BMI Hendon Hospital

Quality Report

BMI Hendon Hospital
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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?	Requires improvement
Are services effective?	Good
Are services caring?	Good
Are services responsive?	Good
Are services well-led?	Good

Summary of findings

Letter from the Chief Inspector of Hospitals

We inspected the hospital on 19, 20 and 21July 2016 as part of our independent hospital inspection programme. The inspection was conducted using the CQC's comprehensive inspection methodology. It was a routine planned inspection. We inspected the following three core services at the hospital: medicine, surgery and outpatients and diagnostic imaging.

We rated the hospital as good overall.

Our key findings were as follows:

Are services safe at this hospital?

We rated safe as requires improvement because:

- At the time of our inspection 88.68% of staff completed their mandatory training. This was below the hospitals target of 100%.
- Staff were not following the appropriate guidance and not separating clinical and non-clinical waste.
- Some of the inpatient patient rooms required to be redecorated to ensure facilities met appropriate standards.
- Colour coded cleaning equipment was not used in theatres and there was no protocol on which cleaning products should be used where.
- The ward environment was not suitable for the care of patients living with dementia.
- The consulting room in the new ophthalmic clinic had no hand basin and the hand basin in the mammography room was removed and not replaced for over three months.
- The plaster room was used for plastering as well as wound dressing and this potentially exposed patients to cross infection in the event of an infected wound.
- The outpatients department was in need of refurbishment.
- Most sinks in the theatre suite were not compliant with suitable building regulations.
- Learning from incidents was not always shared with all staff.
- Maintenance requirements noted in the validation report for the theatre ventilation system were not completed.
- Controlled drugs were not always disposed of correctly.
- Patients' clinical records were sometimes left unattended in an unlocked drawer.
- In the physiotherapy department, the cryotherapy pod was not in service and there was no timeline as to when the ownership and the contractual issues would be resolved.
- There were no timelines for replacing the MRI scanner and the ultrasound machine.
- Some managerial posts were vacant for some time, which has had an impact on both the managerial and clinical work of the departments.

Are services effective at this hospital?

We rated effective as good overall because:

- The hospital had an audit calendar which set out the audits to be undertaken across the hospital over the 12 month period for 2015/2016.
- Theatre staff used the five steps to safer surgery in line with guidance from the National Patient Safety Agency (NPSA).
- The hospital carried out regular audits including use of the World Health Organisation (WHO) safety checklist.
- We found good multidisciplinary team (MDT) working between nurses and consultants.
- Patients' pain was assessed and managed appropriately.
- The hospital followed national guidelines in its policies and procedures, which were kept updated.
- The work of the departments was audited thoroughly, and found to be generally of a high standard. There were regular clinical audits.
- Agency nurses underwent hospital orientation and induction.

Summary of findings

Are services caring at this hospital?

We rated caring as good because:

- Patients gave positive feedback about the care and service provided. They reported that staff were reassuring, approachable and very professional.
- Patients said they were well informed and confirmed they were given time to read the various forms before signing them.
- We observed that staff were friendly and interacted well with patients. Staff provided compassionate, patient-centred care.
- The hospital scored above the national average in the NHS Friends and Family Test.

Are services responsive at this hospital?

We rated responsive as good overall because

- Patients had single rooms that provided privacy and comfort with ensuite facilities and there was no restricted visiting times for patients.
- The hospital had monthly compliments and complaints meeting for staff to receive and give feedback and to facilitate discussion on how to improve patients' experiences.
- Patients referred by their GP could book a convenient date and time for their appointment through NHS 'choose and book' electronic booking system.
- All patients were admitted under the care of a named consultant. The consultants reviewed patients prior to commencement of each treatment.
- Services were planned to meet the needs of patients and to ensure contractual requirements were met.
- The hospital met the referral to treatment target (RTT) of 90% for NHS admitted patients waiting less than 18 weeks from the time of referral to treatment. They achieved 98% in April 2016, 100% in May and 98.8% in June.
- Any radiology required was arranged, usually on the same day as the appointment with the consultant.
- The flow of patients through the various clinics was well organised.
- There was a wide range of physiotherapy treatments available. Interpreters were provided when needed.
- Staff felt they worked well with NHS providers and GPs to meet the needs of local people.
- Complaints were handled and resolved appropriately and quickly.

Are services well led at this hospital?

We rated well led as good overall because:

- Governance and risk management processes were in place.
- The hospital risk register included corporate and clinical risks
- Patient satisfaction was monitored and reported on monthly through the patient satisfaction dashboard.
- Safety outcomes were measured and monitored.
- There was good teamwork and staff enjoyed working there.
- The hospital had an open and transparent culture. The executive team was supportive of their staff; the Eexecutive Ddirector was visible daily and was involved in staff meetings.
- There was an open door policy and staff felt comfortable to speak with the executive director or the clinical director if they had any issues.
- There was good clinical governance and a good quality and risk management process. This ensured patients received safe care and treatment.

We also said that the provider must:

- Carry out remedial work in the sluice where there is exposed plaster and pipes and a hole in the wall from the recent removal of decontamination equipment.
- Ensure that all remedial action highlighted in the theatre ventilation servicing report is completed.

Summary of findings

- Ensure that the facilities are in compliance with Department of Health guidelines HBN26 'facilities for surgical procedures'.
- Ensure confidential patient information is stored in accordance with the Data Protection Act 1998.
- Ensure there are an adequate number of hand basins in the consultation and treatment rooms to minimise the risk of cross-infection.
- Ensure there is an adequate facility for wound dressing to prevent cross infection.

In addition the provider should:

- Improve communication of shared learning from incidents so that all staff are aware and involved.
- Ensure that all staff have the skills needed to fulfil their roles and are supported to develop.
- Ensure staff complete their mandatory training.
- Ensure that the resident medical officer RMO's has regular clinical supervision.
- Improve communications between the theatre and other departments.
- Ensure waste management meets best practice guidelines for the segregation and indication of clinical and non-clinical waste
- Ensure there is oversight of infection prevention and control across all departments including theatres.
- Ensure that inpatient rooms are compliant with HBN00-09.
- Ensure that thermostatically taps are installed in the hand washing basins.
- Ensure disabled shower room facilities are safe and fit for purpose.
- Improve the environment in patient's rooms and bathrooms.
- Ensure the decor of the outpatients department is well maintained.
- Ensure the MRI scanner and the ultrasound machine are replaced in a timely manner.
- Ensure the vacant manager posts for both departments are filled without further delay.
- Undertake audits of national early warning score (NEWS) systems to identify deteriorating patients
- Ensure action plans are in place for high MUST scores

Professor Sir Mike Richards

Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Medical care	Requires improvement 	• At the time of our inspection 88.68% of staff completed their mandatory training. This was below the hospitals target of 100%. • The ward environment was not suitable for the care of patients living with dementia and not all the staff on the ward received dementia training. • There was no audit of national early warning score (NEWS) systems to identify deteriorating patients which meant the hospital was unable to identify if improvements in practice and outcomes were required. • Action plans were not always in place for high MUST scores where an intervention was required. • It was not clear who was responsible for providing the resident medical officer RMO's with clinical supervision. • Waste paper bins were in patient rooms and pedal bins used in bathrooms did not meet the waste management guidelines for segregated waste bins. • Staff were not following the appropriate guidance and not segregating clinical and non-clinical waste. • One hand basin for staff use outside of patient rooms had no thermostatically controlled tap and an open bin stored in the recess stored under the sink. The waste management did not follow the correct classification for offensive/ non-infectious waste. • The disabled shower room had a shower chair with a missing caster from one of the legs and a leg was rusty. • In patient rooms patient lockers were damaged with wood exposed on most of the edges on the tops of the lockers, some fabric chairs had staining on the seat cushions and there were some gaps in between the en-suite flooring and the room carpet.

Summary of findings

- In patient bathrooms some of the Formica tops were stained, tiles were coming away from the walls and sealant around the sinks and toilets were in a poor condition.

Surgery

Good

- Care and treatment was delivered in line with evidence-based guidance. Surgical staff used the five steps to safer surgery in line with guidance from the National Patient Safety Agency (NPSA). The hospital carried out regular audits to monitor performance, including use of the World Health Organisation (WHO) safety checklist.
- There was good communication and team-working between nurses and consultants.
- Staff were compassionate and caring towards patients, and patient feedback was positive about staff.
- The hospital scored highly in the NHS Friends and Family Test.
- The hospital met the referral to treatment target (RTT) of 90% for NHS admitted patients waiting less than 18 weeks from the time of referral to treatment. They achieved 98% in April 2016, 100% in May and 98.8% in June.

Outpatients and diagnostic imaging

Good

- The hospital had good leadership through the executive director and there was good clinical governance.
- The hospital's policies and procedures were in accordance with national guidelines.
- Patients received good care and treatment. They were respected and well supported. Patients were seen by a specialist consultant within days of being referred.
- Patients said they were well informed and involved in making decisions with their consultant.
- Staff of all disciplines worked well together to ensure patients received good care and treatment. They demonstrated an open and transparent culture and felt comfortable to raise concerns and report incidents.

Summary of findings

- There was good multidisciplinary working within the hospital services and externally with other healthcare providers. The hospital made thorough checks on consultants before awarding practising privileges.
- Staff followed the escalation policy when a patient was clinically unwell.
- The x-ray machines were checked regularly and regular monitoring was carried out when using contrast agents.
- The staffing number and skill mix of staff was adequate to keep patients safe. All staff had competency assessments before carrying out clinical tasks and all staff completed mandatory training.

Summary of findings

Contents

Good

BMI Hendon Hospital

Services we looked at
Medical care
Surgery
Outpatients and diagnostic imaging

Summary of this inspection

Background to BMI Hendon Hospital

BMI Hendon Hospital is a combination of a purpose built main block, built in the 1960's and an adjoining consulting room suite formed from two converted residential properties. It is located in a residential area in North London, close to major road and rail links. The hospital is registered for 30 beds, but actually has 21 available bedrooms as nine of the bedrooms were used as either offices or additional clinic spaces. It has a small car park and on street parking around the hospital.

The hospital treated adults only as prior to the inspection, the hospital's senior management team took the decision to stop treating children, with the exception of over 16s who were on an adult care pathway.

The medical services provided at The BMI Hendon Hospital were inpatient and endoscopy. There were a total of 1,011 endoscopy procedures between April 2015 and March 2016. Between April 2015 and March 2016 there were 380 inpatient attendances. The hospital also provides care to a small number of palliative patients. The inpatient medical service is provided by medical consultants with practicing privileges, a resident medical officer (RMO), nurses, health care assistants, a pharmacist, allied health professionals and administrative assistants. The endoscopy service is provided in theatre department and utilises the Dr Bruce ward pre and post procedure for recovery. Procedures undertaken include oesophago-gastro duodenoscopy (OGD), colonoscopy, upper gastrointestinal (UGI) and flexible sigmoidoscopy.

Surgical services consisted mainly of adult elective surgery, including orthopaedic, gynaecology, ophthalmic and general surgery. Surgical services were provided to both insured and self-pay private patients and to NHS patients through local contract systems. The hospital carried out a range of inpatient and day case procedures. There were 17 inpatient bedrooms contained on one ward. Each single room had ensuite facilities with either a bath or shower. There were two operating theatres, one with laminar flow. There were 2,730 visits to theatre between April 2015 and March 2016. The five most commonly performed surgical procedures in that period were: multiple arthroscopic operations on knee (187), phacoemulsification of lens with implant – unilateral (180), therapeutic endoscopic operations on uterus (115) hysteroscopy including biopsy, dilatation, curettage and polypectomy (113), surgical removal of impacted/buried tooth/teeth (107). The service was led by a director of clinical services, a theatre manager and a ward manager. There was also a lead nurse for pre assessment.

The outpatients' service is situated in the consulting room suite. The diagnostic imaging department, the physiotherapy department and the ophthalmology clinic are all situated in the main building. The outpatients department consists of 10 consulting rooms, a minor operations procedure room, a phlebotomy room and a plaster/dressing room. There are two dedicated pre-assessment rooms on the first floor used to facilitate face to face and telephone pre-assessment. The clinical specialties offered on a regular basis in the hospital's outpatients department include gynaecology, haematology, orthopaedics, cardiology, care of the elderly, chest medicine, neurology/endocrinology, ophthalmology, pain management, podiatry, rheumatology, urology, dermatology, ear, nose and throat, gastroenterology, general surgery, breast surgery, cosmetic surgery and oral surgery.

The diagnostic imaging department has a general x-ray room, a mammography room, an orthopantomogram (OPG) room and an ultrasound room. The diagnostic imaging equipment available includes an OPG machine, a urodynamics machine, an ultrasound machine and a magnetic resonance imaging (MRI) machine. There is a dental computed tomography (CT) coned beam machine but this is not in use at the present time.

The physiotherapy department has two private treatment rooms, two curtained cubicles, a hand therapy treatment room, a gym, a compensated weight treadmill and a cryotherapy chamber. The physiotherapy facility is used by both outpatients and inpatients.

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

Summary of this inspection

physiotherapists and pharmacists who were employed by the hospital. The hospital cooperated with 167 consultants, all were self-employed and were not considered to be staff.

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

Previous inspection was carried out on 29 October 2013 and the report from this inspection can be viewed on our website.

How we carried out this inspection

To get to the heart of the patients' experiences of care, we always ask the following five questions of every service and provider: Is it safe? Is it effective? Is it caring? Is it responsive to people's needs? Is it well-led?

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

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

Requires improvement

- At the time of our inspection 88.68% of staff completed their mandatory training. This was below the hospitals target of 100%.
- Staff were not following the appropriate guidance and not separating clinical and non-clinical waste.
- Some of the inpatient patient rooms required to be redecorated to ensure facilities met appropriate standards.
- Colour coded cleaning equipment was not used in theatres and there was no protocol on which cleaning products should be used where.
- The ward environment was not suitable for the care of patients living with dementia.
- The consulting room in the new ophthalmic clinic had no hand basin and the hand basin in the mammography room was removed and not replaced for over three months.
- The plaster room was used for plastering as well as wound dressing and this potentially exposed patients to cross infection in the event of an infected wound.
- The outpatients department was in need of refurbishment.
- Most sinks in the theatre suite were not compliant with suitable building regulations.
- Learning from incidents was not always shared with all staff.
- Maintenance requirements noted in the validation report for the theatre ventilation system were not completed.
- Controlled drugs were not always disposed of correctly.
- Patients' clinical records were sometimes left unattended in an unlocked drawer.
- In the physiotherapy department, the cryotherapy pod was not in service and there was no timeline as to when the ownership and the contractual issues would be resolved.
- There were no timelines for replacing the MRI scanner and the ultrasound machine.
- Some managerial posts were vacant for some time, which has had an impact on both the managerial and clinical work of the departments.

Are services effective?

Good

- The hospital had an audit calendar which set out the audits to be undertaken across the hospital over the 12 month period for 2015/2016.

Summary of this inspection

- Theatre staff used the five steps to safer surgery in line with guidance from the National Patient Safety Agency (NPSA).
- The hospital carried out regular audits including use of the World Health Organisation (WHO) safety checklist.
- We found good multidisciplinary team (MDT) working between nurses and consultants.
- Patients' pain was assessed and managed appropriately.
- The hospital followed national guidelines in its policies and procedures, which were kept updated.
- The work of the departments was audited thoroughly, and found to be generally of a high standard. There were regular clinical audits.
- Agency nurses underwent hospital orientation and induction.

Are services caring?

Good

- Patients gave positive feedback about the care and service provided. They reported that staff were reassuring, approachable and very professional.
- Patients said they were well informed and confirmed they were given time to read the various forms before signing them.
- We observed that staff were friendly and interacted well with patients. Staff provided compassionate, patient-centred care.
- The hospital scored above the national average in the NHS Friends and Family Test.

Are services responsive?

Good

- Patients had single rooms that provided privacy and comfort with ensuite facilities and there was no restricted visiting times for patients.
- The hospital had monthly compliments and complaints meeting for staff to receive and give feedback and to facilitate discussion on how to improve patients' experiences.
- Patients referred by their GP could book a convenient date and time for their appointment through NHS 'choose and book' electronic booking system.
- All patients were admitted under the care of a named consultant. The consultants reviewed patients prior to commencement of each treatment.
- Services were planned to meet the needs of patients and to ensure contractual requirements were met.
- The hospital met the referral to treatment target (RTT) of 90% for NHS admitted patients waiting less than 18 weeks from the time of referral to treatment. They achieved 98% in April 2016, 100% in May and 98.8% in June.

Summary of this inspection

- Any radiology required was arranged, usually on the same day as the appointment with the consultant.
- The flow of patients through the various clinics was well organised.
- There was a wide range of physiotherapy treatments available. Interpreters were provided when needed.
- Staff felt they worked well with NHS providers and GPs to meet the needs of local people.
- Complaints were handled and resolved appropriately and quickly.

Are services well-led?

Good

- Governance and risk management processes were in place.
- The hospital risk register included corporate and clinical risks
- Patient satisfaction was monitored and reported on monthly through the patient satisfaction dashboard.
- Safety outcomes were measured and monitored.
- There was good teamwork and staff enjoyed working there.
- The hospital had an open and transparent culture. The executive team was supportive of their staff; the executive director was visible daily and was involved in staff meetings.
- There was an open door policy and staff felt comfortable to speak with the executive director or the clinical director if they had any issues.
- There was good clinical governance and a good quality and risk management process. This ensured patients received safe care and treatment.

Detailed findings from this inspection

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Medical care	Requires improvement	Requires improvement	Good	Good	Good	Requires improvement
Surgery	Requires improvement	Good	Good	Good	Good	Good
Outpatients and diagnostic imaging	Requires improvement	Not rated	Good	Good	Good	Good
Overall	Requires improvement	Good	Good	Good	Good	Good

Requires improvement

Medical care

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

Information about the service

The medical services provided at The BMI Hendon Hospital were inpatient and endoscopy. There were a total of 1,011 endoscopy procedures between April 2015 and March 2016. Between April 2015 and March 2016 there were 380 inpatient attendances. The hospital also provides care to a small number of palliative patients.

The inpatient medical service is situated in the 17 bedded Dr Bruce ward for patients who were elderly or with medical conditions. The inpatient medical service is provided by medical consultants with practicing privileges, a resident medical officer (RMO), nurses, health care assistants, a pharmacist, allied health professionals and administrative assistants.

The endoscopy service is provided in theatre department and utilises the Dr Bruce ward pre and post procedure for recovery. Procedures undertaken include oesophago-gastro duodenoscopy (OGD), colonoscopy, upper gastrointestinal (UGI) and flexible sigmoidoscopy.

During our inspection we spoke with 17 members of staff: senior managers, nursing staff (including lead nurses and specialist nurses), consultant physicians, resident medical officer, a pharmacist, housekeepers, catering staff, health care assistants (HCAs), and a ward clerk administrator. We also spoke with a number of patients and relatives on Dr Bruce ward, of which three were medical care patients. We observed interactions between patients and staff. In addition, we considered the environment and looked at records, including four patient records. Before and during our inspection we also reviewed performance information about the service.

Summary of findings

We rated this service as require improvement because:

- At the time of our inspection 88.6% of staff completed their mandatory training. This was below the hospitals target of 90%.
- The ward environment was not suitable for the care of patients living with dementia and not all the staff on the ward received dementia training
- There was no audit of national early warning score (NEWS) systems undertaken in 2016 to identify deteriorating patients which meant the hospital was unable to identify if improvements in practice and outcomes were required
- Action plans were not always in place for high MUST scores where an intervention was required.
- It was not clear who was responsible for providing the resident medical officer RMO's with clinical supervision.
- Waste paper bins were in patient rooms and pedal bins used in bathrooms did not meet the waste management guidelines for segregated waste bins.
- Staff were not following the appropriate guidance and not segregating clinical and non-clinical waste.
- One hand basin for staff use outside of patient rooms had no thermostatically controlled tap and an open bin stored in the recess stored under the sink. The waste management did not follow the correct classification for offensive/non-infectious waste.
- The disabled shower room had a shower chair with a missing caster from one of the legs and a leg was rusty.

Requires improvement

Medical care

- In patient rooms patient lockers were damaged with wood exposed on most of the edges on the tops of the lockers, some fabric chairs had staining on the seat cushions and there were some gaps in between the en-suite flooring and the room carpet.
- In patient bathrooms some of the Formica tops were stained, tiles were coming away from the walls and sealant around the sinks and toilets were in a poor condition.

However:

- All incidents were reviewed by the Director of Clinical Services (DOC) and the ward manager also reviewed incidents that occurred for inpatients on the wards.
- Staff were able to identify the potential signs of abuse and the process for raising concerns
- The hospital used a combination of professional guidance produced by the National Institute for Health and Care Excellence (NICE) and the Royal Colleges
- The hospital had an audit calendar which set out the audits to be undertaken across the hospital over the 12 month period for 2016.
- We saw that multidisciplinary team (MDT) working was evident in patient records.
- Nurses told us there were opportunities for learning and development.
- Agency nurses underwent hospital orientation and induction
- Results from the 'Friends and Family Test' showed people would recommend the medical services provided by the hospital.
- Patients told us their privacy and dignity was respected at all times and the care we saw supported this.
- All the patients we spoke with felt involved in their care and were kept informed about their treatment. Care plans were shared with patients.
- We saw patients had their needs assessed. Patient records contained a range of risk assessments which were correctly completed and reviewed as required.
- Patients had single rooms that provided privacy and comfort with ensuite facilities and there was no restricted visiting times for patients.

Are medical care services safe?

Requires improvement

We rated safe as requires improvement because:

We rated safe as requires improvement because:

- At the time of our inspection 88.6% of staff completed their mandatory training. This was below the hospitals target of 90%.
- Waste paper bins were in patient rooms and pedal bins used in bathrooms did not meet the waste management guidelines for segregated waste bins.
- Staff were not following the appropriate guidance and not separating clinical and non-clinical waste.
- One hand basin for staff use outside of patient rooms had no thermostatically controlled tap and an open bin stored in the recess stored under the sink. The waste management did not follow guidance related to infection prevention and control.
- The disabled shower room had a shower chair with a missing caster from one of the legs and a leg was rusty.
- In patient rooms patient lockers were damaged with wood exposed on most of the edges on the tops of the lockers, some fabric chairs had staining on the seat cushions and there were some gaps in between the ensuite flooring and the room carpet.
- In patient bathrooms some of the Formica tops were stained, tiles were coming away from the walls and sealant around the sinks and toilets were in a poor condition.

However:

- All incidents were reviewed by the Director of Clinical Services (DOC) and the ward manager also reviewed incidents that occurred for inpatients on the wards.
- Staff were able to identify the potential signs of abuse and the process for raising concerns

Incidents

- There were 211 clinical incidents reported across the hospital between April 2015 and March 2016. One of them was classed as a serious incident (SI).

- There were no never events for the period April 2015 to March 2016. Never Events are serious incidents that are wholly preventable as guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and should have been implemented by all healthcare providers.
- Between April 2015 and March 2016 a total of 211 clinical incidents and 20 non-clinical incidents were reported across the hospital; 53 were clinical incidents and 8 were non-clinical incidents reported by surgery or inpatients via the hospital incident reporting system. 204 were classed as either no harm or low harm. This meant that the incident resulted in low or no harm to the patient.
- An incident policy (including serious incidents) was available on the hospital intranet site and staff knew how to access it. Staff members we spoke with told us the reporting of incidents improved, they told us what the process was and gave us examples of incidents that were discussed during team meetings.
- Incidents were reported by staff using a paper proforma which were then logged by the quality and risk manager using an on line computer incident reporting system (sentinel) for the monitoring of trends, identifying actions and learning required.
- All incidents were reviewed by the director of clinical services (DoCS) and the ward manager also reviewed incidents that occurred for inpatients on the wards.
- Clinical and non-clinical incidents were reviewed and discussed at a range of meetings including daily operational meetings attended by senior management. The hospital recently introduced “bitesize” weekly education sessions feedback to staff of learnings and outcomes.

Duty of Candour

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

Safety thermometer

- The safety thermometer is an improvement tool to measure patient harm and harm free care. It provides a monthly snapshot audit of the prevalence of avoidable harms in relation to new pressure ulcers, patient falls, venous thromboembolism (VTE) and catheter-associated urinary tract infections. Safety thermometer results were recorded monthly.
- Data provided by the hospital showed that between April 2015 and December 2015 the VTE (venous thromboembolism) screening rate target averaged 84% which was below the hospital target of 95%. However, there were no incidents of hospital acquired VTE or PE (Pulmonary Embolism) in the reporting period between April 2015 and March 2016.
- Staffing level boards were on display in the corridor for relatives and visitor to see. The staffing levels detailed on the boards reflected the planned and actual staffing the levels for the day.

Cleanliness, infection control and hygiene

- We looked at the results of the patient led assessments of the care environment (PLACE) 2016. The hospital scored 98.4% for cleanliness.
- All the patient rooms we visited were visibly clean. We observed support staff cleaning throughout the day and undertaking this in a methodical and unobtrusive way. Rooms had daily cleaning schedules in place, which staff would tick to indicate when specific areas were cleaned. We saw the daily cleaning schedules were up to date and signed. However, we observed that waste paper bins were in patient rooms and pedal bins used in bathrooms did not meet the waste management guidelines for segregated waste bins by using the correct classification for offensive/non-infectious waste. Some patient rooms also had carpet flooring we were advised that there were plans in place for their removal.

- In the dirty utility room we observed there were clinical and non-clinical waste bins, however we observed inappropriate disposal of clinical waste in the non-clinical waste bin. This meant that staff were not following the appropriate guidance and not segregating clinical and non-clinical waste.
- There were limited hand washing facilities available for staff outside of patient rooms. One hand basin exposed wood on the surrounding Formica which could have been potentially hazardous, there was no thermostatically controlled taps and an open bin stored in the recess stored under the sink. The waste management did not follow the correct classification for offensive/non-infectious waste.
- Three hand hygiene audits undertaken between January 2016 and April 2016 demonstrated that on Dr Bruce ward doctors, nurses, health care assistants and other health professionals scored 100%. The audit also checked if staff adhered to the "bare below the elbows" hospital policy in clinical areas; staff were 100% compliant.
- Adequate supplies of personal protective equipment (PPE) and hand washing gel were available and we saw staff using this appropriately when delivering care.
- Between April 2015 and March 2016 there were no hospital acquired cases of
- We observed green 'I am clean' labels were in use to indicate when equipment was cleaned. For example patient commodes and seat risers had green labels to indicate that they were clean and ready for use.
- We observed sharps management complied with Health and Safety (Sharp Instruments in Healthcare) Regulations 2013. We saw sharps containers were used appropriately and they were dated and signed when brought into use.
- We observed scopes management complied with the manufacturer's instructions and as recommended in Department of Health document Choice Framework for local Policy and Procedures 01-06-Decontamination of flexible endoscopes: Operational management 'Cycle of Use and decontamination of endoscopes' Handling of endoscopes after use and before decontamination 3.19. Scopes for decontamination were transported to a BMI hospital close to BMI Hendon that had JAG accreditation and with appropriate decontamination facilities
- We saw that the hospital had regular infection control committee meetings and infection control meetings attended by senior management and that there were standard agenda items and action points were identified and reviewed.
- Infection prevention and control awareness formed part of the mandatory training programme. The hospitals target was 90% of staff having completed the training. Across the hospital only 85.5% of staff competed the training. This was below the hospitals target.

Environment and equipment

- Patient led assessments of the care environment (PLACE) 2016 showed that the hospital scored 92.2% for condition, appearance and maintenance.
- We observed the corridor was generally kept clear of equipment. However we saw that there were two patient monitoring machines being charged in the corridor.
- In the disabled shower room on the ward we found the shower chair was missing a caster from one of the legs and a leg was rusty.
- In patient rooms we found that some of the patient lockers were damaged with wood exposed on most of the edges on the tops of the lockers, some fabric chairs had staining on the seat cushions and there were some gaps in between the ensuite flooring and the room carpet.
- In patient's bathrooms some of the Formica tops were stained, tiles were coming away from the walls and sealant around the sinks and toilets were in a poor condition.
- Resuscitation equipment was stored on a resuscitation trolley, readily available and located in a central position. The equipment was checked daily, fully stocked and ready for use.
- The ward was unable to control the temperature on the ward in hot weather. We saw that was identified on the hospital risk register but was not progressed.

- We saw that Electrical Medical Equipment (EME) had a registration label affixed and was maintained and serviced in accordance with manufacturer's recommendations. We also saw safety check labels were attached to electrical systems showing they were inspected and were safe to use. However, we found portable electric fans in patients rooms were not safety checked within the last 12 months.
- Health and safety was part of the statutory training programme, which staff were required to attend. The hospital's target was 90% of staff having completed the training. Across the hospital 95.5% staff completed the training. This was above the hospital target.

Medicines

- The on – site pharmacist was available Monday to Friday between 9.30am and 1.30pm. There were specific arrangements for staff to gain access to the pharmacy out of hours, with the RMO and senior nurse on duty being able to access keys. Staff were not able to access controlled drugs out of hours.
- We looked at the drugs charts for patients on the ward and saw that there were no gaps and that patients received their medications at the frequency and times prescribed. A missed dose audit was undertaken in December 2015 this provided a snap shot of a 24 hour period. This showed there were no medication omissions in the 24 hour audit period.
- There were two medication incidents on the Dr Bruce ward recorded in February and March 2016, one related to administration and the other to the patient being dispensed the wrong medication. Both these incidents were recorded as no harm and were investigated.
- Staff were clear about the arrangements in place for safely managing medicines, including controlled drugs (CDs). This included policies and processes for ordering, recording, storing, dispensing, administering and disposing of medicines.
- Controlled drugs (CDs) were stored in lockable wall units and were checked on at least a daily basis by registered nurses or pharmacists. We looked at the CDs and found that the stock balanced and that the CD registers and order books were completed in line with local procedures. BMI required an audit of the controlled drugs should be carried out every three months. An audit was undertaken on Dr Bruce ward in January 2016 and there was an action plan in place for completion by the 31st January. All identified actions were completed
- The pharmacist had access to specialist advice from the chief pharmacists within the BMI organisation.
- Patients had access to medicines when they needed them. The pharmacist or the technician would undertake regular stock reconciliation and ensure that there were adequate supplies.
- Individual prescriptions were monitored by pharmacists on a regular basis, who recorded their observations in patient records, and advised staff in the safe administration of medicines.
- Tablets to take away (TTA) were delivered to the patients who were being discharged. The pharmacist would visit patients on the ward that were being discharged to explain to patients why the medicines were prescribed and any side effects. This service was not available to a patient was discharged in the afternoon.
- Emergency medicines used for the treatment of anaphylaxis or cardiopulmonary resuscitation were clearly labelled, available for use, and regularly checked.
- There was an up to date antibiotic protocol which included first and second choice medicines to use, the dosage, and duration of treatment. The bi- annual audit to monitor antimicrobial stewardship completed in April 2016 on the Dr Bruce ward.
- Allergies were recorded in patient records and the medicines administration records.
- Spillage kits were readily available and within date, which meant they were ready for use.
- The blood fridge was out of use for 24 hours as the blood transfusion service was undertaking their annual check. Staff were aware of the contact details if blood was needed and told us it could be obtained within an hour. The Fridge normally held two units of blood. Refrigerator temperature checks were carried out and recorded, and were all within the required range. Staff were aware of the process to follow if the temperature should fall out of the safe range.

Records

Requires improvement

Medical care

- We reviewed four sets of patient records and saw patients care plans included all identified care needs and were completed. Patient records contained a range of risk assessments including; pressure assessment within six hours of admission, Venous Thromboembolism (VTE) checks, nutritional and falls risk assessment which were completed and reviewed as required.
- The hospital undertook monthly audits of patients health records, these included monitoring completion of clinical risk assessments for VTE, pressure areas, moving and handling, bed rails, and falls and that all entries by nursing staff and consultants were signed and dated. The audits undertaken between January and April 2016 demonstrated that patient health record compliance was between 95% and 99%.
- Patients' medical notes (hard copies) were stored in lockable trolleys behind the nurse's station.
- The hospital used a paper based system for recording patient care and treatment. The hospital used a colour coding system to identify patients who were private or funded by the NHS. A complete set of records for all aspects of patient care and treatment were kept on site including a record of the initial consultation and treatment provided by the admitting consultant. Should the consultant wish to keep a copy of their patients' medical notes these would be photocopied. However, the medical records department advised that they didn't always get the records of private patients as some consultants kept them. One of the consultants we spoke with advised that they retained the records of their private patients.
- We observed that when patients had an endoscopy that safety checks undertaken using the World Health Organisation (WHO) 'Five Steps to Safer Surgery. A copy of the WHO checklist was held within the patient's notes.
- Once records were no longer required after the patient was discharged, they were scanned and stored on site in a secure records office prior to being archived.
- A clerk was employed to ensure patient records were available as required, for example to ensure files were available on site for clinic appointments or following a patient re admission.
- Staff were able to access records out of hours and at weekends
- Information Governance was part of the mandatory training programme which all staff were required to attend. The hospital's target was 90% of staff having completed the training. Across the hospital 93.8% staff completed the training. This was above the hospital target.

Safeguarding

- The hospital had no reported safeguarding alerts in the reporting period April 2015 to March 2016.
- Staff had access to the hospitals safeguarding policy via the hospital intranet and knew the relevant safeguarding leads.
- Staff were able to identify the potential signs of abuse and the process for raising concerns.
- Safeguarding adults and children was part of the mandatory training programme for staff and different levels of training were provided according to the job role. Nursing staff we spoke with on the ward told us they attended safeguarding training.Data provided by the hospital showed that 100% of staff across the hospital completed safeguarding adults and children level one and that all require staff completed training safeguarding children and adults level 2. There were no staff currently trained to safeguarding level 3.

Mandatory training

- Staff were aware of the mandatory training they were required to undertake.
- The mandatory training programme included display screen equipment, information governance, documentation and legal aspects, safety, health and the environment, control of substances hazardous to health, equality and diversity, fire safety, moving and handling, adult basic life support, infection prevention and control, safeguarding children level one and two, safeguarding adults level one, dementia awareness, waste management for the disposal of healthcare waste and prevent
- The ward manager demonstrated the system they used locally to monitor their staff attendance at mandatory training to ensure it was completed or refreshed.

- The hospitals target for staff having completed their mandatory training was 90%. At the time of our inspection 88.6% of staff completed their mandatory training. This was below the hospitals target.

Assessing and responding to patient risk

- There was an admission policy setting out agreed criteria for admission to the hospital. All patients were admitted to the medical service under the care of a named consultant.
- Patients' clinical observations such as pulse, oxygen levels, blood pressure and temperature were monitored in line with NICE guidance CG50 'Acutely Ill-Patients in Hospital.' A scoring system known as a national early warning score (NEWS) system was used to identify patients whose condition was at risk of deteriorating. The inpatient medical services assessed patients by using the national early warning score (NEWS). The audit calendar did not include an audit of NEWS systems to identify deteriorating patients. NEWS audits were undertaken in 2015 but no evidence was provided to indicate that NEWS compliance was audited in 2016. This meant that compliance with evidence based practice and patient outcomes in this area were not measured which meant the hospital was unable to identify if improvements in practice and outcomes were required.
- Staff we spoke with were clear about the processes to follow if a patient deteriorated. Staff and managers told us if the complications were more serious, patients were moved out of the hospital to a neighbouring NHS facility by emergency ambulance. However, there was no formal service level agreement between the hospital and any NHS trust although most patients that required transfers were transferred to the local NHS hospital. There were six transfers of patients from inpatient services to the NHS between April 2015 and March 2016.
- The practicing privileges agreement for each doctor ensured there was 24 hour clinical support from the named consultant when they had patients in the hospital. This included making alternative arrangements for a named consultant to attend to patients in an emergency if they were not available. There was always a resident medical officer (RMO) on site who completed advanced life support training, who was able to provide first line emergency treatment.
- Out of hours patients were able to phone the inpatient ward nurses for advice.
- Intentional rounds were undertaken hourly or two hourly checks by nursing staff to monitor patients welfare and any change in the patient's clinical condition. Intentional rounding is a structured approach whereby nurses conduct checks on patients at set times to assess and manage their fundamental care needs.
- Adult basic life support and adult intermediate life support was part of the mandatory training programme clinical staff to attend. The hospitals target was 90% of staff having completed the training. Across the hospital 77.2% of staff completed adult basic life support and 80.6% of staff completed adult intermediate life support training. This was below the hospitals target of 90%.

Nursing staffing

- A senior nurse was in charge as a contact point for staff, consultants and patients 24 hours a day, seven days a week.
- Nursing staffing was planned using an acuity tool to
- The established staffing levels for qualified nurses was 8.3 whole time equivalents (WTE) and 2WTE for health care assistance (HCA), there was currently 1 WTE qualified nursing vacancy. Between April 2015 and March 2016 the hospital used an average of 36% bank and agency nurses and an average of 0.9% bank and agency HCA's were employed in the same period.
- The numbers of staff planned and actually on duty were displayed at ward entrance in line with guidance contained in the Department of Health Document 'Hard Choices'. On the wards we visited we observed staffing levels were in line with planned staffing levels during the day (3 x qualified nurses plus 1 x HCA) and night (3 x qualified nurses plus 1 x HCA). Nurses were allocated to patient rooms, during our inspection there were three inpatients and between six and ten day cases. Nursing staff also had assistance from health care assistances (HCA's). The ward manager was supernumerary to the agreed staffing levels so that if required, they could support ward staff if patient acuity or occupancy increased.
- We observed one handover from night to day staff and found the handover detailed and robust. The ward used SBAR (situation, background, and assessment,

recommendation) to remind staff of the areas to be covered. Staff printed handover notes, which they updated during the handover. All the patients were discussed and actions outstanding for patients were allocated. Staff were allocated to patients who then introduced themselves to the patient.

Medical staffing

- The hospital had 167 doctors and dentists employed or with practicing under rule or privileges for more than six months. Between April 2015 and March 2016 the number of episodes of care carried out by doctors with practicing privileges were 45% (70) of doctors carried out 100 or more episodes of care, 32% (50) of doctors carried out between 10 and 99 episodes of care, 8% (12) of doctors carried between 1 and 9 episodes of care, 14% (22) of doctors undertook no episodes of care.
- A requirement for all consultants within the BMI practising privileges policy was that they remained available (both by phone and, if required, in person), or arranged appropriate named cover at all times when they had inpatients in the hospital. Part of the consultant's practicing privileges agreement was that they should be located within 30 minutes travel time of the hospital.
- The day to day medical service was provided by a resident medical officer (RMO) who dealt with any routine and also emergency situations in consultation with the relevant consultant. Out of hours, consultants provided either telephone advice or attended in person.
- The RMO provided a 24 hour 7 day a week service on a two week rotational basis. All RMOs were selected specifically to enable them to manage a varied patient caseload and particular requirements. The hospital had two inpatient RMOs who rotated for at least six months to ensure continuity of care. The RMOs are provided under contract with an agency (RMO International) who provided training and support.

Major incident awareness and training

- The hospital had a service contingency plan in place for staff to use in the event of interruption to essential services. Staff were aware of the escalation process if there was an incident requiring a major response.
- Members of the senior management team were briefed each morning at the daily 'comms cell' hospital meeting to ensure that there were clear lines of accountability and responsibility in managing emergencies.
- Fire safety in a hospital setting was part of the mandatory training programme for all staff to attend 85.8% of staff the training. This was below the hospitals target of 90%.
- Eight staff were also identified to complete fire warden/ marshall training. Data provided by the hospital showed that no staff completed this training, although training was in progress for four staff members.

Are medical care services effective?

Requires improvement

We rated effective as requires improvement because:

- There was no audit of national early warning score (NEWS) systems to identify deteriorating patients which meant the hospital was unable to identify if improvements in practice and outcomes were required.
- Action plans were not always in place for high MUST scores where an intervention was required.
- It was not clear who was responsible for providing the resident medical officers (RMOs) with clinical supervision.

However:

- The hospital used a combination of professional guidance produced by the National Institute for Health and Care Excellence (NICE) and the Royal Colleges.
- The hospital had an audit calendar which set out the audits to be undertaken across the
- We saw that multidisciplinary team (MDT) working was evident in patient records.
- Nurses told us there were opportunities for learning and development.
- Agency nurses underwent hospital orientation and induction.

Evidence-based care and treatment

Requires improvement

Medical care

- The hospital used a combination of professional guidance produced by the National Institute for Health and Care Excellence (NICE) and the Royal Colleges. For example, the ward provided care in line with NICE Guideline - CG50 - that covers recognising and responding to deteriorating patients. Staff used a national early warning score (NEWS) to identify deteriorating patients and ensured they were escalated to the resident medical officer (RMO).
- Clinical policies and procedures were available on the hospital intranet and staff were aware of how to access them.
- The hospital had an audit calendar which set out the audits to be undertaken across the hospital over the 12 month period for 2015/2016. The audits included for example patient health records, infection control, hand hygiene, controlled drugs and medicines management.

Pain relief

- There was no specialist pain team at the hospital; however staff told us they would alert the resident medical officer or consultant if a patient required pain management who could assess the patient and prescribe pain relieving medicines where necessary.
- The hospital drafted new standard operating procedures for pain assessment which were due to go before the next clinical governance meeting.
- A pain scoring system was used with patients. The scale asked patients to rate their pain level between one (no pain) and ten (very bad pain). We saw evidence that patients were usually asked about their level of pain and this was documented alongside the routine patient observations.
- In patient rooms we saw that there were notices advising patients to speak to their named nurse if they were in pain.

Nutrition and hydration

- Patient led assessments of the care environment (PLACE) 2016 showed that the hospital scored 62.2% for ward food.
- Patient satisfaction dashboards between May 2015 and April 2016 showed that for variety and choice of food the hospital scored 52.9% in May 2015, 65.4% in June 2015, 61% in January 2016 and 53.7% in February 2016. The quality of Food also scored less than 70% on three occasions in May 2015 (56.3%), June 2015 (65%) and in February 2016 (69.7%).
- We saw the patients' nutrition and hydration needs were assessed and met. We observed patients always had drinks available within reach.
- Patients were offered the choice of cooked or cold meals three times a day, seven days per week. The menus were designed to include a range of special diets and healthy eating options. Patients we spoke with told us they had a choice of food from the menu.
- Patient's nutritional needs were assessed using the Malnutrition Universal Screening Tool (MUST) as recommended by the British Association for Parenteral and Enteral Nutrition. We saw that action plans were not always in place for high MUST scores where an intervention was required. It was not clear if speech and language therapists were referred to when required.
- Catering staff and HCAs informed nurses if a patient did not eat their meal or if their food and drink intake was low.

Patient outcomes

- The hospital measured patient outcomes via a range of measures which included mortality, transfers out, infection rates, readmission rates, referral to treatment times, patient satisfaction scores, incidents, complaints, staff questionnaires, audits, Friends and Family Tests, and mandatory training rates,
- Between April 2015 and March 2016 there were three unplanned re-admission of medical in patient within 28 days. The number of unplanned re-admissions was not high when compared to other independent acute hospitals
- Between April 2015 and March 2016 there were six unplanned transfers to acute NHS hospitals. The number of unplanned transfers was not high when compared to other independent acute hospitals
- Between April 2015 and March 2016 two deaths were reported, both were recorded as expected. The rate of mortality was above the average when compared to other independent acute hospitals

Competent staff

Requires improvement

Medical care

- Throughout our inspection we observed staff were professional and competent in their interactions with colleagues, patients and their relatives/carers.
- Staff told us they participated in the appraisals process and they had access to regular training updates. On Dr Bruce ward 85% of staff had an appraisal. Data provided by the hospital showed the completion of staff appraisals was 90% which did not meet the hospital's 100% target.
- Nurses told us there were opportunities for learning and development. Staff completed their e-learning whilst on duty and were not expected to complete their training in their own time or to come into work on their day off to complete. We saw that 90% of staff on Dr Bruce ward completed their e – learning training.
- The hospital had a competency based training programme for nurses and HCAs. We saw each staff member had a personal competency and mandatory training folder where they stored their certificates and recorded evidence of learning and development. This was also used as evidence towards revalidation.
- We saw that agency staff had a formal induction form which was completed when they first worked on the ward. An agency member of staff told us they also had an informal induction on the start of their shift as they did not work at the hospital recently.
- Agency nurses underwent hospital orientation and induction. The use of bank and agency staff between April and March 2016 and January and December 2016 was 36%. Senior staff told us they always tried to book the same staff that were familiar with the hospital.
- Nursing staff told us they felt supported by the consultants, whilst they were on site and if they needed to contact them out of hours.
- The RMO told us they were able to access consultants if they needed advice and the agency that employed them undertook regular appraisals. However it was not clear who was responsible for providing the RMOs with clinical supervision. Consultants advised they monitored the RMO's by speaking to the ward sisters.
- All consultants working with the hospital had practising privileges which required consultants to have an up to date General Medical Council (GMC) registration, evidence of indemnity insurance and revalidation certificate. These were reviewed and highlighted at Medical Advisory Committee (MAC) meetings.

Multidisciplinary working

- Consultants and nursing staff that we spoke with all described good working relationships with other hospital services.
- In patients records were saw that multidisciplinary team (MDT) working was evident. For example a patient was reviewed by a tissue viability nurse for a grade two pressure sores, endocrinologist for thyroid and an orthopaedic surgeon for back pain and a further patient was referred to a dietitian.
- There was pharmacist support on the ward and they provided information to patients on their medications.

Seven-day services

- The arrangements to provide medical and clinical care 24 hours a day, seven days per week was a combination of on-site and on-call arrangements. Two RMOs provided cover on a fortnightly rotational basis. All RMOs received advanced life support training and access to named consultants.
- The RMOs were selected specifically to enable them to manage a varied patient caseload of medical and surgical patients. The management of the RMOs was through liaison with the agency that employed them.
- The hospital had a policy which required all consultants to remain available (both by phone and, if required, in person), and formally arrange appropriate named cover if they were unavailable, at all times when they had inpatients in the hospital.
- There was no pharmacy cover available out of hours or on a Saturday or Sunday. The hospital had a work instruction which detailed the pharmacy dispensing arrangements out of hours. The work instructions had been in place since February 2015; however the document was not signed off by the executive director or approved for use locally.
- Senior managers had an on call rota to cover the hospital.

Requires improvement

Medical care

- A senior nurse in charge was available as a contact point for staff, consultants and patients and was available via bleep or telephone.
- Patients who were discharged were advised to contact the ward staff if they had any concerns out of hours.

Access to information

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

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Mental Capacity Act 2005 (MCA) and Deprivation of Liberties Safeguards (DoLS) training was not part of the mandatory training programme. The provider told us the safeguarding adults training included section relevant to the Mental Capacity Act, Mental Capacity Act and consent.
- Staff told us formal written consent is taken by the consultant involved when the patient is admitted for the procedure.
- Patients told us staff asked their permission before care or treatment was given and medical staff explained their treatment.
- Do Not Attempt Cardio Pulmonary Resuscitation' (DNACPR) decision making was set out by a corporate resuscitation policy. Decisions about DNACPR were communicated during staff handover. We found an example of the DNACPR that was not completed in accordance with national guidelines. The DNACPR indicated that the patient lacked mental capacity and there was no evidence that a mental capacity assessment was undertaken. However documented in the patients' medical notes was a record of the discussion with the patient's family with details of the medical treatment given and reasons why resuscitation would not be successful. The consultant recorded their GMC number on the DNACPR and on the patient's record.

Are medical care services caring?

Good

We rated caring as good because:

- Results from the 'Friends and Family Test' showed people would recommend the medical services provided by the hospital.
- Patients told us their privacy and dignity was respected at all times and care we saw supported this.
- All the patients we spoke with felt involved in their care and were kept informed about their treatment. Care plans were shared with patients.

Compassionate care

- The hospital used the Friends and Family test (FFT) to get patients views on whether they would recommend the service to family and friends. We looked at the latest FFT scores that were available to us and during the period May 2015 to May 2016 these showed satisfaction with the service offered at the hospital was between 95.6% and 100%.
- We looked at the results of the patient led assessments of the care environment (PLACE) 2016. The hospital scored 70.97% for privacy, dignity and wellbeing.
- We saw evidence of thank you cards on display the ward. Staff were identified as "kind and caring" and relatives thanked them for looking after their loved ones.
- We observed professional, kind and friendly interactions between staff and patients.

Requires improvement

Medical care

- The patients we spoke with felt safe in their environment. One patient told us “Most certainly I do 100%”.
- Patients knew who their doctor, allocated nurse and health care assistant were. The name of the allocated nurse and health care assistant were written on the white board in each patient room.
- There was a positive relationship between staff and patients; we observed that people were treated with dignity, respect and kindness during all interactions. Patients’ privacy was maintained by ensuring the doors and windows were locked and covered during personal care or when visitors were in attendance

Understanding and involvement of patients and those close to them

- Staff were able to demonstrate that they were aware of what patients wanted and needed.
- Patients had named consultants looking after them. Patients were allocated a nurse and/or HCA to look after them each shift. Patients told us they were always introduced to their nurse, though sometimes they arrived whilst they were still asleep.
- All the patients we spoke with felt involved in their care and were kept informed about their treatment. Care plans were shared with patients.

Emotional support

- Staff took time with patients and their families if they were upset. We saw staff display empathy and support towards patients and their relatives.
- Staff displayed good understanding of the impact of the patient’s care, treatment or condition on their wellbeing and on the impact on those close to them.

Are medical care services responsive?

Good

We rated responsive as good because:

- We saw patients had their needs assessed. Patient records contained a range of risk assessments which were correctly completed and reviewed as required.
- Patients had single rooms that provided privacy and comfort with ensuite facilities and there was no restricted visiting times for patients.
- The hospital had monthly compliments and complaints meeting for staff to receive and give feedback and to facilitate discussion on how to improve patients’ experiences.
- Patients referred by their GP could book a convenient date and time for their appointment through NHS ‘choose and book’ electronic booking system.
- All patients were admitted under the care of a named consultant. The consultants reviewed patients prior to commencement of each treatment and provided a 24 hour on call service as and when required.

However:

- Not all the staff on the ward received dementia training.

Service planning and delivery to meet the needs of local people

- Inpatient medical care services were provided for both private and NHS patients, 57% were NHS funded while 43% had another source of funding.
- The hospital was able to offer an inpatient medical care service and day patient facilities on the Dr Bruce ward.
- We looked at the results of the patient led assessments of the care environment (PLACE) 2016. The hospital scored 92.25% for condition appearance and maintenance. Although the environment did not meet IPC standards we had no other concerns with the environments responsiveness to patient’s needs. All patients’ rooms were single ensuite.
- There were no restricted visiting times for patients. Relatives were also offered refreshments.

Access and flow

- More of the patients with another funding source stayed overnight (16%) than NHS patients (10%).
- Between April 2015 and March 2016 there were 380 inpatient attendances and 2592 day care attendances.
- Between April 2015 and March 2016 there was 1053 upper gastrointestinal (UGI) endoscopy and colonoscopy.

Requires improvement

Medical care

- The hospital provided care for some NHS patients undergoing endoscopy. They were referred through NHS e-referral service. Patients referred by their GP could book a convenient date and time for their appointment through NHS 'choose and book' electronic booking system.
- All NHS referral to treatment times (RTT) met the target rate of 90% or above.
- Bed capacity was planned on a weekly basis. The ward manager communicated with the hospital admissions team to manage unscheduled overnight stays. Endoscopy had a planned number of patients due for procedures each day.
- The hospital had an admissions eligibility policy which ensured suitable patients were admitted to the ward. Consultants told us patients were discussed with their GPs prior to admission to ensure the hospital was the most suitable place for them and they would not admit patients who might need a higher level of care.
- Consultants admitted medical patients by completing a booking form and referring them through the administration team to the appropriate service.
- All patients were admitted under the care of a named consultant. The consultants reviewed patients prior to commencement of each treatment and provided a 24 hour on call service as and when required.
- To take home tablets (TTOs) were timely on discharge from the pharmacy.
- Patients told us they saw their consultant at least daily, and the nursing staff were always in attendance to check on their condition.
- Patient who are discharged all receive follow up calls from the nursing team within 48 hours of discharge.

Meeting people's individual needs

- We saw patients had their needs assessed. We reviewed four sets of patient records and saw their care plans included all identified care needs.
- The ward had open visiting times which meant relatives could visit their loved ones at any time. Staff told us patients families were encouraged to stay to reassure and or assist patients.
- Patients had single rooms that provided privacy and comfort with ensuite facilities.
- We observed that call bells were answered quickly. Patients told us staff answered bells straight away. The hospital did not audit patient call bell response times.
- The hospital catering service was outsourced at the beginning of 2016, and since the change there was a decrease in the patient satisfaction regarding the choice and quality of the food. Staff told us they had regular meetings with the catering company to change menus and introduce more choice to improve the service.
- In patient rooms the call bells had a designated function for patients to alert catering staff should they need a drink or food between 7am and 8pm. Outside of these hours patients called a nurse or health care assistant (HCA) to assist with meeting their nutritional needs.
- The ward had a lead nurse for dementia, however not all staff on the ward had dementia training.
- The ward environment was not suitable for the care of patients living with dementia. There was no visible signage on toilets, no large clocks displaying the date and time, all the walls on the ward were the same colour and there were no specific feeding utensils, plate guards, coloured crockery or slip mats for patients. Staff told us there were plans to upgrade two rooms for patients living with dementia.
- There was a variety of information leaflets available on the ward though these were only available in English.
- For patients whose first language was not English, staff were able to arrange for interpreters to assist them through Language Line if they were funded by the NHS. Staff were able to arrange interpreters with Language Direct for private patients. BMI also used Language Direct if patients needed support and assistance with sign language. This included NHS patients, for whom BMI would fund the service.
- The hospitals website provided information on the paying for treatment. Patients were able to pay for themselves and fixed price packages were available. Treatment could also be funded through private medical insurance. The hospital also provided services for patient funded through the NHS.

Learning from complaints and concerns

Medical care

- The hospital executive director oversaw the management of complaints. The handling of complaints was monitored to ensure that complaints were dealt with within the time frame set out in the BMI complaints policy. Where there were time extensions in dealing with complaints, the reasons for the extension was recorded. Complaints could be raised in person, by telephone, or in writing.
- Staff told us complaints were discussed at the daily 'comms cell' meetings.
- Staff told us they tried to resolve complaints and concerns at the time where ever possible. Most of the complaints they received were related to food.
- Across the hospital there were 21 complaints raised by patients during the six month period October 2015 to March 2016. The main complaint themes were poor staff attitude and appointments.
- There were three complaints raised concerning the Dr Bruce ward of which two related to poor staff attitude. Complaints were investigated and patients were apologised too. The data received from the hospital did not identify action points or learning opportunities for staff.
- There was a duty manager at the hospital daily who patients or visitors could speak to if they had any concerns or compliments.
- The hospital had monthly compliments and complaints meeting for staff to receive and give feedback and to facilitate discussion on how to improve patients' experiences. The meeting was chaired in rotation by a head of department and attended by a member of staff from every department.
- Information was available on the ward and included in the BMI leaflet "please tell me…" to inform patients, relative and visitors on how they could raise any concerns.

Are medical care services well-led?

Good

We rated well led as good because:

- Staff were aware of BMI's corporate strategy aiming to deliver best quality care, best practice, and best outcomes for patients.
- There was a clear management and operational structure within the hospital. The ward manager was line managed by the director of clinical services.
- The hospital risk register included corporate and clinical risks
- All staff we spoke with felt supported by their colleagues.
- Patient satisfaction was monitored and reported on monthly through the patient satisfaction dashboard.

Vision, strategy innovation and sustainability for this core service

- Staff were aware of plans to develop the medical service to provide an ambulatory care facility within the hospital which would enable the inpatient medical services to develop. The ward currently provided services to day patients.
- Staff were aware of BMI's corporate strategy aiming to deliver best quality care, best practice, and best outcomes for patients. Staff felt some of the recent changes on the ward contributed to this.
- The six C's initiative which encouraged staff to embrace the values of Compassion, Competence, Care, Communication, Courage, and Commitment were displayed throughout the hospital.

Governance, risk management and quality measurement for this core service

- The inpatients service was led by a ward manager and they sat on the clinical governance committee. We reviewed the minutes of four meetings and saw there was good attendance from the senior management team from across the hospital. Incidents, infection prevention and control, and performance indicators were discussed as part of a standard agenda. Meeting was held every two months.
- Medical Advisory Committee (MAC) meetings were held quarterly and attended by consultant representatives and the hospitals executive director.
- The hospital risk register included corporate and clinical risks. In management team meeting minutes in April the five top risks were identified and that new risks were discussed to be added to the risk register.

- The ward held regular ward meetings, minutes of the meeting showed that a variety of topics were discussed including reporting of incidents, mandatory training, and health and safety.

Leadership of Service

- There was a clear management and operational structure within the hospital. The ward manager was line managed by the director of clinical service.
- Staff we spoke with met the executive director. Staff told us the executive director visited the ward daily and also attended their staff meetings.
- The new director of clinical services had recently been appointed. Staff on the ward felt they made an impact in a short period of time with introducing some changes. Staff told us the director of clinical services visited the ward daily and was approachable.
- Staff said managers were supportive and approachable, they also felt they had opportunities for personal development and that when they raised concerns they were listen to and their concerns addressed. Staff told us felt respected and valued.

Culture within the service

- Between April 2015 and March 2016 staff turnover was below average for nursing (4.44%) and health care assistance (2.22%). Staff we spoke with were all positive about BMI as an employer.
- Between April 2015 and March 2016 sickness rates for nursing staff and HCAs on the ward was low.
- All staff we spoke with felt supported by their colleagues and said everyone was approachable and friendly. Staff described good team working on the ward.
- The Hospitals 'BMI Say' staff survey for 2016 showed that :
  - 66% of staff found their role challenging however 86% of staff found their job interesting and fulfilling.
  - 75% of staff have the support needed to do their jobs effectively but only 67% of staff think that their line manager motivated them to improve performance.
  - 58% of staff had the opportunity to develop their skills in the last 12 months but 80% of staff stated they received the sufficient training to do their jobs.
  - 55% of staff feel they can develop their careers within BMI as they would like to.

Pubic and Staff Engagement

- On the ward we saw that there was a patient feedback board. The board included 'you said we did' feedback and the patient feedback results for May 2016.
- Patient satisfaction was monitored and reported on monthly through the patient satisfaction dashboard. This information was discussed at monthly management meetings. There was a satisfaction questionnaire box for patients on the ward.
- A representative from each department attended the monthly compliments and complaints meetings.
- There was a staff forum twice a month on different days and times to encourage staff to attend. This provided an opportunity to share plans and strategy and for staff to ask questions.
- The hospital had recently introduced "bitesize" weekly education sessions feedback to staff of learnings and outcomes for incidents.

Innovation, improvement and sustainability

- The inpatient services were looking to develop a separate ambulatory care unit to accommodate day cases.

Good

Surgery

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

Information about the service

Surgical services consisted mainly of adult elective surgery, including orthopaedic, gynaecology, ophthalmic and general surgery. Surgical services were provided to both insured and self-pay private patients and to NHS patients through local contract systems.

The hospital carried out a range of inpatient and day case procedures. There were 17 inpatient bedrooms contained on one ward. Each single room had en-suite facilities with either a bath or shower. There were two operating theatres, one with laminar flow. Normal operating hours were 8am to 8.30pm Monday to Friday.

There were 2,730 visits to theatre between April 2015 and March 2016. The five most commonly performed surgical procedures in that period were:

Multiple arthroscopic operation on knee (187)

Phacoemulsification of lens with implant – unilateral (180)

Therapeutic endoscopic operations on uterus (115)

Hysteroscopy including biopsy, dilatation, curettage and polypectomy (113)

Surgical removal of impacted/buried tooth/teeth (107)

The service was led by a director of clinical services, a theatre manager and a ward manager. There was also a lead nurse for pre assessment.

During the inspection we spoke with 22 members of staff including theatre nurses, ward nurses, pre assessment nurses, surgeons, health care assistants, operating department practitioners, an engineer, an administrator, an anaesthetist, the clinical services manager, the IPC lead nurse, theatre manager, deputy theatre manager, a cleaner and a pharmacist. We observed two surgical procedures. We spoke with three patients who were undergoing surgery during our inspection.

Good

Surgery

Summary of findings

We rated surgery as good overall because:

- Care and treatment was delivered in line with evidence-based guidance. Surgical staff used the five steps to safer surgery in line with guidance from the National Patient Safety Agency (NPSA). The hospital carried out regular audits to monitor performance, including use of the World Health Organisation (WHO) safety checklist.
- There was good communication and team-working between nurses and consultants.
- Staff were compassionate and caring towards patients, and patient feedback was positive about staff. The hospital scored highly in the NHS Friends and Family Test.
- The hospital met the referral to treatment target (RTT) of 90% for NHS admitted patients waiting less than 18 weeks from the time of referral to treatment. They achieved 98% in April 2016, 100% in May and 98.8% in June.

However,

- The theatre environment did not meet the requirements of Department of Health guidelines HBN26 'facilities for surgical procedures'. However, managers told us the sinks were scheduled to be replaced in August 2016.
- Learning from incidents was not always shared with staff.
- A high turnover of senior management and vacancies meant some staff were not adequately supported in their roles. However, staff said this improved since the new director of clinical services started in June 2016.

Are surgery services safe?

Requires improvement

We rated safe as requires improvement because:

- Most sinks in the theatre suite were not compliant with the Department of Health's Health Building Notice guideline HBN26 'facilities for surgical procedures', however the hospital had ordered replacements which were due to be installed in August 2016.
- Learning from incidents was not always shared with all staff.
- One of the sluices was in poor condition due to the recent removal of a decontamination unit. The wall required immediate remedial work as theatre staff still used this area as a sluice. There was exposed plaster and pipes, a hole in the wall and water on the floor.
- Maintenance requirements noted in the validation report for the theatre ventilation system were not completed.
- Colour coded cleaning equipment was not used in theatres and there was no protocol on which cleaning products should be used where.
- Controlled drugs were not always disposed of correctly.

However,

- We saw that the surgery team used the five steps to safer surgery (NPSA) and the World Health Organisation (WHO) checklist to ensure that patients received safe surgical care
- There were no reported incidents of hospital acquired infections such as MRSA or C Difficile and no reported surgical site infections from April 2015 to March 2016.
- Ward staff used the National Early Warning Score (NEWS) to identify deteriorations in a patient's condition and we saw the NEWS was consistently recorded for all patients in the records we viewed.

Incidents

- No 'never events' were reported at the hospital from April 2015 to the time of inspection. Never events are serious incidents that are wholly preventable as

guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and should have been implemented by all healthcare providers.

- The hospital reported 54 clinical incidents in surgery, inpatients or other services at the hospital from April 2015 to March 2016. The rate of clinical incidents was similar to the average of the 17 other independent acute hospitals that we hold this type of data for. Out of 54 clinical incidents, 98% occurred in surgery or inpatients and 2% in other services. The hospital reported 0.5% of all incidents as severe, this was similar to the average of the 17 independent acute hospitals that we hold this type of data for.
- No surgical site infections were reported between April 2015 and Mar 2016. Staff we spoke with including consultants confirmed that this was accurate.
- The director of clinical services told us there was a case of bacteraemia a week before the inspection and that they were conducting a root cause analysis. A surgical site infection was not found. They said staff were reminded of the sepsis protocol following this incident.
- Staff we spoke with knew what should be reported as an incident and how to report them. The hospital used paper forms for incident reporting. Managers told us there was a culture of over reporting, as they often saw things reported that they thought should not be classed as incidents. However, this demonstrated that staff were vigilant in ensuring that incidents of concern were escalated.
- We viewed completed incident report forms during the inspection which demonstrated that staff applied the duty of candour. For example, one dated January 2016 regarding a cancelled operation due to a missing instrument stated that the surgeon fully explained the issues to the 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. Another incident form showed the action that was taken to rectify a problem with stirrups, stating that they were replaced. The theatre manager showed a good understanding of the duty of candour.
- The hospital's electronic incident log showed that incidents were monitored and actions taken were recorded.
- Managers told us learning was shared at regular meetings. Some staff we spoke with said they heard about shared learning, but others said they did not. The theatre manager said they were not always able to hold the regular meeting for theatre staff due to staffing numbers.
- The director of clinical services said a recent staff survey showed staff felt they didn't get feedback about learning and incidents, and that heads of department were getting it but not cascading it down. They told us of plans they had to improve this which included a regular incident bulletin to share learning.

Safety thermometer or equivalent

- The hospital audit tracker showed the hospital monitored several aspects of safety including falls, the use of the World Health Organisational (WHO) surgical checklist, and venous thromboembolism (VTE). Data showed the hospital scored 97% for falls in January 2016, 100% for the WHO checklist from January to April 2016 and an average of 99% for VTE from January to April 2016.
- All patients were risk assessed for VTE prior to surgery and we saw this was recorded in the patient records we viewed.
- The hospital completed a safety audit for theatres each month, focussing on a different aspect each time. These included: the five steps to safer surgery, anaesthesia, anaesthetic room, immediate pre-op, intra and operative, operating theatre, post-anaesthesia, recovery to ward, and recovery. The audit scores for 2016 were 94% for five steps to safer surgery (January), 98% for anaesthesia (February), 96% for anaesthetic room (March) and 95% for immediate pre-op (April).

Cleanliness, infection control and hygiene

- The ward, theatre suite and pre-operative assessment unit had dedicated cleaning staff. The pre-assessment unit appeared clean and well-organised. However, theatre staff said there were problems with the standard of cleaning over the last four months and they raised their concerns with the manager who oversaw the cleaning team.

- The theatres and most of the theatre suite appeared clean. However, in the week before inspection an endoscope decontamination unit was removed from one of the sluices which meant there was exposed plaster and pipes, a hole in the wall and water on the floor. The wall required immediate remedial work as theatre staff still used this area as a sluice. The theatre manager confirmed that this was logged on their maintenance system.
- The hospital had a lead infection prevention and control (IPC) nurse. However, the IPC lead said they were not involved in the theatre and that the theatre manager took the lead for IPC there. The theatre manager said they attended IPC meetings and that the theatre administrator was the health and safety link.
- The IPC lead told us they used a quality intervention tool (QIT) for IPC audits and that this was based on guidance from the Infection Prevention Society. We saw audits completed for the ward including the individual rooms and nurses' station. The theatre manager told us the hospital wanted theatre staff to start using the QIT audit tool but they did not receive training on the tool.
- Hospital data showed the theatres scored 100% for hand hygiene audits from January to June 2016.
- Cleaners in the ward area used colour-coded equipment to ensure that the correct areas were cleaned according to best practice. However, colour-coded cleaning equipment was not used in the theatre suite.
- There was a cleaning checklist for the theatre suite; however there was no protocol on what products should be used where. However, there was a draft policy in the process of being completed during our inspection.
- The patslide used in theatres was on the floor propped up against a wall, which was an IPC risk.
- Inpatient rooms were not compliant with the requirements of HBN 00-09: Infection control in the built environment. All the rooms were carpeted.

Environment and equipment

- The MAC chair told us the top clinical risk at the hospital was equipment in theatre.
- Most sinks were not compliant with the Department of Health's guideline HBN26 'facilities for surgical procedures'. For example on some sinks the tap was not directly over the hole and the plug hole was not the correct type. This was an infection control risk. However, the hospital ordered new replacement sinks which were due to be installed in August 2016.
- The theatre environment was cluttered and staff had to move equipment around depending on what procedures were being done in each theatre. Generally the operating theatre suite did not comply with HBN 26 requirements. The rooms were smaller than the recommended size.
- One of the operating theatres (theatre one) had laminar flow, which is considered best practice for ventilation within operating theatres (HTM 03-01 Specialised ventilation for healthcare premises).
- The ventilation system for each theatre was serviced in January 2016 and the reports contained instructions on what remedial works were required. The site engineer oversaw this. However, there was outstanding work still to be completed at the time of our inspection. Managers were not aware of the outstanding work required.
- Staff told us the smaller of the two theatres (theatre two) was only used for endoscopies and less invasive surgery due to the limited space and the absence of laminar flow. The theatre manager said they also tended not to do gynaecological surgery in theatre two due to the height of the lights. More invasive surgery, including all orthopaedic surgery, was performed in the larger theatre. We viewed theatre records for the last 12 months which confirmed this. However, the department did not have a policy on what surgery should and should not be done in each theatre. The theatre manager said all staff just knew. The size of the theatres was not on the risk register.
- There was no prep room for the theatres and staff said this meant they had to open sets before anaesthetising the patient. They said the department would be more efficient with a dedicated prep room.
- The servicing of equipment in the theatre suite was up to date. The theatre manager oversaw the servicing of all equipment in the theatre suite and kept a local paper record. They did not use the corporate log as they felt this was not adequate and had previously resulted in errors. Some equipment had out of date servicing

stickers on as well as the in date ones, which could potentially cause confusion. We informed the deputy theatre manager who removed the labels immediately and checked other equipment.

- The phone in theatre two did not work, which was a potential risk in case of an emergency. This was on the risk register.
- The warming cabinet was monitored and records showed that both sections were within the required limits. The upper compartment warmed to a maximum 37C (used for irrigation fluids only and max is 65C), and the lower compartment warmed to a maximum of 55C and was used for blankets only.
- The resuscitation trollies were checked daily and we saw that the drawer content was correct against the checklist.
- There was a malignant hyperthermia kit in the anaesthetic room together with a process checklist and 36 ampules in line with Association of Anaesthetists guidance.
- Before a surgery, we observed the anaesthetic operating department practitioner (ODP) checking the anaesthetic machine and supporting medical devices in accordance with the Association of Anaesthetists guidelines, and they recorded this action in the log book. The Association of Anaesthetists checklist was printed, laminated and attached to the induction machine and main anaesthetic machine in the operating theatre as an aide memoire, which was in line with best practice. All previous entries in the log book were completed including recording when the anaesthetic machine was not used due to theatre closure or other reason. On arrival the anaesthetist rechecked the anaesthetic induction and theatre machines according to safe practice and guidelines.
- One of the theatre doors did not close properly and needed to be pushed to fully shut. This was highlighted on the theatre validation report in January 2016 but was not rectified.
- The theatre computer keyboards did not appear clean and the hospital did not use easy to clean keyboard covers.
- We found that the air handling units and ductwork in the plant room were not compliant with HTM 03-01 specialised ventilation for healthcare premises (chapter 4 - AHU drainage system 4.21 – 4.26). Glass drain traps were not built into the system to observe if there was rust or contamination developing in the pipework. However the hospital engineer was aware of this and mitigated the risk by regularly cleaning/ purging the pipework . A ventilation system upgrade was planned but the engineer could not confirm dates or specification.
- We found sharps bins were used to discard items that were not sharps products.
- There was no clear line of responsibility for ensuring the correct equipment and materials were available. Surgeons we spoke with said they tended to oversee it themselves. However, an incident occurred where a cataract operation had to be cancelled because the correct size lens was not available. Staff told us this was because it was outside of the normal size range. The theatre manager said surgeons were expected to complete a booking form to request any specialist equipment or materials.
- The theatre manager said they often did not have enough scrubs. They said they raised this with the customer services manager and brought it up in meetings but it was still a problem, and they sometimes had to borrow them from other BMI hospitals. The customer services manager told us it was a problem with the external laundry service and they tried to mitigate it by keeping spares aside.
- Staff said the ophthalmic clinic rooms at the satellite site were often too hot and very uncomfortable.
- We checked a sample of 20 sets in the sterile instrument room and found that all were within date.

Medicines

- The hospital's theatre medicines management audit for May 2016 showed medicines were being managed appropriately but highlighted areas for improvement. For example, it stated that the right forms were not used for monitoring temperature and that the theatre manager would be reminded to use the correct standard corporate form.
- Controlled drugs were not always disposed of correctly. We found some partially used controlled drugs were

discarded in a sink or sharps box instead of using a disposal kit and being recorded as wastage. This was not highlighted in the hospital's medicines management audit.

- However, we found that controlled drugs were stored securely. The controlled drugs log book showed that appropriate stock checks were undertaken daily and at change of shift when the theatres were open.
- The pharmacist described the process for ordering and receiving controlled drugs and we viewed the register showing that ordering and receipt of controlled drugs was recorded. Sometimes controlled drugs were signed as received by the same person ordering them which was not best practice. Managers were aware of this, as highlighted in the theatre's controlled drugs audit report for April 2016. It stated that it was not always possible for a different person to the one ordering the drugs to receive them, but that staff were reminded that this should be adhered to as much as possible. The audit also found that on one occasion there were not two signatures in the log for the balance brought forward, and stated that staff were reminded of the importance of this. The audit and action plans showed that there were good processes in place both for managing medicines including identifying when things have gone wrong.
- We looked at the drugs charts for patients on the ward and saw that there were no gaps and that patients received their medications at the frequency and times prescribed. A missed dose audit was undertaken in December 2015 which showed a snap shot of a 24 hour period. The results showed there were no medication omissions in the 24 hour audit period.

Records

- The hospital's records audit showed an average score of 97% for January to June 2016. The audit looked at various aspects of record keeping including secure storage, referral information, nutritional assessment, pre-assessment, risk assessment, discharge summary and evidence of completed 48 hours post discharge follow up telephone call.
- We looked at five sets of notes for surgical patients and found that all were completed, with evidence of daily ward rounding including review with senior clinicians. Patient observations were recorded using the NEWS system, consent forms were signed and VTE risk assessments were completed. Two sets of notes did not have the name and grade of the staff member reviewing the patient clearly documented. We saw this was noted as an area for improvement in the hospital's records audit.
- The executive director told us consultants were registered with the Information Commissioner's Office to transport patient records. They said the hospital PA had a checklist to monitor this as part of the yearly review of practicing privileges.
- Records were stored securely and were accessible to staff when they needed them.

Safeguarding

- The theatre manager told us about a gap analysis the hospital prepared in March 2016. This identified that there were insufficient processes in place to safeguard children and that therefore the hospital would no longer treat children.
- Records showed staff in theatres had completed level two safeguarding training. However, staff we spoke with were not sure what level they had completed.
- Nurses who worked on the ward and in the pre-assessment unit had all completed level 1 and 2 safeguarding training. There were no staff with level three training.
- Nurses we spoke with said if they thought a patient had undergone female genital mutilation (FGM) they would raise it with their line manager.

Mandatory training

- Records provided by the hospital showed some areas of mandatory training were not meeting the hospital's target of 90%. The compliance rate for adult basic life support for clinical staff was 77% and adult intermediate life support was 81%. Infection prevention and control (high impact intervention/care bundles & ANTT) was 70%, patient moving and handling 61%, waste management for disposers of healthcare waste 75%, and dementia awareness 85%.

Assessing and responding to patient risk

- For most operations, patients came in for a pre-assessment appointment with a nurse which

included blood tests and an ECG, if needed. Patients had a telephone assessment with a health care assistant for some endoscopies, colonoscopies and cataract surgery. A pre-assessment nurse made a proforma for the health care assistants to use for this. The pre-assessment nurses reviewed the notes from the telephone assessments and invited patients in for a face to face assessment if required.

- The pre-assessment process was thorough and surgeons spoke highly of the work done by the pre-assessment nurses. The process helped to ensure that only patients suitable for surgery at the hospital were treated, and that any patients deemed to have risk factors were identified and brought to the attention of the surgeon and/or anaesthetist as required.
- Staff used the National Early Warning Score tool (NEWS) to monitor patients. This helped them to identify a deteriorating patient. We saw evidence of the use of NEWS in patient records.
- The director of clinical services told us there was a guidance list of when the RMO should be called, which included a NEWS score of five or more or three in one single parameter. The RMO would see the patient, then contact the consultant who would contact their counterpart at an NHS hospital if required. The hospital also had an agreement with BMI Clementine Churchill Hospital to transfer to ITU there if required.
- There were six cases of unplanned transfer of an inpatient to another hospital in the reporting period (April 2015 to March 2016).This number of unplanned transfers was not high when compared to a group of independent acute hospitals which submitted performance data to CQC. There was no formal service level agreement with a local NHS hospital.
- Patients were screened for VTE prior to surgery. The rate of screening was on target from April 2015 to March 2016 except for the three month period October to December 2015.
- Nurses called patients within 48 hours of discharge to assess their progress and ensure they were not experiencing complications.
- We saw the surgery team used the five steps to safer surgery, which was in line with best practice guidance from the National Patient Safety Agency, and the WHO checklist to ensure that patients received safe surgical care.

Nursing staffing

- From April 2015 to March 2016 the use of bank or agency nurses was below the average of the 20 independent acute hospitals that the CQC holds this type of data for. The average was 13% over the 12 month period.
- The use of use of bank or agency operating department practitioners (ODPs) and health care assistants (HCAs) was above the average of the 20 independent acute hospitals that the CQC holds this type of data for. The average was 24% over the 12 month period. However, managers told us this high figure was due to the small number of staff in the department and that only regular bank staff were used.
- The full time equivalent (FTE) staffing establishment for theatres as at 1 April 2016 was 1.7 for ODP and HCAs, and 3.3 for nurses. For wards it was 2.0 for HCAs and 8.3 for nurses.
- The rate of sickness for theatre nurses was similar to the average of the 19 independent acute hospitals that we hold this type of data for.
- The rate of sickness for ODPs and theatre health care assistants was similar to the average of the 19 independent acute hospitals that we hold this type of data for except in February 2016, but this rise was only due to the small number of staff.
- The rate of sickness for ward nurses and HCAs was below the average of the 19 independent acute hospitals that we hold this type of data for.
- There were no unfilled theatre or ward shifts from January to March 2016.
- The vacancy rate for ward and theatre nurses, HCAs and ODPs was higher than similar organisations, however this was due to small staff numbers. There was one FTE nurse post vacant and one FTE HCA/ODP vacancy for theatres, and 1.25 FTE nurse post and one HCA post for wards.
- Staff turnover was low for theatre nursing staff, HCAs and ODPs compared with similar organisations.

Good

Surgery

- Nursing staffing was planned using an acuity tool to calculate staffing based on patient nursing dependency levels and skill mix. The nursing dependency within the acuity tool clearly defined levels in accordance with NICE safer staffing guidelines. The tool was designed to ensure the right staff were on duty at the right time with the right skills to ensure excellent patient care. We found the number and skill mix of staff during our inspection was compliant with guidance from the Association for Perioperative Practice 'Staffing in Operating Departments' and staff confirmed this level of support was standard practice.
- The director of clinical services told us they often went to the ward and observed handovers. They said the new ward manager had made changes which resulted in a more robust handover system, which was based on the Situation, Background, Assessment and Recommendation (SBAR) structure recommended in NICE guidance. Handovers were recorded on the handover sheet.
- Ward nurses confirmed that handovers were done with the patient present. This was a recent change, as they were previously done in the office.
- We observed appropriate theatre handover practice, for example when a consultant was handing over a patient to a nurse they confirmed that the patient had a penicillin allergy.

Surgical staffing

- Patient care was consultant led and consultants visited inpatients admitted under their care at least daily or more frequently according to clinical needs. We saw evidence of daily consultant review in the records we looked at. Part of the consultant's practicing privileges agreement was that they should be located within 30 minutes travel time of the hospital.
- The hospital had two inpatient resident medical officers (RMOs) who rotated for at least six months to ensure continuity of care. The RMOs were provided under contract with an agency that also provided training. The RMOs provided a 24 hour, seven day week service.
- Some staff commented that the RMO worked too much as they did two weeks at a time and often seemed exhausted. However, they said managers were aware and that the RMOs were responsive and worked well with the wider team.
- There was no formal out of hours anaesthetist cover. Anaesthetists were each responsible for their own list. The theatre manager commented that although this was an informal arrangement, they had seen it work, and gave a recent example of an anaesthetist attending out of hours. However, the MAC chair said there were periods of no cover when consultants were covering their NHS work.
- The MAC chair said consultants' homes and their NHS hospital must be within 30 minutes of BMI Hendon. However, they did not review how long it took consultants to get there. On one occasion when a consultant did not answer the phone they had a discussion with them and the consultant received a formal letter of advice.
- We observed good handover practices. The surgeons' and anaesthetists' handover process involved speaking to the recovery nurse and reading out the clinical notes.

Major incident awareness and training

- The hospital had a business continuity plan detailing what to do in various situations that may affect the day to day running of the ward and theatres. Copies of the business continuity plan were available on the ward and in theatres. The theatre manager showed a good understanding of the business continuity plan and told us they had to deal with a major incident when flooding occurred in the hospital two years prior to inspection. The deputy theatre manager was also aware of the protocol for theatres in the event of a major incident. Staff received fire training as part of the mandatory training programme. Hospital records showed that 86% of staff had up to date fire training.

Are surgery services effective?

Good

We rated effective as good because:

Good

Surgery

- Care and treatment was delivered in line with current evidence-based guidance. Theatre staff used the five steps to safer surgery in line with guidance from the National Patient Safety Agency (NPSA).
- The hospital carried out regular audits including use of the World Health Organisation (WHO) safety checklist.
- We found good multidisciplinary team (MDT) working between nurses and consultants.
- Patients' pain was assessed and managed appropriately.

However,

- Regular meetings for ward and theatre staff were not taking place.
- Some staff did not receive an induction for their role.

Evidence-based care and treatment

- We saw that staff used the five steps to safer surgery which is recommended best practice by the NPSA. This included the WHO surgery checklist.
- Staff told us the aseptic non-touch technique (ANTT) principles were used for urinary catheter insertions in theatre.
- Minutes showed updates in national guidelines including NICE and MHRA were discussed in clinical governance meetings. Managers said they were disseminated to other staff through meetings and emails.
- Staff had access to corporate policies via the intranet.
- The hospital had a corporate audit tracker tool which set out what audits were carried out across a 12 month period. It included the results of those already completed. Audits included a monthly WHO checklist audit, a quarterly consent audit, a controlled drugs audit, and a different theatre based audit each month.
- Surgeons told us they received emails about new policies and updates and were required to sign to say they read it.
- The pharmacist audited the use of antimicrobials every six months, which was in line with NICE guidance on antimicrobial stewardship. The target was 90% and the most recent audit result was 88%.
- The BMI guidelines for assessing patients on anti-coagulants was based on NICE guidelines.

Pain relief

- Pain relief for patients undergoing surgery was managed by the anaesthetist. The anaesthetist prescribed regular and 'as required' analgesia to be administered post-operatively.
- Nurses assessed patients' pain levels at regular intervals using a scoring system. This was recorded in patient notes.
- We saw a new standard operating procedure (SOP) was written for pain assessments and the director of clinical services said this was due to be reviewed at the next clinical governance meeting. It included guidance on assessing and treating pain in elderly patients and patients unable to communicate. The SOP was based on WHO guidelines (Pain and Palliative Care Communications plan, 2012)

Nutrition and hydration

- Patients' nutritional needs were assessed using the Malnutrition Universal Screening Tool (MUST) as recommended by the British Association for Parenteral and Enteral Nutrition.
- Records showed that nurses and health care assistants completed nutrition assessments and staff told us they supervised mealtimes and assisted as required, and felt they had enough time to help patients.
- We observed patients always had drinks available within reach.
- Catering staff and HCAs informed nurses if a patient did not eat their meal or if their food and drink intake was low.
- Patients were offered the choice of cooked or cold meals three times a day, seven days per week. The menus were designed to include a range of special diets and healthy eating options. Patients we spoke with told us they had a choice of food from the menu

Patient outcomes

- Surgeons said they monitored patient outcomes by length of stay and readmission rates.

- There were three cases of unplanned readmission within 29 days of discharge from April 2015 to March 2016. This number of unplanned readmissions is not high when compared to a group of independent acute hospitals which submitted performance data to CQC.
- There was one case of unplanned return to the operating theatre in the same period.
- Orthopaedic outcomes were submitted to the National Joint Registry.
- Patient reported outcome measures (PROMs) data was not available. Consultants told us they collected PROMs data, however the director of clinical services said the numbers of operations performed were too small to audit PROMs.

Competent staff

- Theatre staff appraisals were up to date and staff also had mid-point reviews between the annual appraisals.
- Some staff said they did not have adequate support and training for their role but that this had improved since the new director of clinical services started in June 2016. For example, the infection prevention control (IPC) lead was due to go on an IPC course, and another nurse was training to become a nurse practitioner which would include being able to prescribe.
- Some staff did not have an induction when they started their role. The IPC lead told us they overcame this by networking with IPC leads from other BMI hospitals and attended quarterly meetings. A pre-assessment nurse said they had to work extra hours to learn their role when they started.
- Data provided by the hospital indicated that there was no system for validation of professional registration for theatre nurses and operating department practitioners. However, at the time of inspection the theatre manager developed a system to check when staff revalidation dates were and was monitoring these.
- Some staff commented that they were occasionally asked to do things that they felt were outside of their role/competency, but that they were vocal about their concerns when this happened.
- The theatre manager recently completed an NVQ for endoscope management and was on a management course funded by the hospital.
- Nurses performed catheterisation but did not have training updates for this from the hospital.
- The theatre manager was training the deputy theatre manager to do appraisals for health care assistants.
- The hospital had a competency based training programme for nurses and HCAs. We saw each staff member had a personal competency and mandatory training folder where they stored their certificates and recorded evidence of learning and development. This was also used as evidence towards revalidation.
- We saw an induction pack for a recent new starter which contained a job description, details of the employee advice line, minutes from a recent theatre management meeting and a new starter checklist relating to infection prevention and control.
- A surgeon commented that the nurses were very good at assisting but that there were some things they couldn't do, and that investment in training nurses would be beneficial.

Multidisciplinary working

- The pre-assessment nurses and surgeons we spoke with said they had good communications between them. For example, when nurses were concerned about whether a patient was fit for surgery they were able to contact the surgeon directly and liaise with them. The nurses said they could either call or email the surgeons. The surgeons we spoke with confirmed that they often liaised with the pre-assessment nurses and spoke highly of them. A nurse also commented that they communicated with anaesthetists if patients needed further assessments done.
- Staff commented that ward and theatre staff meetings were not happening regularly. The director of clinical services was aware of this and planned to ensure that regular meetings were held and staff were able to attend.
- The IPC lead was not involved in any IPC audits or checks in the theatres. Staff told us this was due to strained relations between the departments. The theatre manager took on the responsibility of IPC audits in the theatre suite. However, the IPC lead planned to be more involved in future.

- Surgeons said they had good working relationships with managers. They said they saw the theatre manager "all the time", and often spoke to the executive director.
- There was good communication between the theatre manager and the ward manager. The theatre manager said they spoke most days and also attended head of department meetings.
- The theatre manager said they felt some staff on the ward would benefit from understanding theatre processes. There were plans to enable ward staff to spend time in theatre to increase their understanding.
- Heads of department met regularly and minutes showed good attendance levels.
- Consultants had good MDT relationships with external colleagues. A gynaecology surgeon told us the hospital did not see two week cancer referrals but if they found a suspected cancer they put the patient straight on the MDT list at a local NHS hospital.
- Consultants and nurses said they had good relationships with physiotherapists, although surgeons often referred patients to external physiotherapists depending on their individual needs.
- There was no service level agreement with a local NHS hospital. Consultants relied on informal arrangements with colleagues. In the case of an emergency staff would dial 999.

Seven-day services

- Normal operating times for theatres were 8am to 8.30pm Monday to Friday, with operations on Saturdays by exception.
- The RMO was available on site 24 hour per day, seven days per week.
- Physiotherapy was available seven days a week.

Access to information

- Staff had access to patients' paper records which included a copy of the original referral letter and pre-assessment documentation.
- Historical notes were sometimes unavailable due to problems with the hospital's admissions system. If a patient was seen at the hospital over a year before administrative staff would not be able to know this and created a new set of notes, which meant surgeons did not have access to the old notes. Surgeons told us this was not a high risk as any problems were picked up during pre-assessment.
- Blood results were received electronically. Staff printed these to put in patients' paper notes to ensure that all information was there. Staff said this system worked well.
- Handovers were thorough and ensured that all information was passed on as required.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff showed a good understanding of the consent process and issues around capacity and said capacity and consent was part of their mandatory e-learning. The theatre manager gave an example of when a different type of consent form was used for a patient who lacked capacity.
- Staff working in the pre-assessment unit demonstrated a good understanding of how to assess capacity and one nurse gave an example of an instance where they saw a patient who they felt did not have capacity and referred them back to the GP.
- We observed the anaesthetist confirming consent with a patient and checking that the consent form was completed correctly and that the patient understood the nature of the procedure. This was documented in the patient record.
- A consent audit dated March 2016 showed that the hospital scored 76% which meant it was not meeting its target of 90% for recording consent. The details of the audit showed that the shortfall was due to the name of the health care professional performing the procedure not being clearly written. The action plan stated "Consultant handwriting is an issue, all consent forms signed but block capitals not clear." It did not detail any action that would be taken. The consent audit result for June 2016 showed improvement, with a result of 100%.

Good

Surgery

Are surgery services caring?

Good

We rated caring as good because:

- Staff provided compassionate, patient-centred care.
- Patients were treated with dignity and respect and staff responded to patients' needs.
- Feedback from patients was positive about the way staff treated patients.
- The hospital scored above the national average in the NHS Friends and Family Test.

Compassionate care

- We observed staff providing compassionate care and treating patients with dignity, respect and kindness.
- Patients spoke highly of staff and one said they were "amazing" and would do anything to help. Another commented that staff were approachable.
- We saw thank you cards from patients on the walls in the ward.
- Staff respected patients' privacy and patients had their own private rooms. Doors were closed during personal care, or if a patient had a visitor.
- The hospital's monthly NHS Friends and Family Test score was regularly above 97%.It scored 71% for privacy, dignity and wellbeing in the patient led assessment of the care environment (PLACE) 2016.
- The MAC chair said patients were usually very happy, but occasionally they were less happy about food, and some reported that nurses did not always come when called. However, results we saw on the patient satisfaction dashboard showed that patient satisfaction with the nurse response time improved from May 2015 to May 2016 – from 82.4% satisfaction rate to 96.6%.

Understanding and involvement of patients and those close to them

- Patients were involved in decisions about their care and staff ensured they had a good understanding of the surgery including pre and post-operative aspects.
- The pre assessment nurses ensured patients were aware of any pre-operative self-care requirements such as not eating on the morning of surgery.
- Patients knew who their doctor, allocated nurse and health care assistant were. The names of the allocated nurse and health care assistant were written on the white board in each patient room.
- Visitors were welcome on the ward and visiting hours were flexible.
- The hospital reported that patient feedback indicated patients were not always aware of how long they would need to wait for surgery once they were admitted, and as a result staff were trying to ensure patients were kept informed.

Emotional support

- Staff were supportive and responsive to patients emotional needs. We observed staff displaying empathy towards patients and their relatives. Patients we spoke with said they felt well supported by staff.
- Staff helped to enable patients to manage their own health and care when they could.
- The hospital did not offer counselling services.

Are surgery services responsive?

Good

We rated responsive as good because:

- Services were planned to meet the needs of patients and to ensure contractual requirements were met.
- The hospital met the referral to treatment target (RTT) of 90% for NHS admitted patients waiting less than 18 weeks from the time of referral to treatment. They achieved 98% in April 2016, 100% in May and 98.8% in June.
- The hospital responded to complaints in a timely manner and complaints were discussed at meetings to address issues and identify learning.

However,

- The needs of different people were not always taken into account as rooms had baths instead of walk-in showers.
- There were not adequate provisions for those with a hearing impairment.

Service planning and delivery to meet the needs of local people

- Fifty-seven percent of patients were NHS-funded. The hospital ensured that services were planned to meet contractual requirements.
- All surgery carried out at the hospital was elective which made service planning and delivery straightforward.
- Operating theatre lists were booked in advanced and patients had a choice of dates and times. This meant, where possible, they were able to choose a date to fit in with their personal, family and work commitments.
- Care and treatment was coordinated with other services and other providers. NHS patients were referred by local hospitals, GPs, and via the local CCG's 'Choose and Book' system.
- The hospital had a 'five day rule' for surgical admissions, which meant all patients were booked at least five days prior to admission. This helped to ensure sufficient resources were available.
- There was a plan in place to open an ambulatory unit for day-case patients so that they would not have to be admitted onto the ward.
- Patients received a follow-up telephone call 48 hours after discharge to ensure they were managing at home. This included day case patients. Any issues were addressed during the phone call, if possible, or patients would be booked in for a review with the consultant or nurse.

Access and flow

- The hospital met the referral to treatment target (RTT) of 90% for NHS admitted patients waiting less than 18 weeks from the time of referral to treatment. They achieved 98% in April 2016, 100% in May and 98.8% in June.
- The hospital had a tracking system linked to the NHS RTT report which enabled managers to monitor waiting times and adjust appointment times to ensure patients do not breach the waiting time. Additional theatre lists could be created or existing theatre lists extended, to meet demand.
- A weekly 'bed meeting' was held to review forthcoming activity to assist planning.
- Consultants with regular work patterns at the hospital had pre-booked theatre slots that enable them to book patients in promptly.
- The hospital monitored unplanned returns to theatre. There was one case of unplanned return to the operating theatre between April 15 and March 2016.
- Hospital data showed that 47 scheduled operations were cancelled between August 2015 and June 2016. Most of these were due to 'natural circumstances', such as the patients having eaten on the morning of surgery. The theatre manager confirmed this during inspection. They said staff tried to call patients two days before their surgery to ensure they were clear on all the instructions provided, but it wasn't always possible to make contact.
- When patients arrived at reception a porter or ward clerk escorted them to the ward. They gave the patient a room orientation which included showing them where the call bell was. A nurse then admitted the patient. The anaesthetist and consultant would then see the patient on the ward prior to surgery. This process was for both inpatients and day cases.
- An orthopaedic surgeon and a gynaecology surgeon told us they recently started staggering admission times. For example two patients arrived at 7am, the next two at 7.15am, and so on. They did mini team briefs between patients to ensure they met them before surgery. They said this helped the ward flow, and was better for patients too, they usually went into theatre within an hour.
- Patient pathways were not standardised, they varied depending on the consultant and the patients' needs. The director of clinical services told us they wanted to create a standardised pathway and planned to discuss it at the MAC. Consultants we spoke with told us they did use different pathways but that it was always based on the patient's individual needs and circumstances.
- A surgeon told us all orthopaedic surgeons were trying to put patients on the enhanced recovery programme

which meant that those having joint operations could be discharged within two or three days. They commented that this could sometimes be too quick. However, they felt they always ensured it was safe for the patient.

- Patients were assessed before being discharged and a discharge letter was sent to the patient's GP.

Meeting people's individual needs

- All surgical patients were pre-assessed prior to admission to ensure that the hospital was able to accommodate any special requirements.
- Facilities were available for people with a physical disability, such as access ramps and lift facilities. However, the bathroom facilities in the rooms were not accessible for people with mobility issues as they had baths instead of walk in showers. There were two showers available on the floor, but this meant patients had to go past other rooms to get to the shower.
- Staff said they rarely saw patients with a learning disability or patients living with dementia.
- The theatre manager said only one patient living with dementia had undergone surgery at the hospital within the 12 months prior to inspection. They explained the provisions that were made and said all staff involved in care of the patient took extra measures to ensure that everything was in place to meet the patient's needs. For example, they ensured that the patient's carer was present as the patient came round from general anaesthesia.
- Staff said they always booked an interpreter for patients who did not speak English. An incident occurred in October 2015 where an interpreter was not booked and the operation had to be cancelled. This resulted in a review of the interpreter booking protocol at BMI Hendon which was ratified at the December 2015 clinical governance meeting.
- A patient complained that there were not adequate provisions for those with a hearing impairment. They requested to be contacted via post or text message but were telephoned several times.
- A surgeon told us the hospital recently employed a women's specialist physiotherapist in response to the high number of gynaecology patients seen at the hospital. They said gynaecology patients were pleased with this.
- A patient said they were given choices at breakfast, lunch, dinner, and could choose hot or cold food.

Learning from complaints and concerns

- The hospital reported there were 46 complaints from April 2015 to March 2016. The assessed rate of complaints was higher than the 20 independent acute hospitals we hold this type of data for.
- The executive director told us the main theme of complaints was regarding food and the facilities. They said they worked closely with the catering company to address issues raised and were securing funding to improve the facilities of the hospital. Another theme was consultant communication, as some patients reported that they felt they did not explain things clearly. They told us complaints were always investigated and discussed with all parties involved, and that complaints were acknowledged and responded to within the agreed time period.
- We viewed one complaint from May 2016 about the inaccessibility of the bathrooms on the ward. The complainant stated that they could not access a bath and had to wait for one of the only two showers on that floor to become available. We saw that the hospital sent an acknowledgement letter within two days, and a full response within three weeks. We saw that they liaised with the catering company to address concerns about food choices, and were working to address the concerns regarding the facilities.
- The hospital told us complaints were discussed in brief within 24 hours of receipt in the daily morning meeting. Dependent upon the nature of the complaint, they were then discussed either at the monthly heads of department meeting or the bimonthly clinical governance meeting.
- A separate monthly compliments and complaints meeting was held, chaired in rotation by a head of department. Complaints were discussed and staff talked

about how things could be done differently. The executive director said they tried to encourage different staff to attend from every department. We saw minutes from meetings showing that complaints were discussed.

Are surgery services well-led?

Good

We rated well led as good because:

- Governance and risk management processes were in place. Safety outcomes were measured and monitored.
- Whilst some staff reported feeling unsupported in their roles, they said this improved since the new director of clinical services started. There was good teamwork and staff enjoyed working there.
- Both staff and managers we spoke with were aware of the hospitals vision for the future.

However,

- A high turnover of senior management and vacancies meant some staff were not adequately supported in their roles.
- Teamwork between the theatre and other departments required improvement.

Vision and strategy for this this core service

- The service's strategy and vision involved becoming more efficient and improving patient flow. The hospital planned to open an ambulatory unit for patients undergoing day case surgery. This would improve the experience for patients and utilise theatre and ward space more efficiently.
- Staff we spoke with were aware of the vision and strategy of the service and gave specific examples of future plans.
- The chair of the medical advisory committee (MAC) said the MAC fed into the hospital's vision as an MAC group but were not always involved in deciding on issues relating to vision and strategy.

Governance, risk management and quality measurement for this core service

- The hospital followed the corporate framework of formal weekly senior management team meetings, monthly heads of department meetings, and bimonthly clinical governance meetings. Minutes showed that there were good levels of attendance at these meetings and that planned agenda items were discussed, and actions were reviewed.
- Managers told us they held a daily morning meeting, with a pro-forma agenda, to reflect on the previous day and prepare for the coming activity of the day. They said the brief notes of this meeting were then taken back to the departments to update the teams.
- The Medical Advisory Committee (MAC) met quarterly with the executive director and director of clinical services.
- A clinical governance board met bimonthly. Leads of all clinical departments were required to attend in addition to non-clinical managers responsible for governance in the hospital. Minutes were circulated and available on the hospital shared drive.
- The audit tracker showed that a structured audit programme was in place to support the hospital to manage and monitor patient safety.
- The monthly quality audit was reviewed centrally by the regional management team.
- A representative for each clinical department was required at the MAC meetings. Minutes showed that there was a representative for surgery at the MAC meeting in January 2016 but not in April.
- The hospital maintained a risk register which included corporate and clinical risks. However, the theatre sluice room that required remedial work was not on the risk register. The director of clinical services said this should have been listed on it. The outstanding works on the theatre ventilation system were also not on the risk register.
- We saw that the risk register was discussed in management team meetings.
- The hospital provided evidence of actions taken as a result of an incident involving a cardiac arrest and resuscitation in September 2015. A root cause analysis was completed, and the actions were followed up including a new guideline on pre-assessment

medication management. Advice to staff was that a risk assessment must be done by both the consultant surgeon and consultant anaesthetist regarding stopping anti-coagulation therapy and that pre-assessment staff must liaise with consultants and anaesthetists . This was confirmed in minutes of the resus meeting in March 2016. The incident was also discussed at a clinical governance meeting in October 2015 and the MAC meeting the same month. However, the hospital did not audit adherence to the guideline on medication in pre-assessment as a result of the incident.

Leadership / culture of service related to this core service

- The service was led by the director of clinical services who was in post for four weeks at the time of inspection, the theatre manager and the ward manager. There was also a lead nurse for pre assessment.
- Staff said the executive director was supportive and approachable. One member of staff said the executive director was "involved and present".
- Some staff said they did not have adequate support and training for their role due to the lack of leadership and high turnover of senior managers. However, they said this improved since the new director of clinical services started in June 2016. Staff also commented that work was stressful due to the absence and instability of senior management.
- The director of clinical services told us their top priorities included staff training and development. Staff spoke highly of the newly appointed director of clinical services.
- Most staff felt well-supported by the theatre manager. However, there were some communication issues with staff outside of the department.
- The executive director commented that the different departments needed to "gel" more and work together as one team rather than in separate groups.
- Theatre staff including nurses and non-clinical staff said they enjoyed working there and that there was good teamwork. We observed good communication between staff of all levels and there was a positive atmosphere. Staff were passionate about their work. A surgeon commented that there was a "family feel" at the hospital.
- There was good communication between nurses and consultants.
- Staff spoke highly of the ward manager and said they made positive changes.
- The MAC chair said they were in the hospital twice a week and attended the clinical governance meeting every two months.
- The pharmacist said they had good support through the corporate network and the senior pharmacists were responsive when they had queries.

Public and staff engagement

- Patient-led assessments of the clinical environment (PLACE) audits were conducted annually. Managers reviewed results and focused on areas for improvement.
- The hospital also conducted a regular patient satisfaction survey. Every patient was given the survey to complete and managers reviewed the results monthly. Feedback cards were also given to patient family members and visitors.
- Meeting minutes showed that patient satisfaction results were discussed at the MAC meetings.
- Results of the patient satisfaction survey were displayed in the main building and included a 'you said, we did' section which showed the changes that were made as a result of patient feedback.
- The hospital conducted an annual staff survey; however it was not done in 2015 due to restructuring and staffing issues.
- The 2016 staff survey was conducted in April 2016 and 78% of staff participated. This was better than the corporate average of 68% participation.
- The executive director said the 2016 results showed that staff felt there was a lack of trust between some teams. They said personal development was also low scoring as staff were not sure "where they are going". An action plan was put in place, and one of the key focuses for the clinical director was staff education and development.
- The executive director held a staff forum twice a month. They did this on different days at different times to enable staff members from different areas to attend.

- Staff we spoke with were aware of the forum and some said they regularly attended. One commented that the executive director listened to them and "walks the talk" (implying that their actions were consistent with what they said).

Innovation, improvement and sustainability

- BMI Healthcare planned to submit data to the Private Healthcare Information Network (PHIN) from September 2016, which would be available to the public in April 2017.
- The hospital planned to open an ambulatory care unit for patients undergoing day surgery. The aim of this was to improve flow in the theatres and to improve the patient experience.
- The director of clinical services said their top priority was to improve staff training, education and development. This included ensuring staff with specialist roles had adequate time to fulfil their duties. They also planned to have a "bitesize" weekly education session debriefing, which would include learning from incidents.

Good

Outpatients and diagnostic imaging

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

Information about the service

BMI Hendon Hospital is located in a residential area in North London, close to major road and rail links. It is a combination of a purpose built main block, built in the 1960s and an adjoining consulting room suite formed from two converted residential properties that was developed later.

The outpatients' service is situated in the consulting room suite. The diagnostic imaging department, the physiotherapy department and the ophthalmology clinic are all situated in the main building.

The outpatients department consists of 10 consulting rooms, a minor operations procedure room, a phlebotomy room and a plaster/dressing room. The department is open from 08:00 to 21:00 Monday to Thursday, 08:00 to 19:00 on Friday and 8am to 2pm on Saturday. Health screening is carried out on Sunday from 9am to 1pm. There are two dedicated pre-assessment rooms on the first floor used to facilitate face to face and telephone pre-assessment, which is carried out between 8am and 4pm on weekdays, except for Wednesdays, when it is carried out between 11am and 7pm.

The clinical specialties offered on a regular basis in the hospital's outpatients department include gynaecology, haematology, orthopaedics, cardiology, care of the elderly, chest medicine, neurology/endocrinology, ophthalmology, pain management, podiatry, rheumatology, urology, dermatology, ear, nose and throat, gastroenterology, general surgery, breast surgery, cosmetic surgery and oral surgery.

The diagnostic imaging department has a general x-ray room, a mammography room, an orthopantomogram (OPG) room and an ultrasound room. The diagnostic imaging equipment available includes an OPG machine, a urodynamics machine, an ultrasound machine and a magnetic resonance imaging (MRI) machine. There is a dental computed tomography (CT) coned beam machine but this is not in use at the present time. The diagnostic imaging department is open from 8.30am to 8.30pm on Mondays to Thursdays and 8.30am to 5.30pm on Fridays. The MRI department is open from 8.30am to 5pm on Mondays to Fridays. There is an out-of-hours on-call service. (There is also a 3D ultrasound service offering specialist female health and fertility screening and a private GP service, each of which are operated by independently registered service providers).

The ophthalmology clinic within the hospital has been relocated to the main building. Since September 2014, the hospital has been responsible for the operation of a community ophthalmology service in the London Borough of Brent. There are two community-based sites (Sudbury and Willesden). This service operates under the hospital's CQC registration and is on a five year, fixed term contract.

The physiotherapy department has two private treatment rooms, two curtained cubicles, a hand therapy treatment room, a gym, a compensated weight treadmill and a cryotherapy chamber. The department is open from 7.30am to 7pm two days a week and from 8.30am to 7pm three days a week.8.30am to 4.30pm on Mondays to Fridays. Opening times are flexible, depending on patient requirements, including at weekends. The physiotherapy facility is used by both outpatients and in-patients.

During our announced inspection in July 2016, we visited the outpatients, diagnostic imaging and physiotherapy departments and the ophthalmology clinic based at the hospital. We spoke with five patients and 30 members of

Good

Outpatients and diagnostic imaging

staff, including consultants, nurses, clinical leads, senior managers, radiographers, healthcare support workers and domestic staff. We reviewed patients' clinical notes and medical records and observed care being delivered in the various departments.

Summary of findings

Overall we rated this service as good because:

- The hospital had good leadership through the Eexecutive Ddirector and there was good clinical governance. The hospital's policies and procedures were in accordance with national guidelines.
- Patients received good care and treatment. Patients were respected and well supported. They were seen by a specialist consultant within days of being referred. Any radiology required was arranged at the same time. Patients said they were well informed and involved in making decisions with their consultant.
- Staff of all disciplines worked well together to ensure patients received good care and treatment. Staff demonstrated an open and transparent culture. Staff felt comfortable to raise concerns and report incidents.
- There was good multidisciplinary working within the hospital services and externally with other healthcare providers. The hospital made thorough checks on consultants before awarding practising privileges.
- Staff followed the escalation policy when a patient was clinically unwell. Staff adhered to the medication policy. The x-ray machines were checked regularly and regular monitoring was carried out when using contrast agents.
- The staffing number and skill mix of staff was adequate to keep patients safe. All staff had competency assessments before carrying out clinical tasks and all staff completed mandatory training.

However:

- Confidential patient information not always was stored in accordance with the Data Protection Act 1998.
- The outpatients department was in need of refurbishment.
- There was a risk of cross-infection because there was no hand basin in the consulting room in the new ophthalmic clinic and the hand basin in the

Good

Outpatients and diagnostic imaging

mammography room was removed and not replaced for over three months. The plaster room was used for plastering as well as for wound dressing and this potentially exposed patients to cross-infection in the event of an infected wound.

- Patients who needed cryotherapy treatment were not able to receive it because the cryotherapy pod was not in service and there was no timeline as to when the ownership and contractual issues would be resolved. There were no timelines for replacing the MRI scanner and the ultrasound machine.
- The vacant manager posts for both of the departments were not filled for some time.

Are outpatients and diagnostic imaging services safe?

Requires improvement

We rated safe as requires improvement because:

- Patients' clinical records were sometimes left unattended in an unlocked drawer. This meant that confidential information was not always kept in accordance with the Data Protection Act 1998.
- The consulting room in the new ophthalmic clinic had no hand basin and the hand basin in the mammography room was removed and not replaced for over three months. These missing items meant that staff and patients were exposed to risk of cross infection.
- The plaster room was used for plastering as well as wound dressing and this potentially exposed patients to cross infection in the event of an infected wound.
- In the physiotherapy department, the cryotherapy pod was not in service and there was no timeline as to when the ownership and the contractual issues would be resolved.
- There were no timelines for replacing the MRI scanner and the ultrasound machine.
- The posts of manager of each of the two departments have been vacant for some time, which has had an impact on both the managerial and clinical work of the departments.

However:

- There were no never events or serious incidents reported in the last financial year.
- There were thorough checks before consultants were awarded practising privileges, and the privileges were suspended if the documentation was not kept up to date.
- Medicines were obtained and handled appropriately. The use of contrast agents were monitored because of the risk of allergic reactions. The intensity of the x-ray machine was regularly checked and adjusted.
- There was an escalation process when a patient was clinically unwell.
- All staff received mandatory training

Incidents

Good

Outpatients and diagnostic imaging

- The trust reported there had been no never events between April 2015 and March 2016 for the Outpatients and Diagnostic Imaging Department. Never events are serious incidents that are wholly preventable, where guidance or safety recommendations that provide strong systemic protective barriers are available at a national level, and should have been implemented by all healthcare providers.
- We were told the quality risk manager reviewed all the incidents reported and met with the executive team to ensure all incidents were discussed and that they were categorised appropriately. An investigation was started within 48 hours and root cause analysis was initiated where required.
- The outpatients and diagnostic imaging service had 157 reported clinical incidents between April 2015 to March 2016. The rate of clinical incidents was above the average of eight independent acute providers with similar data. There were no notifications of serious incidents and none wereas reported during this period.
- There were 11 non-clinical incidents within the outpatients and diagnostic imaging service between April 2015 and March 2016. The rate was similar to the average of the eight independent acute providers with similar data.
- In the last 12 months, the diagnostic imaging department had 18 incidents which were reported and recorded on the incident reporting system. These were investigated and a report produced, in accordance with the Quality and Risk Management process. Any actions and lessons learnt were cascaded down to all the staff. For example, in one reported incident, an OPG (orthopantomograph of the jaws and teeth) cassette was used in error instead of a normal cassette during an x-ray. In response, all OPG cassettes were labelled differently, to distinguish them from normal cassettes.
- Staff had access to the policy on duty of candour. Staff we spoke with were fully aware of their responsibilities in regard to the duty of candour. Patients and their relatives would be informed within ten days following an adverse incident.
- All staff were given training in duty of candour. The radiographers we spoke with said they received accountability training which included duty of candour and was last held in July 2016. A certificate was issued following the training session.

Cleanliness, infection control and hygiene

- We observed staff using personal protective equipment (PPE) and following the 'bare below the elbows' guidance in clinical areas. Staff wore aprons and gloves before taking blood from patients.
- We observed staff washing their hands and using alcohol gel before attending to each patient.
- In April to May 2016 a hand hygiene audit was conducted which found that the hospital was 100% compliant. We saw a log of handwashing audits.
- We noted the domestic staff carrying out their daily cleaning schedules in the outpatients, ophthalmology and diagnostic imaging departments. We saw the cleaning charts, which were updated regularly.
- Patients reported that the outpatients department (OPD) was clean and tidy every time they visited. We noted some of the clinical areas appeared cluttered. We were shown the plaster room and told that it was used for orthopaedic patients as well as for patients requiring wound redressing. This potentially exposed patients to the risk of cross infection in the event of an infected wound.
- The diagnostic imaging department was clean and spacious. We observed that pillowcases and sheets were changed in-between patients having MRI scans. The cleaning charts showed all equipment in use was wiped and kept clean daily and in-between patients. However, a broken hand basin in one of the imaging rooms was removed over three months ago and hadwas not been replaced. Staff said they had to wash their hands in the room next door before attending to each patient in the mammography imaging room. There was, however, a bottle of alcohol gel in use in the room.
- We observed the consulting room in the ophthalmology department had no hand basin installed. The consultant told us they had to use the hand basin in the next room before and after attending to each patient, which was a hazard to infection control.

Good

Outpatients and diagnostic imaging

Environment and equipment

- There was a reception desk in the waiting area in the OPD, with two receptionists to assist patients as they arrived. Reception staff greeted all visitors and verified their identity on entry.
- Senior staff were not able to give us the date when the hand basin would be fixed in the mammography imaging room. We were told the ultrasound machine and the MRI scanner were due to be upgraded, as a high priority. However, these equipment were still in good working order.

  The physiotherapy department had a whole body cryotherapy pod, which exposed the entire body to extreme cold at approximately minus 80°C to aid certain medical conditions. This equipment was currently out of service. We were told the temperature control was unreliable and there were problems regarding the ownership of the equipment and the service contract.
- We noted the television in the outpatients' waiting room was off. Staff said it was out of order and the engineer was informed but it was not clear when it would be repaired.
- During the afternoon of our visit to OPD, we noted there was a new leak from the ceiling in the waiting area. Staff said it was due to the air conditioning system; we observed a member of staff had immediately put a health and safety sign near the bucket used to collect the dripping water. We were told the engineer was informed.
- The OPD had only one minor operation room and therefore minor procedures sometimes had to be postponed to another day.
- Staff confirmed there was adequate clinical equipment in use to meet the needs of patients and the equipment we examined, such as sterilised dressing packs and syringes and needles, were in date. We noted the trolleys set up for clinical procedures were clean and fully equipped.
- Equipment that required regular servicing was in date.
- We saw that the resuscitation trolley in OPD was placed in the corner of the waiting room next to the reception desk and was easily accessible. The contents, including emergency drugs, were checked every seven days to ensure they were all in date. The trolley was closed and tagged to show it was not used since the last check. The trolley was checked daily and it was tagged to show it was checked. Staff checked the defibrillator and the suction equipment every morning to make sure they were in good working order. We saw that the daily log sheet was signed and dated by the designated member of staff who carried out the checks.
- There was a separate resuscitation trolley in the diagnostic imaging department. The logbook showed that staff checked the equipment daily and ensured the trolley was tagged when not in use. The trolley contents were checked every Monday and daily checks were carried out to ensure all equipment kept on top of the trolley, including suction and oxygen equipment, were in good working order. An anaphylactic kit was taken into the x-ray room with the resuscitation trolley when a patient was undergoing a scanning procedure. We saw the equipment checklist and logs were signed and dated by the designated member of staff.

Medicines

- The OPD had no control drugs in stock. The drugs that were in stock were for the consultants to use as required, such as local anaesthetic drugs and steroids. These were recorded in the patients' notes by the consultant who administered the drugs. The nurse kept a record of the drug being supplied to the consultant.
- We were shown the drugs which were appropriately stored in a locked drug cupboard. A drug register for the ordering and receiving of stock medicines was kept. We saw the date and signature of the designated member of staff responsible for the ordering or receiving of these medicines.
- A member of staff confirmed that patients were not given any medicines unless prescribed by their consultants. We saw prescription pads in the locked drug cupboard. These forms were used for private patients. Separate prescription forms were used for NHS patients. Patients were able to use the hospital pharmacy during opening hours.
- The hospital pharmacy was open from 9.30am to 1.30pm, Monday to Friday. The resident medical officer had access to the pharmacy out of hours.

- Staff said the hospital pharmacist carried out regular medication audits. The audit of the administration of medication in the outpatients' department in December 2015 showed that the department was compliant except for the extravasation kit, which was out of date. Action was taken to replace the kit.
- The hospital employed one pharmacist, who was assisted by a technician. Arrangements were made with a locum pharmacist to cover annual leave or sickness.
- In the diagnostic imaging department, medicines were stored appropriately. The radiographers carried out contrast media intravenous injections required in certain diagnostic imaging procedures. The injections were obtained using approved patient group directions (PGDs). PGDs are documents permitting the supply of prescription only medicines to groups of patients without individual prescriptions. These were administered appropriately by the registered radiographers.
- There were regular intravenous injection audits. Data was collected for each patient who was given an intravenous contrast medium injection. Details of the contrast agent used, the amount and whether the patient experienced an allergic reaction were recorded. If the details were not entered, the radiology information system raised an alert.
- The x-ray dose delivered by the x-ray machine was checked regularly against the appropriate diagnostic reference levels and adjusted as necessary to ensure patient safety. These checks were audited.

Records

- We were told that a patient's medical records were always obtained before the patient was seen in the outpatients' department. We were informed that all NHS patients' hospital notes were delivered to the OPD the day prior to the patient's outpatient clinic appointment and the notes were returned to the NHS hospital the following day. During the out-of-hours clinic sessions, the notes could be accessed if required.
- Should a consultant need to take the hospital records of NHS patients off-site, advance permission had to be sought in writing and granted by the Director of Clinical Services or by the Operations Manager. The Operations Manager managed the medical records department. The consultant was required to follow the BMI protocol that conformed to data protection legislation and the Caldicott Principles. In a situation where consent was granted, the records had to be signed out by the consultant on the hospital's medical records tracker.
- The OPD used paper records for patients seen in the clinics. There was a clinical folder set up for each new patient. These folders were kept in locked cabinets in the medical records room when not in use. Private patients' medical notes were held by their consultants.
- All imaging, histology and blood results were available on the IT system. The service planned to eventually hold all patients' medical records online; so far, only booking forms were placed online.
- During the clinic sessions, we observed paper clinical notes were temporarily kept in lockable drawers in the nurses' station. We were told all clinical notes when completed would be returned to the medical records room on the first floor.
- However, we found that after a clinic session, a new patient's clinical notes folder was kept in one of the stationery drawers where the receptionists sit. The patient was due to be rebooked for the following week. Staff said the clinical folder was left in the drawer temporarily as the receptionist left the desk to assist a patient; the second receptionist was on another task at the time. However, these drawers were not locked and there were no keys attached to the drawers.
- We were told the administrative staff at the reception desk would also print out registration forms for between 50 and 120 newly booked patients. This was done the evening before in readiness for the clinics the next day. However, these confidential records were kept every night in the unlocked drawer of the reception desk when the office closed at night. Staff did not adhere to the policy on the safe storage of confidential information.
- In the diagnostic imaging department, all imaging records were digital and stored on the hospital computer system. All clinical staff had access to these using individual secure passwords.
- All the staff we spoke with said they received training on the Data Protection Act 1998 and were aware of the BMI policy on the safe handling and storage of confidential information.

- Staff completed an e-learning module on information security which included data protection. Emails were monitored to ensure only secure servers were used and some staff were provided with an NHS email address for confidential transfer of patient data relating to NHS contracts.
- Consultants holding practising privileges had to be registered as independent data controllers with the Information Commissioner's Office (ICO), since the consultants were responsible for handling the medical records for their private patients.

Safeguarding

- Staff knew what constituted a safeguarding incident and the actions to take in the event of such an incident. Staff knew who to report the incident to and who the safeguarding lead was.
- All the staff received safeguarding training, level 1. The hospital stopped seeing children from 1 June 2016 therefore nurses were not required to have safeguarding training level 3. However, the hospital had been seeing children before the 1 June 2016. We were told nurses had only received safeguarding level 2 training even before 1 June 2016.
- In this hospital, clinical staff such as nurses receive safeguarding training only up to level 2. However two nurses who were working for BMI for some years confirmed they received safeguarding training up to level 1 only.

Mandatory training

- Staff we spoke with confirmed they undertook mandatory training such as in health and safety, fire safety, moving and handling, infection control, safeguarding and basic or intermediate life support, depending on their role. Long-term staff confirmed they completed their yearly refresher courses on time. All nurses were trained in intermediate life support the last training session being in February 2016.
- We examined the records for mandatory training and found that, for the hospital as a whole, 86.71% of staff attended the mandatory training appropriate to their role.
- Staff were given access to computer terminals where they could undertake an e-learning programme. Rolling training was provided. Staff said they also received group training organised by a contractual company on the topics in the training programme. The OPD sister and the diagnostic imaging lead told us all their staff completed their mandatory training and refresher courses.

Assessing and responding to patient risk

- In the OPD, we observed receptionists and nurses were visible in the waiting area where there was a reception desk and a nurses' station. In the diagnostic imaging department, a receptionist was present during clinic hours.
- The ophthalmic clinic, which was relocated a month ago to level 2 of the main building, currently had no receptionist or a nurse on site during clinic hours. Potentially patients could be at risk of delayed treatment in the event of an emergency, as there were no nursing staff in the location. However, there was a healthcare assistant (HCA) present to assist the consultant. The HCA was trained in basic life support. We noted there was no signage to direct patients to the eye clinic.
- Staff said patients undergoing treatment or minor operations or those who felt unwell during clinic visits would be given routine observations. Staff were trained to use the National Early Warning Score (NEWS) chart to assess a patient's condition and to call the medical team for assistance when necessary.
- Staff were aware of the escalation procedure when a patient became unwell. In an emergency, staff said they would press the emergency call bell if urgent medical assistance was required. The emergency call bells were in every clinical room and consultation room in the physiotherapy and diagnostic imaging departments.
- In the diagnostic imaging department, radiographers were trained in intermediate life support and followed the escalation procedure. For example, in the event of a patient having an allergic reaction to the contrast medium, they were taken straight to the theatre recovery room for observation and treatment by the theatre team.
- Radiographers completed safety risk assessments and safety questionnaires. We saw that last menstrual period records were checked and signed for five female

patients under 55 years. We checked that the records were entered on the system. All these patients signed to confirm they were not pregnant. In the case of patients with dementia, staff went through the appropriate safety questionnaires with the patient's next of kin.

- We saw the policy on completing the safety checklist which all staff working in the diagnostic imaging department was inducted to follow. Patients needed to be on a patient pathway to have an MRI scan; patients were not able to self-refer. No MRI scans were performed on pregnant patients in the first trimester.
- Staff were aware of the quench policy and procedure to be followed when using the MRI machine to switch off the magnetic field in an emergency. If a ferromagnetic object was brought near to the MRI machine, it would be attracted with an intense force which could be dangerous. If this happened, it was therefore necessary to turn off the magnetic field immediately. This was termed a 'quench'. Staff checked that no patients had such objects in their possession.
- Staff highlighted awareness of patients who were at risk such as elderly patients who might be confused or lived with dementia and people with learning disability. Staff said the consultants were supportive and would assist if staff were not able to take blood from a vulnerable patient.

Nursing staffing

- The BMI nursing dependency and skill mix tool was used to plan the staffing level and skill mix of staff required to meet the needs of patients in outpatients and the diagnostic imaging department. The tool was applied when planning the staffing rota, which was planned a month in advance. The rota was then reviewed weekly in advance and updated daily. The outpatients' sister and the diagnostic imaging lead were responsible for reviewing and reporting the staffing and skill mix over a rolling 24-hour period from midnight to midnight for their departments. This ensured the department had the correct number of skilled and experienced staff on duty daily.
- The OPD staff team consisted of one sister, three registered nurses and two healthcare assistants. However, the service had no manager for two years and the outpatients' sister was acting as the manager for the service. We were told this had an impact at times on managerial tasks and staff cover. The staff worked well as a team and agency staff was not used to cover shifts. Staff said they sometimes worked an extra hour, for which they were paid.
- On the day of our inspection, the department was well managed and by 11.30am there were only two patients waiting to be seen. We noted every member of staff had to clock in on arrival for work.
- There was a vacancy for a registered nurse to cover 22.5 hours and a new recruit was waiting to be given a start date. There were two vacancies for healthcare assistants covering a total of sixty hours but now one post was filled.
- We were told the vacant post for an outpatients' manager was advertised but no suitable candidate was found. Similarly, the provider experienced difficulty recruiting and retaining a manager for the diagnostic and imaging department. An experienced radiographer lead was currently managing the service, until a suitable applicant was found.
- The staff in the OPD were assisted by at least two receptionists who formed part of a team of administrative staff based on the first floor of OPD. We were told the administrative services lead was in charge of the booking of private patients and oversaw the receptionists and the administrative staff working on the first floor, which included the pre-assessment and pathology departments. The business service manager managed the administrative staff in the pre-assessment and pathology departments and negotiated the contracts with NHS providers.
- The OPD did not use agency staff for some time.

Medical staffing

- All consultants and radiologists working at BMI Hendon hospital had practising privileges, worked on a self-employed basis and were not regarded as employees of BMI.
- There were two neuro-radiologists among the radiologists working at BMI.
- As part of the application process, a consultant's General Medical Council (GMC) registration number was checked and references were obtained. The application was submitted to the chair of the medical advisory

committee (MAC) when all checks were completed. There was a yearly renewal process. The consultant's status could be checked on the database. GMC and ICO registrations were checked online. The consultant's Disclosure and Barring Service (DBS) expiry and hepatitis B status were also checked on the database. Four weeks before expiry the consultant was asked for updated renewal documentation, including their latest appraisal and their indemnity insurance document and was asked to complete the renewal and self-declaration forms.

- In the last 12 months, six consultants ceased practising, two withdrew their services for personal reasons and four had their practicing privileges withdrawn for failing to provide information requested to keep their personal files up to date.
- There were six consultants whose practising privileges were suspended in the last 12 months, but five were subsequently reinstated when they fulfilled the requirements to supply the necessary documentation.
- We were told the diagnostic imaging department occasionally used agency staff, which were last used for MRI in early 2016. All agency staff came from a single BMI approved agency. Currently four bank radiographers were being used, two for MRI and two for x-ray.
- Consultants attended OPD to see their own private patients. Some consultants had private and NHS funded patients. NHS patients were referred to BMI for treatment as part of a contractual agreement with BMI. Consultants used the BMI hospital facilities to see and treat patients.

Major incident awareness and training

- Staff were aware of the policy for major incident awareness. A member of staff gave an example of what staff had to do in the event of a fire and showed us the notice board with the names of staff appointed as fire marshals. We were shown the staff fire safety log. We were told the fire alarm was tested every Friday and periodic evacuation drills took place.

Are outpatients and diagnostic imaging services effective?

Not sufficient evidence to rate

We did not have sufficient evidence to rate effective, however we found:

- The hospital followed national guidelines in its policies and procedures, which were kept updated.
- The work of the departments was audited thoroughly, and found to be generally of a high standard. There were regular clinical audits.
- All staff had competency assessments for the clinical tasks they needed to perform.
- Staff discussed pain relief with new patients at the pre-assessment session.
- There are clinics on every day of the week and out of hours.
- There was good multidisciplinary working internally and with external healthcare providers.
- Patients confirmed that they checked and signed the consent form before treatment began.

Evidence-based care and treatment

- The hospital followed national guidelines such as those from the National Institute of Health and Clinical Excellence (NICE) and the royal colleges. Staff were expected to follow the BMI policies and procedures.
- We checked the policy and procedures folders and saw that they were kept up to date. The policies and procedures present included health and safety, infection control, the needle prick policy and the chaperone policy. The policies for the diagnostic and imaging service included the MRI policy and the quench policy for the MRI machine, both of which were revised in 2016. Staff, including agency radiographers, could easily get access to the policy folder for each department and knew the policies and systems of work. This helped to ensure patients received the correct care and treatment.
- Each month, the hospital carried out a number of clinical audits, as part of ensuring good clinical

governance. Local audits were carried out on patient records, consent forms and medication, among others. For example, patient records were last audited in March 2016. The hospital was found to be 99% compliant.

- In the diagnostic imaging department, there were regular quality assurance checks on the work of the radiographers and radiologists. Radiographers carried out image quality audits, which involved assessing the images from 10 patients. Staff had a discussion session and produced a conclusion and an action plan to improve the imaging service. In addition, the radiologists carried out regular audits on each other's reports.
- We examined the audit reports, which included monthly health and safety audits, intravenous injection audits, image quality audits and audits regarding the x-ray dose delivered by the x-ray machine, all of which were found to be satisfactory.
- We were shown a clinical audit carried out regarding the Ionising Radiation (Medical Exposure) Regulations (IR (ME) R). We saw the reports by the Radiation Protection Adviser (RPA), the last being dated 18 January 2016. The audit and reports were satisfactory.

Pain relief

- Staff said they followed the hospital policy on pain management during minor clinical procedures and for pain relief.
- Staff discussed pain relief with new patients at the pre-assessment session.

Patient outcomes

- BMI did not participate in any level of the Imaging Services Accreditation Scheme (ISAS). However, BMI had an arrangement with another private provider (BUPA) for accreditation regarding the diagnostic and imaging service.
- The department received a Radiation Protection Audit by Royal Berkshire NHS Foundation Trust on 23 November 2015 and passed on all issues except two, as follows: The change of hospital name was not notified to the Health and Safety Executive. The local rules were not reviewed annually. Actions were raised for both of these issues and were carried out.

Competent staff

- Staff undertook mandatory training and competency assessments before they carried out clinical procedures. A competency certificate was issued when the assessment was completed. The OPD sister and the diagnostic imaging lead monitored the training programme and the dates training was due for each member of their staff and ensured all required training was provided to staff.
- HCAs working in outpatients were given competency assessments so they could assist in certain procedures such as phlebotomy, colposcopy, coil insertion and removal and flexible cystoscopy. HCAs also carried out 24-hour, 48-hour and seven day ECG monitoring and 24-hour blood pressure monitoring.
- HCAs working in the ophthalmology clinic received training in minor eye procedures and carried out visual field tests.
- Nurses, radiographers and physiotherapists had intermediate life support training and revalidation of their registration, which were kept up to date.
- The HCAs and receptionist working in outpatients and diagnostic imaging were trained in basic life support. A member of the reception team in OPD explained that staff in OPD often had drills using a doll on how to resuscitate as part of life support training. One receptionist confirmed they were involved in the life support drills three times since they commenced working just over a year ago.
- Radiographers working in diagnostic imaging attended courses to enhance their skills as radiographers. We saw the staff training records which were kept up to date with relevant courses. Radiographers attended a mammography course every two years. Radiographers also had training on how to insert a cannula.
- We saw the letters of appointment of two Radiation Protection Supervisors (RPSs), both of whom were trained in 2015.
- All physiotherapists were registered with the Health and Care Professions Council and were members of the Chartered Society of Physiotherapy. There were physiotherapists employed specialising in sports rehabilitation, muscle stimulation, hand therapy and splinting, temporomandibular joint disorder, women's health, acupuncture and pilates.

Good

Outpatients and diagnostic imaging

- Staff confirmed they received annual appraisals and regular clinical supervision. Staff told us they had team meetings every four to six weeks and were involved in submitting topics for discussion to improve staff performance and maintain good practice.

Multidisciplinary working

- Staff established good MDT working with the consultants, radiographers, physiotherapists, the NHS providers who had service level agreements, and with the ambulance services.
- Consultants we spoke with felt they had a good working relationship with the nursing team and with other internal hospital services such as the radiographers, the physiotherapists and the theatre staff.
- There was good MDT working among consultants themselves in sharing their clinical expertise in treating patients. We noted this during our inspection when a patient's condition was seen by one consultant and referred to another on the same day on site. A multidisciplinary discussion took place before treatment began. This meant that patients could obtain fast referrals to specialist consultants in the OPD and had access to imaging technologies to better diagnose their condition and to guide treatment decisions.

Seven-day services

- There are clinics on every day of the week and out of hours.
- The clinics were supported by services such as the pharmacy, radiology and physiotherapy should support be required, including out of hours. There was also an on-call theatre team.

Access to information

- Staff had access to BMI policies and clinical guidelines and other information via the BMI intranet.
- There was regularly updated information on clinical incidents and lessons learnt through emails and the hospital bulletin.
- Information was communicated through regular staff meetings and multidisciplinary team meetings.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- The day before a patient's first outpatient appointment, a registration form was printed. This was given to the patient on arrival to check that all their details were correct, including their name, their address, their insurance company if they were privately funded and their medical history. The patient was asked to sign the form to indicate the information was correct.
- Patients confirmed that staff explained the registration and consent forms and that they were given time to check the details before signing the forms. The consent form was checked and signed before treatment was begun.
- Staff confirmed they had training on the Mental Capacity Act and they had knowledge of the Deprivation of Liberty Safeguards (DoLs). During the pre-assessment appointment, the pre-assessment team carried out a risk assessment which included checking if the patient required a DoLs application. There were no recent applications.

Are outpatients and diagnostic imaging services caring?

Good

We rated caring as good because:

- Patients gave positive feedback about the care and service provided. They reported that staff were reassuring, approachable and very professional.
- Patients said they were well informed and confirmed they were given time to read the various forms before signing them.
- We observed that staff were friendly and interacted well with patients.

Compassionate care

- Patients were asked to give their feedback using the Friends & Family Test (FFT) form before they left the hospital. The FFT data showed a score consistently above 97%.
- Staff said patients were encouraged to complete a patient satisfaction survey during or after their outpatient visit. The patient satisfaction survey forms were analysed by an independent company called

Good

Outpatients and diagnostic imaging

Quality Health who generated and disseminated reports monthly. These were site specific and provided the opportunity for comparison with other BMI hospitals. The Quality Health reports were distributed monthly to each site. As a result of the feedback from the patient satisfaction survey, a new customer care training day would be introduced in the summer of 2016.

- In July 2016, four CQC feedback boxes were placed in the reception area of the main building and in waiting rooms on the second floor and the lower ground floor. There was also a box in the OPD waiting room. The comments received included:
- "Main appointment diagnosis excellent. MRI very helpful in dispelling fears. Excellent follow up. Very friendly and supportive staff."

Emotional support

- A patient told us they were nervous on their first visit but the staff were very helpful, which they found reassuring.
- One patient told us they were booked to see the wrong specialist. However, the patient added that the consultant they saw on the day was "excellent and very accommodating". The consultant explained very clearly about the error in the referral process and another appointment was made for the patient to return the following week to see the correct specialist.
- Staff told us the consultant would inform the nursing team when a patient was about to be told distressing news and a designated nurse would be present in the same room as the consultant to give support. The nurse would stay with the patient afterwards to ensure the patient had no delayed reaction.

Understanding and involvement of patients and those close to them

- All patients we spoke with said the consultant they saw explained things clearly to make sure they understood. They all found the consultants to be very supportive.
- Staff said all new patients had to check and verify the details on the registration form and signed and date the form before they saw the consultant.
- We spoke with five patients in the waiting area. They reported that staff were approachable and very professional. We observed that staff in the waiting area were friendly and interacted well with patients.
- Patients told us the reception staff were polite and readily available to assist both patients and visitors. They said all the staff in OPD were helpful and polite and that they had no concerns.
- However, a patient said on a previous visit there were no staff to assist them when they returned to the waiting area. The patient felt dizzy at the time following a surgical procedure.

Are outpatients and diagnostic imaging services responsive?

Good

We rated responsive as good because:

- BMI Hendon Hospital treated both private and NHS patients and had a number of regular patients from the local community who had built a relationship with the hospital.
- Patients were seen by the specialist consultant within days of being referred by their GP or the NHS provider. Any radiology required was arranged, usually on the same day as the appointment with the consultant.
- The flow of patients through the various clinics was well organised.
- There was a wide range of physiotherapy treatments available. Interpreters were provided when needed.
- Staff felt they worked well with NHS providers and GPs to meet the needs of local people.
- Complaints were handled and resolved appropriately and quickly.

However:

- In the physiotherapy department, the cryotherapy pod used to aid certain medical conditions was currently out of service.
- The outpatients department was in need of refurbishment.

Service planning and delivery to meet the needs of local people

Good

Outpatients and diagnostic imaging

- The OPD saw both private and NHS patients. Of patients seen in outpatients, 38% were NHS funded, while 62% had another source of funding.
- Between April 2015 and March 2016, the OPD had 4,626 first attendances that were NHS funded. During the same period, 7,541 that attended OPD for the first time were privately funded.
- BMI Hendon Hospital offered 'choose and book' NHS services for diagnostics, orthopaedics, urology, gynaecology, ophthalmics, endoscopy and general surgery. Choose and book referrals can be made via the online choose and book system or by fax. NHS patients represented over 50% of admissions for the financial year.
- The diagnostic imaging department saw 33% NHS patients and 67 % private patients. Between 30% and 40% of patients who had ultrasound scanning were NHS patients.
- For each patient, the radiographer sent the images to a radiologist, who analysed them within the standard reporting time of 48 hours and sent the results to the consultant concerned. Images and results were transferred using the Pacsmail or IEP networks. A signed and dated log was kept of patients undergoing diagnostic imaging, and their date of birth, clinical conditions, and radiation dose. The images were sent to the Picture Archiving and Communications System (PACS). The report was prepared by a radiologist.
- Staff felt they worked well with NHS providers and GPs and that communication on the whole was effective among the MDT team, both externally and internally, to meet the needs of local people.
- In the OPD there were two dedicated pre-assessment rooms used for face-to-face pre-assessment of patients prior to their outpatient appointment. Telephone pre-assessment was also available for patients who preferred this method and for selected conditions such as ophthalmology.
- The pre-assessment team consisted of a full-time and a part-time registered nurse and a receptionist to provide administrative support. The team operated from 8am to 4pm hours Monday, Tuesday, Thursday and Friday and from 11am to 7pm on Wednesdays.
- The OPD also had a Saturday clinic from 8am to 2pm with consultants and nursing staff on site. On Saturdays, the staff were supported by a ward sister.
- The physiotherapy department had private treatment rooms and a gym.
- The physiotherapy department had a specialised treadmill designed in association with NASA that cancelled out up to 80% of a patient's weight using garments fitted with an inflated air bladder. This speeded a patient's recovery, by making it possible for the patient to exercise at a stage in recovery where normal exercise would be damaging or impossible.
- Extracorporeal shockwave therapy was provided to treat painful tendons by accelerating the natural healing process. Specially trained physiotherapists were employed to administer this.
- The hospital offered cryotherapy treatment, but this was currently not available because the cryotherapy pod was out of service.
- The OPD was in need of refurbishment. Staff felt some of the rooms in use as offices were too small and lacked ventilation. We noted one spacious clinical room was being used as a storage room. Staff said this room was not in use for some time. We were told there was a refurbishment plan in place and a rolling programme was underway for rooms and communal areas.
- Staff assisted patients who required transportation. Staff provided leaflets on support groups, aftercare support and advice for long-term care and rehabilitation, following surgery.
- There was information displayed in the waiting area, including leaflets with contact numbers for the support network and helplines for specific illnesses to support local people.
- In the waiting area, there was a water dispenser and tea and coffee machines for patients to help themselves and free soft drinks were provided.

Access and flow

NHS Funded Patients

- Patients seen in BMI Hendon were referred initially by their own GP. One patient said they waited only a few days for their first appointment at OPD. Another said their first appointment took a few weeks due to the need to make arrangements with the insurance company.
- Patients funded by the NHS were initially referred by their GP to an NHS provider. The latter had a service provider agreement with BMI, and referred the patient in turn to the BMI lead for NHS patients. The patient was

then triaged and an appointment with a consultant was arranged. The consultant arranged for the patient to have images taken in the diagnostic imaging department if required.
- The results of radiology were reported within 48 hours of the images being taken
- We examined data from April 2015 to March 2016 for the time from referral to treatment for patients in the Outpatients and Diagnostic Imaging service whose treatment pathways were incomplete at the end of the reporting month. The provider did not meet the target of 92% of such patients treated within 18 weeks of referral in the following 6 months: June 2015 (91%), July 2015 (89%), August 2015 (85%), September 2015 (84%), October 2015 (91%) and December 2015 (90%).
- We examined data from April 2015 to March 2016 for the time from referral to treatment for patients in the Outpatients and Diagnostic Imaging service who had not been admitted for treatment at the end of the reporting month. The percentage of such patients treated within 18 weeks from referral was 100% every month, except for March 2016, when it was 97%.
- Most of the RTT waiting time occurred before BMI was involved. However, statistically, BMI was still shown as sometimes not meeting the RTT target. This occurred for June to December 2015 and for December 2015, within the reporting period from April 2015 to March 2016.

Privately Funded Patients

- In the case of privately funded patients, the GP faxed the referral letter to BMI or the patient contacted the hospital and brought the referral letter. A member of staff working in the booking office explained the process when a patient phoned up or used the online 'choose and book' system. A member of staff made the booking if the patient phoned up. Staff checked the online system daily and dealt with any bookings. A clinical folder with the registration form, the patient's details, the GP referral letter, the insurance details, if applicable, the consultant's name and the clinical details were set up ready for the patient's appointment with the consultant.
- If the booking list for the consultant was full, the consultant was contacted before the patient was booked. All appointments were booked electronically.

Follow-up appointments were arranged on the day before the patient left the clinic. Any radiology would be done on the same day or within a few days. If a patient required physiotherapy, this would be booked.
- On the day of our inspection, we observed that the flow of patients through the outpatients and the diagnostic imaging department was smooth and organised.
- Patients who attended OPD previously confirmed that their appointment was kept on time and the longest wait was 10 minutes. One patient said they came early, which was a personal choice.

Meeting people's individual needs

- During the pre-assessment session, the nurse carried out risk assessments depending on each patient's healthcare needs. The risk assessments included the Waterlow score for patients prone to pressure sores and a falls risk assessment for people with restricted mobility. Staff also risk assessed people with dementia or learning disability to see if they should be referred for mental capacity assessment with their own doctor before seeing the consultant at BMI. Staff also assessed if people with learning disability or elderly patients with dementia required additional support from social services if they were NHS funded.
- Physiotherapy was provided for patients with a range of conditions, which included sports injuries, back and neck pain, hand injury, repetitive strain injury and post-surgery rehabilitation. A wide range of therapies were provided, which were often applied in combination, and which included manual therapy, massage, acupuncture and exercises. The physiotherapists also offered personalised training and customised rehabilitation. Each patient was first assessed and an individual treatment programme was drawn up.
- The physiotherapy department had a whole body cryotherapy pod, which exposed the entire body to extreme cold at approximately minus 80°C to aid certain medical conditions. However, this equipment was currently out of service.
- For NHS patients whose first language was not English, staff were able to arrange for interpreters to assist them through Language Line. For private patients staff arranged interpreters with Language Direct. BMI also used Language Direct if patients needed support and assistance with sign language. This included NHS patients, for whom BMI would fund the service.

Good

Outpatients and diagnostic imaging

- BMI ceased treating children in the outpatients and the diagnostic imaging department on 01 June 2016.

Learning from complaints and concerns

- The Eexecutive Ddirector (ED) oversaw the handling of complaints and all responses to complaints were signed by the ED. The customer services manager (CSM) managed the complaints process, including the dissemination of the complaint to the relevant departments and the management of the timescales. This ensured the company's complaints policy was followed. The CSM sent out updates to complainants if the final response to a complaint was going to be delayed due to an ongoing investigation.
- Complaints were discussed in brief within 24 hours of receipt at the daily morning meeting, and, depending on the nature of the complaint, were further discussed at the monthly heads of department meeting or the bimonthly clinical governance board meeting.
- Over the six months from 1 October 2015 to 31 March 2016, there were 13 complaints about outpatients and one complaint about physiotherapy. All the complaints were dealt with. Most complaints were resolved with a cash refund and an apology. The complaints procedure was followed within the required timescale and the dates for each stage of the complaints process was recorded.
- Lessons were learnt from complaints, concerns were raised and prompt action was taken. For example, during a procedure in OPD, a patient raised an issue about staff being very noisy; staff were made aware of this and an apology was sent to the patient.
- There was a duty manager available on site daily to speak with patients, visitors and staff if they wished to raise any concerns or offer compliments. There was an on-call duty rota out of hours.
- A compliments and complaints meeting was held monthly for staff to receive and give feedback and to facilitate discussion on how to improve patients' experiences. The meeting was chaired in rotation by a head of department and attended by a member of staff from every department.
- Patients had access to a patient guide booklet which included a section outlining the formal complaints procedure. Copies of the BMI leaflet entitled 'Please tell us...' were available in the OPD and throughout the hospital, to inform patients, relatives and visitors on how they could raise any concerns.
- The patient satisfaction survey also included a section where people could ask the hospital representative to contact them. Staff said they were encouraged to identify and address any concerns or issues raised by a patient or their relative whilst they were still on site and to escalate such concerns quickly to their line manager or one of the senior managers or the Executive Directorexecutive director if the issues raised were serious, so that the matter could be resolved promptly. This action helped to avoid an issue developing into a formal complaint.

Are outpatients and diagnostic imaging services well-led?

Good

We rated well led as good because:

- The hospital had an open and transparent culture. The executive team was supportive of their staff; the Eexecutive Ddirector was visible daily and was involved in staff meetings.
- Staff felt involved in fulfilling BMI's vision and strategy.
- There was an open door policy and staff felt comfortable to speak with the Eexecutive Ddirector or the clinical director if they had any issues.
- There was good clinical governance and a good quality and risk management process. This ensured patients received safe care and treatment.

However:

- Both the outpatients and the diagnostic imaging departments had no managers for some time.

Vision and strategy for this service

- BMI Healthcare had a corporate strategy aiming to deliver best quality, best practice and best outcomes to the business and a high quality service to the local community. To further these goals, there was an extensive clinical governance process, combined with a continuous improvement strategy, tailored to the specific needs of acute care. BMI Hendon Hospital covered a wide range of clinical specialties and provided a community service to regular patients living in the locality, including older people.

Good

Outpatients and diagnostic imaging

- Staff we spoke with felt involved in fulfilling the BMI's vision and strategy. This was reflected in the way staff worked together to support their clinical leads in both the outpatients and diagnostic imaging departments, where there were no permanent managers for some time. The services continued to be maintained with good staff morale. Patients' feedback in June 2016 and during our inspection was highly complementary about the staff performance in providing a quality service.

Governance, risk management and quality measurement

- The clinical governance board meeting was held every two months and the Non-clinical managers could attend governance meetings.
- A Medical Advisory Committee meeting was held quarterly. Through the work of a multidisciplinary group and the Medical Advisory Committee, action was taken to continuously improve the quality of care.
- The Regional Clinical Quality Assurance Groups monitored and analysed trends and ensured that the quality improvements were actioned.
- At corporate level, the Clinical Governance Board had an overview and provided the strategic leadership for corporate learning and quality improvement. There was an ongoing focus on robust reporting of all incidents, near misses and outcomes.
- We were shown an updated booklet 'Guidance for reporting incidents and completion of incident report forms' which was produced in June 2016. This new guidance included pathways for clinical and non-clinical incidents. The Quality and Risk Manager ensured the information was cascaded down to all departments so that staff understood the process for incident reporting and investigation and the correct forms to use. This ensured that the quality of incident reporting and investigation continued to improve.

Leadership of service

- All the staff we spoke with knew and met the Eexecutive Ddirector, who took over two years ago. Staff said the Eexecutive Ddirector visited the various services daily and often attended staff meetings. Staff said the Eexecutive Ddirector was a good listener, was very approachable and would take action promptly to resolve any issues raised.
- Staff said they had met the new clinical director, who started work a month ago. The clinical director was also the director of nursing. Staff felt comfortable talking to the executive team.
- During our inspection, we were informed of a concern raised by a member of staff highlighting a clinical procedure where the hospital protocol was not followed. The executive team listened and the matter was being investigated.
- Both the outpatients and the diagnostic imaging departments were managed by clinical leads that helped maintain the services although both departments had no managers for some time. Staff were complimentary of the clinical leads.

Culture within the service

- Staff were very confident about speaking with the executive team about any issues and felt there was good communication among multidisciplinary teams and senior managers.
- There was regular communication to all staff via email; staff were regularly informed and updated with information via the hospital bulletin and the 'above and beyond' hospital newsletter.
- The hospital had a targeted training programme for identified members of staff to ensure understanding and implementation in relation to the duty of candour. As part of BMI Healthcare, the hospital followed BMI's Being Open and Duty of Candour policy, which stated that if mistakes were made:
  - The affected person would be given an opportunity to discuss what went wrong.
  - The investigating team would discuss what could be done to deal with any harm caused.
  - The investigating team would decide what would be done to prevent any recurrence.
  - The affected person would receive an apology.

Public engagement

- There was a public education event in OPD in May 2016, where one of the topics presented was alternative treatments for osteoarthritis.

Good

Outpatients and diagnostic imaging

- There was a monthly event for GPs and consultants to get together socially and discuss matters of interest.
- BMI liked to be involved in the local community and sponsored the local football club.
- As a result of feedback from past patient surveys, a new Customer Care training day was to be introduced in the summer of 2016.

Staff engagement

- Staff we spoke with said they enjoyed working for the service. Staff confirmed there was good team work displayed. Staff felt well supported by their clinical leads.
- A member of staff from each department attended the monthly departmental compliments / complaints / compliance meeting.
- There was a monthly staff forum where staff could discuss issues and received insight into how other departments worked and how they solved similar problems.

Innovation, improvement and sustainability

- BMI Healthcare hopes to introduce Patient Recorded Outcome Measures (PROMs) for all their private patients, as well as those outcomes they already captured for their NHS patients.
- The new national Private Healthcare Information Network (PHIN) website, which will be launched shortly, will enable patients to make informed choices about their consultants and care, through a comprehensive website covering the most popular private procedures and their outcomes.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

Surgery

- Carry out remedial work in the sluice where there is exposed plaster and pipes and a hole in the wall from the recent removal of decontamination equipment.
- Ensure that all remedial action highlighted in the theatre ventilation servicing report is completed.
- Ensure that the new sinks are in compliance with Department of Health guidelines HBN26 'facilities for surgical procedures'.

Outpatients and diagnostic imaging

- Ensure confidential patient information is stored in accordance with the Data Protection Act 1998.
- Ensure there are an adequate number of hand basins in the consultation and treatment rooms to minimise the risk of cross-infection.
- Ensure there is an adequate facility for wound dressing to prevent cross infection.

Action the provider SHOULD take to improve

Medicine

- Ensure staff complete their mandatory training.
- Undertake audits of national early warning score (NEWS) systems to identify deteriorating patients
- Ensure action plans are in place for high MUST scores
- Ensure that the resident medical officer RMO's has regular clinical supervision.
- Ensure Waste management meets best practice guidelines for the segregation and indication of clinical and non-clinical waste
- Ensure that thermostatically taps are installed in the hand washing basins.
- Ensure disabled shower room facilities are safe and fit for purpose.
- Improve the environment in patient's rooms and bathrooms.

Surgery

- Improve communication of shared learning from incidents so that all staff are aware and involved.
- Ensure that all staff have the skills needed to fulfil their roles and are supported to develop.
- Improve communications between the theatre and other departments.
- Ensure there is oversight of infection prevention and control across all departments including theatres.
- Ensure that inpatient rooms are compliant with HBN00-09.

Outpatients and diagnostic imaging

- Ensure the decor of the outpatients department is well maintained.
- Ensure the MRI scanner and the ultrasound machine are replaced in a timely manner.
- Ensure the vacant manager posts for both departments are filled without further delay.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment 12.— 1. Care and treatment must be provided in a safe way for service users. 2. Without limiting paragraph (1), the things which a registered person must do to comply with that paragraph include— a. assessing the risks to the health and safety of service users of receiving the care or treatment; b. doing all that is reasonably practicable to mitigate any such risks; c. ensuring that persons providing care or treatment to service users have the qualifications, competence, skills and experience to do so safely; d. ensuring that the premises used by the service provider are safe to use for their intended purpose and are used in a safe way; h. assessing the risk of, and preventing, detecting and controlling the spread of, infections, including those that are health care associated;