to escalate for sepsis in post operative wound care. There were posters for sepsis 6 and staff liaised with infection control lead. There were procedures in the event of sharps injuries. Staff were trained in the monitoring of mobility for patients at risk of falls and referred on to physiotherapy if deterioration was detected. VTE was monitored in assessment.

Are outpatients services effective?

Not sufficient evidence to rate

Evidence based care and treatment

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

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

Nutrition and hydration

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

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

Pain relief

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

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

Patient outcomes

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

- In information provided prior to our inspection visit we were told that outcomes were monitored following discharge through follow up appointments and physiotherapy sessions. Patients were given the option to receive a follow up telephone call soon after surgery to review progress.
- We were told the service participated in the National Joint Registry and Patient Reportable Outcome Measures (PROMs) and submitted data to the National Joint Registry for all hip, knee & shoulder replacement patients. Patients were given forms in pre- assessment and given a unique identifying number so they could be tracked. We were also told that Commissioning for Quality and Innovation initiatives (CQUINs) were agreed with commissioners to promote improvement in patient care. This was a system introduced in 2009 to make a proportion of a healthcare provider's income conditional on demonstrating improvements in quality and innovation in specified areas of care.

Competent staff

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

- We were told that the appraisal year ran from September to October and 90% of staff had an appraisal so far in the current appraisal year (and 100% completion in the previous full year). All staff we spoke with told us they had completed their appraisals. Objectives were set and reviewed with their line manager.
- All staff completed competencies for individual skill sets. This information was kept in individual staff folders. We reviewed staff files that covered competencies. This was based on a BMI assessment form and was rated and signed by each staff member.
- Most healthcare assistants had completed a programme to develop them into associate nurse roles. Healthcare assistants had carried out a competency process which, when trained, enabled them to take on extra

responsibilities. These included taking bloods, wound care, suture removal and taking off plastercasts. They were also trained in the use of national early warning score (NEWS) assessment of the deteriorating patient and were provided with training for equipment use such as the blood pressure machine.

- These competencies involved shadowing nurses and completing online training. One outpatients nurse told us the associate nurse roles had greatly helped the service, which enhanced the available skill mix to support clinics.
- One healthcare assistant we spoke with told us they had been trained, in house to level 3 and were currently studying for the associate nurse role. They were competent to take bloods, do ECGs, remove sutures, clip removal and wound checks. Learning was via e-learning and practice learning. Their individual staff folder that we checked contained competencies that had been signed off. Healthcare assistants told us they reported to the on-site outpatient sister.
- There was an infection prevention and control nurse. They supervised outpatient staff competencies for dressings and suture removal. The healthcare assistants also had the support of the trained nurse on duty. Nurses and healthcare assistants were trained to take bloods as required.

Multidisciplinary working

Healthcare professionals supported each other to provide good care.

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

Seven-day services

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

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

Health promotion

- **Some health promotion information and advice was available.**

- Leaflets were available by reception on patient conditions such as orthopaedics, urology, breast health, varicose veins, physiotherapy and women's health. There was a display board on prostate cancer and urinary problems.

- Health questionnaires and advice was given in clinics on smoking, alcohol intake and mobility. Patients were referred for further help to cessation clinics if required.

Consent, mental capacity act and deprivation of liberty safeguards

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

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

Outpatients

Good

not mean this group of patients were outside of the referral criteria. Private patients who lacked capacity came as day cases. Also, those with the Power of Attorney in place were provided with one to one care.

Are outpatients services caring?

Good

Compassionate care

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

- We spoke with three patients waiting for their appointment. All patients told us they found staff to be friendly and kind. Everyone we spoke with had been before and told us they were confident about being treated with respect and compassion.
- The service told us they had a patient centred culture that put patients at the centre of how services were organised. We were told that importance was placed on treating all patients with dignity and respect. Patients we spoke with gave us positive feedback about the service and all members of staff they had come in to contact with. Some patients told us they had been here numerous times and that staff always treated them with respect. One patient told us that orthopaedic staff were fantastic and that the physiotherapy staff were very helpful.
- We observed nurses and healthcare assistants speaking to patients in a kind and polite manner. Reception staff were friendly and considerate in every interaction we observed. We observed medical staff being welcoming and warm towards patients. All healthcare staff we observed introduced themselves to patients.
- We were told the service actively encouraged patients to complete the patient satisfaction questionnaire, so the patient experience could be reviewed and improved. Patient surveys were distributed through an independently managed questionnaire which was available by email and paper form. A monthly report was provided to the hospital for review and analysis. The results were reviewed at the patient satisfaction meeting that occurred monthly, where trends and improvement actions were identified. They were also discussed at the clinical governance, departmental and head of department meetings.
- We were provided with the overall patient satisfaction survey results for the hospital last six months, which averaged 97% satisfaction rate with an average response rate of 70%.

Emotional support

Staff provided emotional support to patients to minimise their distress.

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

Understanding and involvement of patients and those close to them

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

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

Good

Outpatients

Are outpatients services responsive?

Good

Planning and delivering services which meet people's needs

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

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

Meeting people's individual needs

The service took account of patients' individual needs.

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

Access and flow

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

Good

Outpatients

- All referrals were triaged before being accepted for a first appointment by the service. We were told this was a time consuming undertaking for the senior nurses involved because of the large volume of referrals. The quality and risk manager, imaging manager, outpatients manager, infection control lead, paediatric lead and ward manager all carried out triaging. Staff were often undertaking this task at weekends when not on duty in order to clear the backlog. The referral criteria included a BMI of under 40 and no comorbidities such as asthma or COPD. We were also told that this occasionally resulted in rejecting a referral due to incomplete information often being provided on referrals. This was understood to be an issue but remained the way it was done.
- There was a team of four staff who ensured files were available for appointments. Files were stored on site. When needed, sets of files were sent to or from the Kings Oak hospital in secured locked boxes which were transported by porters. Lists were produced for clinics in advance and sent to the patient records team for making up the files, usually one day in advance. Staff checked that consultants had confirmed the clinic was going ahead before making up files for each clinic. All NHS 'choose and book' appointments were booked electronically and the referral printed off by the bookings team and placed in case notes, which included the outcome form from the clinic.
- For NHS contract work, the reservations team had access to the NHS e-referral system (choose and book) and were responsible for transferring information on to BMI patient information software, which identified treatment targets and whether 18 week targets were being met. The national enquiry centre for BMI booked patient appointments for self paying patients and consultants ring fenced these appointment slots. The service also held spot contracts with NHS trusts.
- The NHS 18 week referral to treatment (RTT) key performance indicator target was 92% and the service currently stood at 95%. This was tracked within an RTT dashboard which was shared with the CCG. An overall report was completed by the bookings manager and sent alongside the dashboard.
- The RTT dashboard also showed non attendance rates by outpatient clinic. There was a target rate of under 5% per month. Statistics for the year to date; April 2018 to February 2019, showed that most clinics were within this target. However, ENT, trauma and orthopaedics, gynaecology and gastroenterology were consistently above this threshold.
- Patient outcome slips from clinics went back to the reception to enter the patient outcome of the clinic appointment. The reception staff entered the outcome live into the patient administration system. Notes were sent to the bookings office after clinic outcomes had been completed, which were then checked by the validation team to ensure the 18 week clock was correct against the clinic outcome and notes. Prior approval forms, booking forms and coding forms were then actioned. For invoicing, charges were added by site and processed by the company's main billing centre, based in Manchester who sent out an invoice. When a patient was unhappy with the invoice, the team contacted the site, to recheck the notes and reverify the invoice.
- The bookings team reported on the number of referrals that had been received undated in the daily morning meeting, which was attended by senior staff from both Cavell and Kings Oak sites. If required, this was escalated to the senior team. There was an access policy that required 6 week's notice of any clinic cancellation. We were told this was difficult to implement, as clinics were cancelled at late notice.
- Information on late running clinics were fed into the daily morning meeting. There was a weekly utilisation meeting and we were told that all front facing services attended. Waiting times for clinics were not displayed in waiting areas. There was a notice on display at the reception desk that advised patients to report to reception if they had been waiting more than 20 minutes. This was an action taken from a complaint regarding waiting times. We were also told that the director will write to consultants inviting them in to discuss clinic and theatre waiting times if they consistently arrived late. This was then followed up by letter to the clinician.
- We were told that when consultants were delayed, patients were called by reception and nursing staff and informed of when they were expected. We also witnessed this in practice. However, clinic delays were not communicated to the patients on arrival.
- Speaking to patients, a theme was that waiting beyond appointment times was common. Patients who had attended on a number of occasions told us they had waited for long periods before, sometimes up to an

hour. Patients confirmed that when there was a wait to see the consultant, staff and consultants were always apologetic. We were told they felt they received a good service from the doctors and did not mind if the doctor was delayed or overrunning but just wanted to be informed of this.

Learning from complaints and concerns

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

- Patients we spoke with told us that staff were helpful and approachable. We were told that when something was not to their satisfaction and they raised it with staff, the response was very constructive and helpful. Staff we spoke with told us that if they were approached by a patient who was not happy about the service they had received they would, in the first instance, try to resolve the issue there and then for the convenience of the patient.
- Between March 2018 and February 2019 the service received 50 complaints overall. None were referred to referred to the Independent Healthcare Sector Complaints Adjudication service (ISCAS). Staff were able to give us examples of recent complaints and learning. This included clinic delay and not being informed of overrunning clinics. We were told that the notice at reception requesting patients report back to reception had been introduced as a result.
- We were told that other complaints had included unexpectedly incurring extra costs for having bloods taken or a scan carried out. When calling the call centre, self paying patients were now told they could incur further costs outside of the consultation such as for x ray and bloods tests. This was not however, documented in appointment letters on any leaflet. The lessons learnt was to add to the 20 minute wait notice at reception, and that extra costs could be incurred. However, by this time the patient is already presented for their appointment. This was escalated for action for the bookings team to address and was described as a work in progress.
- Another recent complaint related to if a patient changed hospital site for any reason, from Kings Oak to Cavell or vice versa. Due to having two different hospital numbers, it was a requirement for 'group and save' bloods samples to be retaken. This had been escalated to the senior BMI leadership team to work with the pathology lab for resolution. Currently, the results of bloods cannot be transferred to the other site.
- We were told that patient complaints followed a three-stage process, with each stage having set time frames for responses. Stage one involved an investigation and response by the hospital within 20 days, whilst stage two resulted in regional or corporate review and response within 20 days. Stage three provided for an independent, external adjudication.
- All written complaints were received via the executive director's office, who acknowledged receipt to the complainant within 48 hours by letter or email (depending on the method of delivery). Copies of the complaint were then distributed to the relevant head of the department or consultant for investigation. The final response came from the executive director.
- We were told that the hospital had generally been compliant with these time frames, with a small number of occasions within the last twelve months where the hospital has failed to meet the timescales set out. Instances in which timescales had proved more difficult to achieve were ones where input from a number of individuals was required. In these situations, an update or further holding letter was sent to the complainant to keep them informed of progress.
- We were told that the service also monitored patient feedback received through complaint and compliment letters and responded to feedback that was posted on the national 'NHS Choices' website and other associated websites. Electronic feedback was responded to and shared with the team in the same way as written feedback.

Are outpatients services well-led?

Good

Leadership

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

- The Kings Oak Hospital and The Cavell Hospital were located a mile apart from one another and the same hospital leadership team managed both sites. The outpatient manager worked across both sites and there

was an outpatient sister in charge at each hospital. The outpatient manager ordinarily reported to the clinical director and associate clinical director. However, both posts had been vacant for three months. There were new starters for both on the first day of our unannounced inspection. In the three month absence, the outpatient manager had been reporting to the quality and risk manager, who was part of the senior management team.

- We were told a senior nurse in charge was available as a contact point for staff, consultants and patients and was available via bleep or telephone. There was also an on call rota where hospital managers provided on call support for a week at a time and from the 1 April 2019 the manager on call would be in attendance every Saturday, providing support to the teams.

Vision and strategy

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

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

Culture

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

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

Governance

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

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

Management of risk, issues and performance

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

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

Information management

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

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

Engagement

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

- Patient surveys were managed through an independently managed questionnaire which was available by email and paper form. Friends and family leaflets were available at reception on 'how well did we do?'. They included how likely to recommend the service, who did you see today, were you self-funded and demographic questions. A monthly report was provided to the hospital for review and analysis. The results were reviewed at the patient satisfaction meeting that occurred monthly, where trends and improvement actions were identified. They were also discussed at the clinical governance, departmental and head of department meetings. There an average response rate of 60%.
- Patient feedback was also gained from patients writing in to the service to say thank you or with issues that have arisen during their contact with the hospital. All comments will be logged as feedback within the online incident and risk reporting system where there was a feedback section. We were told this information could also be fed in to the morning brief for individual praise. The brief gets emailed to all staff to read. This is found to be effective and the manager often finds that staff are aware of what has been discussed before they contact the staff following the meeting.
- The staff survey was completed annually. The most recent was survey was conducted in February/March 2019 and we were told that the results had not yet been seen by staff.

Learning, continuous improvement and innovation

The service learnt by promoting improvement and innovation.

- The clinical services managers for outpatient departments within the London BMI group, met quarterly to discuss outpatient issues and business at a wider level. We were told this acted as a good reference point where good practice, new initiatives and solutions to challenges were shared. There was also a group email for advice and shared learning.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider SHOULD take to improve

Medicine:

- The provider should ensure there are appropriate qualified and competent oncology staff in place for the oncology patients during out of hours and clinical emergencies such as neutropenic sepsis.
- The provider should ensure the oncology 24 hour helpline is managed by appropriately trained oncology staff.
- The provider should ensure staff in the oncology and endoscopy department only work within the scope of their qualifications, competence, skills and experience.
- The provider should ensure nursing staff are competent and appropriately trained in endoscopy procedure.
- The provider should ensure that staff are appropriately trained and competent to complete the UK Oncology Nursing Society triage tools.
- The provider should ensure that all staff had completed their appraisal.
- The provider should ensure that pain assessments were completed for all patients.
- The provider should consider how to address the low morale and staff experience in endoscopy.

Surgery:

- The provider should ensure that records are completed and available when needed in pre-operative assessment.
- The provider should ensure there are adequate, qualified staff in pre-operative assessment.
- The provider should ensure all staff receive a yearly appraisal.

Outpatients:

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