BMI The Blackheath Hospital

Quality Report

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

Ratings

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

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

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

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

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

Summary of findings

Letter from the Chief Inspector of Hospitals

BMI The Blackheath Hospital is an acute independent hospital that provides outpatient, day care and inpatient services. The hospital is owned and managed by BMI Healthcare Limited. A range of services such as physiotherapy and medical imaging are available on site. The hospital offers a range of surgical procedures and cancer care as well as rapid access to assessment and investigation and level 2 critical care. Services are available to people with private or corporate health insurance or to those paying for one off treatment. The hospital also offers services to NHS patients on behalf of the NHS through local contractual arrangements.

We carried out a comprehensive inspection of BMI The Blackheath Hospital on 12 to13 July 2016. We reviewed how the hospital provided outpatient, medical care, surgical services, care to children (outpatients from birth and interventional from aged three to 15 years) and critical care. Information about critical care and services for children and young people is included in surgery and outpatient and diagnostic imaging.

This was a comprehensive planned inspection of all core services provided at the hospital surgery, outpatient and diagnostic imaging and services for children and young people. General medical, endoscopy and children & young people services are provided to patients using the same nursing staff, patient rooms and facilities as other patients. There were no patients in the critical care unit during the inspection. For these reasons we have not reported these separately but have included the services within surgery.

Prior to the inspection the hospital an interim Executive Director was appointed.

We rated this hospital as good overall.

For the hospital overall we rated the key questions as follows:

Are services safe at this hospital

We rated safety as requiring improvement overall because; some safety procedures required further development. The endoscopy unit had a decontamination room that was used for both clean and dirty equipment. Although there was a sign on the wall there was no colour coding or other barriers to separate the areas.

In surgery some staff did not always receive feedback from incidents and staff did not always adhere to infection prevention and control guidance.

Some chairs in both the OPD and oncology suite did not meet infection control standards as they could not be thoroughly cleaned . There were no dedicated hand wash basins in patient bedrooms for staff or visitors and no hand washing facilities within the ward corridors.

There was no formal system in the urgent care centre to monitor patients who may deteriorate while waiting to be seen by a doctor.

However;

We also found the hospital had made many improvements since the previous inspection.

A rolling programme to replace the carpets in clinical areas was underway.

The number of paediatric trained nurses had been increased and arrangements for where children were cared for had improved and was more child friendly.

The wards were clean and tidy and equipment was checked and stored appropriately.

Medicines were stored securely and chemotherapy was prescribed and administered in line with best practice guidance.

Summary of findings

There were sufficient staff to care for patients and consultants were supported by an on site resident medical officer twenty four hours seven days per week.

Are services effective at this hospital

We rated effective as good overall because;

Patients received care that was informed by national and best practice guidance such as the National Institute for Health and Care Excellence. Radiologists followed guidelines from the Royal college of Radiologists.

All staff groups, nursing, medical and physiotherapists were involved in audits. There was evidence of monitoring of outcomes and the number of unplanned readmissions was low.

Patients had their pain assessed and analgesia could be administered via different routes depending on the individual needs of the patients.

Staff had access to training and nurses were supported to complete their revalidation. Staff were supported to maintain their clinical competencies. For example critical care staff worked in theatres when they had no patients.

However;

Appraisal uptake was low for some staff groups.

Some staff were unclear of their responsibilities in relation the Mental Capacity Act 2005. They could not describe the way to obtain consent for a patient who lacked capacity.

There was no formal on call rota for radiologists.

Are services caring at this hospital

We rated caring as good overall because; patients were very positive about the staff and how they were treated by them. They felt involved in discussions about their care and treatment and that staff had time to talk to them. A support group had been established for oncology patients which they found helpful.

Responses to the family and friends test and surveys carried out by the hospital were very positive. Scores for Patient-led assessment of the care environment (PLACE) were generally the same as or higher than the England average. However for privacy dignity and wellbeing it was lower than the England average.

Information about fees was visible in public areas.

However;

Confidentially for patients when registering at the urgent care centre (UCC) was potentially compromised as screens in reception meant they had to talk loudly to be heard.

Are services responsive at this hospital

We rated responsive as good overall because;

Services were planned to meet the needs of people. Some services including physiotherapy had extended their opening hours to enable patients to attend before or after work.

Privately funded patients could arrange their admission in agreement with their consultant and NHS funded patients were generally seen with national waiting times. In the urgent care centre patients were seen within 15 minutes of arrival or were given a refund of the fee.

Cancellations on the day of surgery were low and the hospital policy was that children should be operated on before 3pm.

Summary of findings

Since the last inspection the hospital had improved training for staff to care for people with a learning disability or who were living with dementia.

Information about how to complain was available in public areas and we saw complaints had been responded to within the 20 day standard.

However;

Some staff were unaware of who the dementia champion was.

Are services well-led at this hospital

We rated well-led as good overall because;

Since the last inspection the hospital had improved the leadership on the wards and in theatres through the recruitment to key posts including the theatre manager and lead nurse for infection prevention and control.

There were plans to improve the facilities and at the time of the inspection the hospital had received planning permission to build a new endoscopy unit to replace the existing suite. Alongside this were plans to expand the critical care unit and provide level 3 care.

The hospital had plans to expand the critical care unit to a four-bed unit and provide level three care as per the Faculty of Intensive Care Medicine (FICM) standards.

There was a clear management structure and staff knew who their line manger was and members of the senior management team. Staff told us their manager and senior team were visible and supportive and they felt able to raise concerns. They felt they were treated with fairness and respect. All staff who responded to the 2016 hospital survey said they were proud to work at the hospital.

Systems to monitor the quality and safety of the service had been strengthened since the last inspection and now included a Children's and Young People Committee. The risk register was up to date and included endoscopy as a risk. The Medical Advisory Committee met quarterly and minutes demonstrated that clinical governance, practising privileges and patient satisfaction were among the standing items.

Staff told us about the employee of the month award and how it promoted good team work.

However;

Action had not been taken to mitigate all the risks in endoscopy.

Patient engagement was limited to surveys and comment cards.

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

Importantly the provider MUST take to improve;

Take action to mitigate the risks in endoscopy.

Action the provider SHOULD take to improve;

Ensure learning from incidents is consistently shared with staff and incidents reports are available for outpatients and the urgent care centre.

Be clear in their policies where they have deviated from national guidelines with regards to pregnancy testing female patients prior to surgery.

Ensure all staff comply with infection prevention and control policies.

Increase the screening levels of MRSA compliance to targeted levels as set out in policy and procedure.

Summary of findings

Ensure hand washing facilities on the wards are compliant with infection prevention and control guidance.

Produce infection prevention and control audits with quantifiable data to enable comparisons to take place and identify areas of good practice and those that require improvement.

Ensure theatre staff are aware of the correct disposal of wasted medications.

Review access to the operating theatre to make secure.

Review the secure locking system for medicines cupboards in theatres.

Formalise and embed the triage system in the urgent care centre.

Ensure that staff have a good understanding of the Mental Capacity Act 2005 and how to care for and consent patients who may not have capacity to do so themselves.

Increase the uptake of appraisals for staff for all staff groups in all areas.

The hospital should benchmark itself against similar services to monitor its performance and identify areas of good practice or those that require improvement.

Ensure patients' privacy is protected when booking in at the urgent care centre.

Consider how access to occupational therapists could be improved.

Ensure staff have access to training about caring for patients living with dementia or learning difficulties and are aware of the dementia champion.

Continue to work to improve patient engagement.

Professor Sir Mike Richards
Chief Inspector of Hospitals

Overall summary

Overall we rated this hospital as good.

Many improvements had been made since the previous inspection including the recruitment of more paediatric trained nurses, a rolling programme to replace the carpeting in clinical areas and the upgrading of the critical care unit to provide care for patients requiring level 2 care.

The hospital had taken action to minimise most of the risks to patients. There was a system for reporting and learning from incidents and safety checks including the World Health Organisation checklist were completed. The rate of clinical incidents was similar to the average when compared to the 15 other independent acute providers.

Staff had received the appropriate level training and were aware of the action to take in response to abuse/ suspected abuse of children or adults.

Patient areas were clean and equipment was available and safety checks carried out.

Children were cared for by paediatric trained nurses and medical staff providing treatment for children had to confirm on an annual basis that they met basic requirements for volumes of children treated.

There was evidence of some national and local audits taking place and care and treatment was evidence based.

The majority of staff had attended mandatory training and were supported to develop their clinical and leadership skills.

Patients' had their personal, nutritional and pain needs met by staff who were kind, friendly and treated them with dignity.

Summary of findings

Privately funded patients were able to access treatment in agreement with their consultant and NHS funded patients were generally treated within national waiting times. Some services had expanded their availability to meet patient's needs.

Local leadership had been improved and senior leadership had been strengthened. Staff commented positively about leaders at all levels, they felt able to raise concerns and were proud to work at the hospital. They were committed to providing high quality care for patients.

There was some patient engagement through hospital surveys and the family and friends test.

However;

Decontamination in endoscopy did not meet best practice guidance.

There were no dedicated hand wash basins in patient bedrooms for staff or visitors and no hand washing facilities within the ward corridors.

There was a low uptake of appraisals in some staff groups and there was no formal on call rota for radiologists

Some staff were unaware of their responsibilities in relation to the consent, capacity and the deprivation of liberty safeguards and who the dementia champion was.

Confidentially for patients when registering at the urgent care centre (UCC) was potentially compromised and there was no system to monitor patients who may deteriorate while waiting to be seen by a doctor.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Urgent and emergency services	Good	Overall we have rated the urgent care centre (UCC) as good because: • There were systems for reporting and learning from incidents and examples of changes in practice following incidents. • Staff adhered to infection prevention and control policies and medicines and prescription pads were stored securely. • There were separate patient records for children and all records were stored securely. • Equipment had been checked and included a separate resuscitation trolley for children. • Staff were aware of safeguarding adult and child protection policies and knew the action to take in the event of suspected or actual abuse. The UCC had a standard operating procedure for children involved an attendance history check. • There were processes for managing adults and children who became acutely unwell including admitting them to the hospital or transferring them to the local Emergency Department. • With the support of bank or agency nurses there were sufficient nursing and medical staff, including paediatric trained nurses, to care for patients. • Care and treatment was informed by national guidelines. • Patients spoke positively about how staff cared for them and we saw staff being kind and courteous to patients and treating them with respect. Staff tried to make children feel at ease. • The service was responsive to patients needs and the majority of patients were seen within 15 minutes of arrival. • There were systems to monitor the quality and safety of care provided. • Senior staff were visible and staff told us they were approachable. They felt they were supported by their line manager and their work was acknowledge by local and senior managers. However:

Summary of findings

- Patient confidentiality was sometimes compromised when they were registering at the reception.
- There was no formal system to monitor patients who may deteriorate while waiting to be seen by a doctor.
- Staff were not aware of the action to take should a patient lack capacity to consent to treatment.
- There was a low uptake of appraisals for nurses and health care assistants.

Surgery

Good

We have included the critical care service and endoscopy in this report.
Overall we have rated surgery centre as good because:

- Medicines on the wards and critical care unit were stored securely. In theatres they were stored in a locked cabinets but during the inspection one of the cabinets was left open.
- Records we reviewed were complete and up to date.
- Staff had attended training on safeguarding adults and child protection and were aware of the action to take should they suspect abuse.
- Since the last inspection the hospital had increased the number of paediatric trained nurses.
- Children were cared for on the same ward as adults but, since the last inspection they were now cared for in dedicated rooms in one area by the nurses station.
- Following the last inspection the hospital has implemented a rolling programme to replace carpets in clinical areas.
- Patients received effective care and there was some monitoring of outcomes.
- The critical care unit had been developed and now met national standards for level 2 care.
- There was good multidisciplinary working and patients were positive about the way they were treated by staff.
- They told us staff were "friendly and nice" and we observed staff treated patients with dignity and maintained their privacy.
- The hospital had recruited to the some of the key vacant posts and there was good leadership in many areas.

However:

Summary of findings

- Staff knew how to report incidents but learning from incidents was not always shared with staff.
- The endoscopy unit did not conform to best practice in relation to infection prevention and control. The endoscopy unit had a decontamination room that was used for both clean and dirty equipment. There was no clear demarcation between the dirty and clean areas. There was a sign on the wall that stated 'clean' and another that stated 'dirty'; however there was no colour coding or other physical barrier to separate the areas.
- There was only one sink to wash and rinse the endoscopes which was not in line with best practice guidance. Following the inspection the hospital had a second sink fitted.
- Hand washing facilities on wards was limited.

Outpatients and diagnostic imaging

Good

We have included the outpatients oncology service in this core service report.
Overall, we rated outpatients (OPD), diagnostic imaging and the oncology service as good because:

- Since the last inspection the hospital had made many improvements to the OPD and diagnostic and imaging.
- The departments had improved processes to minimise risks to patients and ensure they received quality care. Staff were encouraged to report incidents and received feedback and learning was shared. Daily meetings took place where issues/ incidents/updates were shared with staff.
- All areas were clean and equipment had been checked and there was specific equipment for children. Equipment such as ultrasound and laser devices had been subject to recent and regular audit.
- Medicines and chemotherapy were stored safely. There was a chemotherapy spillage policy and kit with appropriate processes for the disposal of chemotherapy drugs.
- Radiology had a specific safety checklist for CT and MRI scans to ensure patients were not given contrast if they had certain health problems.
- There were sufficient staff and following the last inspection the number of paediatric trained nurses has been increased. There were chemotherapy trained nurses.

Summary of findings

- Staff had access to evidence based guidelines and carried out local audits to review and improve patient care.
- A range of audits were carried out by the OPD, diagnostics and imaging and physiotherapists.
- Patients were treated with dignity and respect and were positive about the care and treatment they received. They told us staff were polite and listened to them and they felt involved in their care.
- A support group had been established for oncology patients.
- Patients were treated within national referral to treatment times.
- Staff were responsive to the individual needs of patients.
- Staff were positive about the support they received from their line managers and senior staff who were visible and approachable.
- The Medical Advisory Committee met every two months and reviewed practising privileges, incidents and complaints .
- We saw examples of innovation and improvement including implementation of a pain assessment tool for children and peer review feedback by physiotherapists.

However:

- We saw consent was completed correctly but, some staff were unaware of the action to take for patients who lacked capacity.
- There was no formal on call rota for radiologists.

Summary of findings

Contents

Good

BMI The Blackheath Hospital

Services we looked at:
Urgent care centre, Surgery, Critical care and Outpatients and Diagnostic imaging.

Summary of this inspection

Background to BMI The Blackheath Hospital

BMI The Blackheath Hospital in Blackheath, London is part of BMI Healthcare Limited, the UKs largest provider of independent healthcare. The hospital has 69 inpatient and day care beds and a two bed level two critical care. In addition the hospital provides day services to oncology patients, outpatient and diagnostic services. It has an urgent care centre which provides diagnosis and treatment for minor accidents and injuries on a walk in basis to adults and children over the age of three.

The hospital operates across two sites: the main hospital building is in Lee Terrace and the outpatients department and urgent care service is in a separate building close to the man hospital. It provides services to people within the catchment of Greater London but will take patients from across the country.

Our inspection team

Our inspection team was led by:

Inspection Manager: Margaret McGlynn, Care Quality Commission

The team included CQC inspectors and a variety of specialists. There was a consultant anaesthetist an executive level nurse and senior nurses with backgrounds in surgery, paediatrics and medicine.

We had one expert-by-experience assisting us and analytical support.

Why we carried out this inspection

We carried out this inspection as part planned programme of independent hospital inspections.

How we carried out this inspection

To get to the heart of 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 peoples' needs?
- Is it well led?

Before visiting we reviewed a range of information we held about the hospital. Patients were invited to contact CQC with their feedback. We visited the hospital on 12 and 13 July to undertake an announced inspection. As part of the inspection visit process we spoke with members of the executive management team and individual staff of all grades. We also met with groups of staff in structured focus groups.

We spoke with both inpatients and people attending the outpatient's clinics as well as those using day services such as the oncology unit. We looked at comments made by patients who used the services of BMI The Blackheath Hospital when completing the hospital satisfaction survey and reviewed complaints that had been raised with the hospital.

Summary of this inspection

We inspected all areas of the hospital over a two day period, looking at outpatients, medical care, surgical care and children and young people services, urgent care centre and critical care.

Our inspectors and specialist advisors spent time observing care across the hospital, including in the operating theatres and the radiology department. We reviewed patient's records where necessary to help us understand the care that they had received. We also reviewed maintenance, training, monitoring and other records held by the hospital.

Information about BMI The Blackheath Hospital

At the time of the inspection visit, there were 342 doctors working at the hospital under practicing privileges. There were no employed medical or dental staff.

There were 69.8 full time equivalent (FTE) registered nurses employed at the Hospital at the time of our inspection. Of these 37.6 were working on the inpatient department, 17.6 were working in theatres and 14.7 in the outpatients department.

There were WTE operating department technicians and health care assistants; 12.7 FTE working in the inpatient departments, 4.1 FTE in the outpatient department and 9.7 in theatres.

During the period April 2015 - March 2016 the hospital had 1,956 inpatients, 5,515 day case patients and there were 6, 756 visits to theatres. There were 50,200 outpatient attendances.

Between April 2015 - March 2016 30% of inpatients were funded by the NHS while 70% had another funding source. A higher proportion of patients with another funding source were overnight patients compared to NHS funded patients (29% compared to 19%). 86% of outpatient activity had another funding source while 14% was NHS funded.

Pathology, emergency blood supplies, histopathology and catering were outsourced to third party suppliers.

Accident and emergency, end of life care, maternity services and termination of pregnancy services are not provided at the hospital.

At a previous CQC inspection, in February 2015, we found concerns the care of children and young people, the inpatient environment, how the hospital was monitoring the quality of care provided, the recording of information in patients' notes and the endoscopy unit was not compliant with national guidance.

What people who use the service say

Many patients and families we spoke with were positive about the care they received. They said staff were polite and listened to them. They found staff reassuring and involved them in discussions about their care and treatment.

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

We rated safe as requires improvement because;

- Although many aspects of patient care were safe more work was needed in endoscopy. The hospital had taken immediate action following the inspection and install a second sink in the decontamination area and commissioned an external review of the unit.
- Not all staff on the wards washed their hands between seeing patients.
- There were no dedicated hand wash basins in patient bedrooms for staff or visitors and no hand washing facilities within the ward corridors.

However;

- We found there were sufficient staff to care for patients and staff were up to date with their mandatory training.
- Medicines were stored securely and equipment was available and had safety checks completed.
- Patient records were up to date and contained risk assessments as required.
- Staff had completed safeguarding training for adults and children and knew the action to take if they suspected abuse.

Are services effective?

Good

We rated effectiveness as requires good because;

- All the services we inspected were providing evidence based care information informed by best practice guidance.
- There was monitoring of patient outcomes and where possible the hospital submitted information to national audits.
- Patients were cared for by competent staff.
- Patients had risk and nutritional assessments carried out and action taken where appropriate.

However:

- Appraisal rates were low in some staff groups.
- Some staff were unclear about the responsibilities in relation to consent, capacity and the deprivation of liberty safeguards.
- There was no formal on call rota for radiologists.

Are services caring?

Good

We rated caring as good because;

Summary of this inspection

- Patients were treated with dignity and respect and received compassionate care. Staff had time to answer their questions and patients felt they were involved in decisions about their care and treatment.

Are services responsive?

Good

We rated responsive as good because;

- Services were planned and delivered to meet the needs of patients. The hospital had a level 2 critical care unit and pre-assessments were carried out by phone or face to face.
- Patients did not experience long waiting times for outpatient or inpatient treatment and the number of operations cancelled on the day of surgery was less than 1%.
- In the urgent care centre the majority of patients were seen within 15 minutes of arrival and those that weren't were offered a refund of the costs.
- The hospital had improved support to meet the differing needs of patients. For example there was child friendly bed linen and children were given a teddy post surgery.
- Both children and adults had follow up phone calls post discharge.
- Information about complaints was available in patient areas and complaints were responded to within the agreed timescales. Discussion and learning from complaints was discussed at clinical governance and team meetings.

However;

- Although staff received training in caring for patients who were living with dementia some staff were unaware of who the dementia champion was.

Are services well-led?

Good

We rated well-led as good because:

- The hospital had reviewed and strengthened it's systems to monitor the quality and safety of care. There were mechanisms for staff to raise concerns and receive feedback about the quality of care they provided.
- The leadership had improved at local and senior level since the previous inspection. Staff were positive about their line managers and senior staff and the support they received from them. There was evidence of staff engagement and managers responding to feedback.
- The hospital had systems to monitor and review practising privileges for consultants.

Summary of this inspection

- Staff we spoke with were proud to work for the hospital and described the culture as "open", they felt there was good team work . They were supported to develop both their clinical and leadership skills.

However;

- More work was required to improve the arrangements for decontamination in endoscopy.

Detailed findings from this inspection

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency services	Good	Good	Good	Good	Good	Good
Surgery	Requires improvement	Good	Good	Good	Good	Good
Outpatients and diagnostic imaging	Good	Good	Good	Good	Good	Good
Overall	Requires improvement	Good	Good	Good	Good	Good

Notes

Good

Urgent and emergency services

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

Information about the service

BMI The Blackheath Hospital Urgent Care Centre is within in a four storey outpatients building called Winchester House. There is a two room urgent care centre (UCC), which is open from Monday to Friday 8am-8pm and Saturday 8am-6pm. The service saw 1115 adults and 335 children from September 2015 to October 2016.

This is a walk-in service providing care for a range of minor illness and injuries. The team can see patients over the age of three. The team offer private onward referral to specialist BMI consultants for further investigation. This is a fee paying service, and costs were visible in the waiting areas and treatment rooms.

We visited BMI The Blackheath Hospital during an announced inspection on 12 and 13 July. We spoke to five members of staff including managers, resident medical officer (RMO), nurses and a healthcare assistant. We spoke with two patients and two relatives. We looked at three sets of medical records, and reviewed other information on display or provided to us.

Summary of findings

Overall, we rated the Urgent Care Centre (UCC) as good.

- BMI The Blackheath Hospital had improved on several areas of care provision following the last CQC inspection, February 2015, including new flooring in the outpatient building, carrying out audits and employment of specialist paediatric trained staff nurses.
- There were systems to ensure incident reports were investigated and lessons learned. Staff understood the duty of candour, although some staff felt it was the medical staff's duty to complete this, instead of the nursing staff. 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) ofcertain 'notifiable safety incidents'andprovide reasonable support to that person.
- We observed good infection prevention and control (IPC) practices but not all equipment, such as chairs, met IPC standards. New flooring was being installed and work was due to finish in August 2016 following recommendations during the last inspection. Clinical equipment was serviced, appeared clean and functioning. Daily monitoring of resuscitation equipment had taken place.
- The training information provided showed 89% to 100% of staff had attended mandatory training. Medical staff provided by an agency, had all training via their employment agency.

Good

Urgent and emergency services

- All UCC staff had completed intermediate life support (ILS) training and there were paediatric-trained staff to care for children under the age of 18. Staff told us they could ask for additional courses and managers would support them.
- We saw use of evidence based practice and national guidelines.
- Assessment of patient risk was completed and there was an admission exclusion criterion for patients whose conditions were acute or significantly complex. The services had protocols and guidelines to assess and monitor patient risk such as the use of national early warning scores for both children and adults.
- We saw consent was completed correctly, however, some staff did not know how to complete consent for adult patients who lacked capacity.
- Following the previous inspection there was evidence of local audits through the departments, and staff showed how these had driven improvement and change in the services.
- Staff provided dignified, compassionate and respectful care. Patients and their families were positive about the care they received at the BMI Blackheath Hospital. They told us they felt involved in their care and staff were very helpful.
- The urgent care centre aimed to see patients within 15 minutes and refunded the fee if they did not. They achieved this target in most cases, and we saw audits were completed confirming this.
- The BMI Blackheath Hospital was benchmarked against other BMI providers and staff told us they were attempting to improve their current rating.
- Staff were positive about working in the service and felt encouraged to make suggestions for improvement. They showed us examples of new equipment they had received following these suggestions.
- Staff told us there was strong teamwork and managers were visible and easy to talk to.

Are urgent and emergency services safe?

Good

We rated the service as good for safety. This was because:

- The departments had systems to minimise patient risks, which were used by staff to ensure patient safety.
- There were effective incident reporting systems and staff felt confident in using them. They told us they received feedback from incidents through meetings and a written communication book.
- Staffing levels were adequate to meet the needs of patients.
- Staffs' completed safeguarding referrals appropriately and staff knew who to contact if there were any concerns of abuse for both children and adults.
- The environment was clean, tidy and equipment was fit for purpose.

However,

- There was no formal triage system for the UCC if it got busy, this may put unwell patients at risk of deterioration without staff being aware.

Incidents

- There were only three incidents reported in urgent care from April 2015 to March 2016.
- In the same period there were no serious incidents. A serious incident is an incident that causes permanent or severe harm to a patient, staff, visitors or members of the public.
- Staff described the type of incidents they would report and showed us the paper system used to record incidents. These would then be entered onto a computer system by the quality and risk manager.
- Staff across the UCC told us they felt confident in reporting incidents and were encouraged to do so by senior staff.
- UCC staff attended a daily one o'clock meeting in the outpatients department (OPD) where they discussed any incidents which had occurred in the department and learning from these. UCC staff attended this meeting to feedback any issues. Heads of department across the hospital met at 10am each morning to discuss any incidents they had in their department.

- UCC staff could refer to an OPD folder with incidents and their outcomes for learning purposes if they could not attend the one o'clock meeting.
- A senior member of staff told us it would be up to the consultant to ensure duty of candour was upheld if required. Nursing staff described the process of being open and honest with patients if something went wrong. The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support to that person.

Cleanliness, infection control and hygiene

- Clinical areas we visited were visibly clean and tidy.
- An infection prevention and control (IPC) audit in April 2016, of the OPD building included the UCC and showed there was poor flooring and décor and areas were cluttered. Since the last inspection new flooring was being installed.
- Domestic staff we spoke to told us that the UCC was cleaned daily. We saw checklists had been completed to indicate areas that had been cleaned.
- Hand hygiene audits were completed and covered both OPD and UCC. Junior staff were encouraged to assist with audits. Bare below the elbows compliance was 100% and hand hygiene compliance was between 70% and 100%. The IPC lead nurse told us they were trying to carry out more teaching around hand washing to improve these numbers.
- There were hand washing facilities in UCC each room and hand gel in all patient areas. Personal protective equipment (PPE) including gloves and aprons was available for staff in all clinical areas and we saw that staff used this appropriately.

Environment and equipment

- There was an adult resuscitation trolley in the UCC which also serviced the OPD and imaging departments. The adult resuscitation trolley was checked daily with no equipment noted as missing.
- There was a dedicated children's resuscitation trolley. This was checked daily and labels were used for easy access to the correct size of equipment appropriate to the size and age of children. If any children were having a minor operative procedure this was taken to the required consulting room or minor operative theatre.
- All equipment we checked was clean and stored appropriately. There was evidence of safety checks having been undertaken in the form of Portable appliance testing (PAT).
- On arrival, UCC patients had to give their details through a screen. The receptionists had microphones to help communication but, it was difficult for patients and staff to hear each other, which may compromise patient confidentiality. Receptionists told us this had been raised with their managers.

Medicines

- Prescription pads were kept locked away in the UCC. The keys to obtain the pads had to be signed out and back in again at the beginning and end of each shift.
- The UCC kept some pre-packed medications for patients to take home if required. The stock levels were recorded on a spread sheet and when the levels were low staff would order more stock. This meant the team knew which member was responsible for ordering and ensuring the medications arrived.
- Emergency drugs were checked daily and fridges were locked and temperatures checked. No controlled drugs were kept within the department.
- We saw a medication error had prompted a change in the way medications in the OPD and UCC were stored to avoid the wrong drug being dispensed.
- There were no available patient group directives (PGDs) and staff told us this could be frustrating waiting for doctors to prescribe simple medications. PGDs provide a legal framework, which allows some registered health professionals to supply and administer specified medicine to a pre-defined group of patients, without them having to see a doctor.
- UCC staff undertook an audit on the use of antibiotics for chest infection. Action points following the audit showed not everyone should be given antibiotics, and the use of these drugs had been reduced.

Records

- During inspection we looked at three sets of UCC patient's records.
- We saw a different recording pathway for children and adults. Each included observations, pain assessments, nurse assessment and past medical history.
- These had times, dates and legible signatures documented. They contained a complete patient history and the care that the patient had received.

- Medical records for NHS patients were kept in the medical records department and this was in a building near the outpatients department. A recent flood had destroyed some old records, which prompted consultants to destroy historic notes that were no longer required as per policy.
- Following the flood staff had moved all records to a secure room within the building. Locked bags were used to transport any notes moving around the hospital. Staff told us there was never any issue with providing patient notes at the time of their appointment.
- We saw that paper records were kept in a locked cabinet for 12 months in case a patient re-attended in this time and the doctor could review their past attendances. These were moved to the medical records secure room once 12 months had passed.

Safeguarding

- The hospital had up-to-date safeguarding policies and procedures for both children and adults. Staff knew the safeguarding leads in their areas and how to contact them.
- Staff we spoke to understood how to raise a safeguarding concern and we were able to see UCC staff completing a safeguarding referral during our inspection. They told us for adults they would complete a capacity assessment and contact the GP if there were any safeguarding concerns.
- We saw that the UCC standard operating procedure for children involved an attendance history check. Notes were kept for 12 months in the UCC so that a child with six attendances in a year, four in a month or three in a weak would be automatically referred to the paediatric lead nurse for follow up. If there were any concerns the children safeguarding policy would be followed.
- Safeguarding training was mandatory for all staff and all registered nurses were required to complete level two as a minimum. All paediatric nurses and urgent care staff were trained to level three, which is in line with the "Safeguarding children and young people: roles and competences for health care staff intercollegiate document" 2014.
- There was no access to the local authority children's risk register. Staff told us they would contact the child's school and GP if there were concerns.
- The hospital had a chaperone policy, which was visible in all patient care areas and documented in patients notes.
- All staff we asked told us they would feel confident to challenge any concerning practices or behaviours.

Mandatory training

- Mandatory training for staff was a mixture of online e-learning and face to face sessions.
- Information we received pre-inspection showed 86% of staff in the UCC and ODP department had completed their mandatory training up to 16th May 2016. There was no way to separate these departments training numbers. One staff member told us if they had to do it at home this would be paid time. Most staff told us they were given protected time to complete their mandatory training.
- Training was monitored online and each staff member had a password protected training account. This meant the staff could be alerted when a module was due to be completed. Managers had access to this and would remind staff if they had not completed their training.
- The resident medical officer (RMO) completed all mandatory training through their agency including advanced life support.

Assessing and responding to patient risk

- Reception staff told us they had no training in identifying the deteriorating patient but would always ask the nurse in charge or RMO for advice if they were concerned.
- In the UCC patients were seen within 15 minutes of arrival and we saw evidence of audits that showed patients were seen within 15 minutes in most cases.
- Nursing staff told us there was no formal triage system for the UCC. Staff told us it was rarely busy enough to triage; however, they could do this if required as they were trained to do so. If necessary, at busy times, the nurse would do a walk round of the waiting room to identify any deteriorating or acutely unwell patients. This did not provide us with assurance that staff would identify acutely unwell patients in a timely manner. Following the inspection the hospital told us there was a triage system but we did not observe it in practice during the inspection.
- If the waiting room is busy with UCC patients, the nurse is able to leave the doctor with the HCA and continue with assessing the next patient, guaranteeing the patients are seen and assessed within 15 minutes.

Should any patients present with life threatening illness/ injury the nurses are trained to a level where they are able to identify this and the resuscitation policy will then be followed.

- UCC had exclusion criteria for patients who were not appropriate to be seen in the department. It included those with acute major illnesses, very complex medical problems and children under the age of three. These criteria ensured patients were seen safely by staff. However, we saw that there was a clear procedure for staff to follow is a patient did present with an acute illness. This included where they should be nursed and what to do if the patient collapsed. This was available for both adults and children.
- We saw the use of NEWS charts for adults and PEWS charts for children in the UCC. These were used appropriately and ongoing monitoring of patients was completed according the to the NEWS/PEWS protocols on the observations charts. The child and adult resuscitation policy also detailed the use of observations charts and how they should be used.
- The outpatients department met with staff across the building, including UCC staff, in the morning to allocate staff roles in the event of a cardiac arrest or patient emergency. This was visible on the board in both the UCC staff room. Staff carried bleeps for such an emergency. Response times were audited during the daily checks.
- There was a bleep system set up in each room so staff could alert others in case of an emergency.
- If a patient became acutely unwell during their time in the urgent care centre an ambulance would be called. We did see the policy for this after the inspection. Staff would stabilise the patient and then transport them to the nearby accident and emergency. Staff gave examples of this happening whilst we were on inspection and stated there was never a problem with ambulance waits. They told us they had good relationships with the local hospitals and would ring them to make them aware of the patient.
- We saw evidence that between April 2015 and March 2016, 9 patients were admitted to the hospital from the UCC and 107 patients were referred to an A&E department due to inappropriate attendance, uninsured patients and patients within the hospital exclusion policy.
- UCC staff were trained in paediatric immediate life support (PILS) and advanced life support (ALS) in case of cardiac or respiratory arrest.

Nursing staffing

- The UCC should have had one trained nurse and one HCA on duty; however, during the first day of our inspection there was no HCA available. There was always one paediatric trained nurse for OPD and UCC. Staff told us this had happened in response to the last CQC inspection.
- There was no use of staff acuity tools. Senior staff told us staff turnover rates were high between the OPD and UCC, 30% from April 2015 to March 2016 but were unsure why this was. This often left the unit needing to use bank staff to ensure patient safety. They told us they had not needed to use any agency staff until the week prior to our inspection.
- Bank and agency staff were given an induction in all the departments we inspected. There was no induction checklist for nurses.

Medical staffing

- Medical staffing in the UCC was provided by a resident medical officer (RMO). They worked in a rotation of one week on and then had one week off. They were employed by an agency that completed all the training they required to work in the hospital. They could care for both children and adults.
- Any RMO absence was covered by another agency RMO but we were told this was rarely needed. The RMO told us they felt consultants were supportive and they could ask for help at any time.

Major incident awareness and training

- Staff in the UCC told us the major incident policy was available on both the intranet and in paper form in the major incident folder which we saw.
- There were fire marshals available on each floor of the building and high visibility tabards were available for these staff. Each staff member understood their responsibility in evacuation in case of a fire.
- Senior staff told us they did not practice for terrorist attacks as they would not be able to admit patients in this instance.

Good

Urgent and emergency services

Are urgent and emergency services effective?
(for example, treatment is effective)

Good

We rated effective as good, this was because:

- We saw evidence based care was informed by national guidelines, policies and protocols.
- Local audits were completed and staff showed us ways in which they had driven improvement.
- Staff were offered courses to improve their clinical knowledge and skills. Revalidation for nurse was on-going and staff felt well supported in completing this. Revalidation for nurses is a new scheme set up by the Nursing and Midwifery Council (NMC) to ensure that nurses and midwives are practising safely and effectively.
- Staff told inspectors about the importance of consent for children and explained Gillick competency and Fraser Guidelines.

However;

- Appraisal rates across UCC were low and senior staff told us they aimed to improve this year.
- Staff were unsure of their duties around the Mental Capacity Act (2005) and Deprivation of Liberty Safeguards (DOLS).

Evidence-based care and treatment

- Clinical staff we spoke to were aware of relevant clinical guidelines in their areas including the National Institute for Health and Care Excellence (NICE) and Royal College of Emergency Medicine (RCEM).
- Standard operating procedures we viewed were referenced with evidence of best practice and national guidelines.
- Guidelines were easily accessible on the hospital intranet or as a hard copy although staff were aware this may not be the most up to date version. We saw that policies and procedures referenced NICE and RCEM.
- There was evidence of a wide range of local clinical audits including infection control and waiting times. Senior staff audited staff response times to emergency bleeps to ensure staff were responsive to emergencies. They initially checked the bleep system at the same time every month but after discussion now completed the check at a random time and this had improved staff response times.

Pain relief

- Appropriate pain relief was offered for patients attending the UCC including paracetamol and ibuprofen. Low strength morphine was available if needed.
- The UCC used modified pain scales for children which included faces with different expressions that children could point to show the clinical staff their level of pain.
- Patients were advised to contact their GP if they required further pain relief on leaving the department.

Patient outcomes

- Patients could be referred to specialist consultants at the hospital for further investigations if require and could be admitted from the UCC. In the year prior to inspection nine patients were admitted to the main hospital from UCC. 107 patients were referred to the UCC due to inappropriate attendances or acute illness.
- The hospital provided on-site imaging, plastering of simple breaks/fractures, pathology testing, pharmacy and physiotherapy to support patients.
- The hospital carried out audits of waiting times in the UCC. They offered a cancellation of the assessment fee if patients waited longer than 15 minutes to be seen by a member of clinical staff.

Competent staff

- There was a paediatric nurse available during UCC opening times who worked between the UCC and OPD. We saw this worked well during our inspection and ensured children were getting the correct care.
- Nurses we spoke to were preparing for revalidation and had begun to prepare their portfolios. They had received feedback from consultants, peers and patients for evidence.
- Revalidation for nurses is a new scheme set up by the Nursing and Midwifery Council (NMC) to ensure that nurses and midwives are practising safely and effectively. Nursing staff, we spoke to felt well supported in preparing for revalidation.
- Medical revalidation for RMOs was managed through the agency with which they were employed.

Good

Urgent and emergency services

- Appraisal rates were recorded for the OPD and UCC nurses as a whole and from April 2015 to March 2016 was 50% for both nurses and healthcare assistants. This was a low number of staff receiving appraisal. However, from April 2016 to the time of inspection 55% of nurses and 25% of health care assistants (HCAs) had already received an appraisal. Senior staff told us they aimed to significantly improve the year's appraisal rate but did not have a plan to achieve this.
- Staff we spoke to said their appraisals were completed online in two stages. Their appraisal had allowed them to ask for further courses and discuss their progressions within the department. We saw some completed appraisals, which showed learning and improvements.
- Staff we spoke to had the opportunity to attend courses such as ILS and advanced life support (ALS) to improve their ability to care of patients safely.
- RMO appraisals were completed by the agency with which they were employed and consultants had to provide evidence of appraisal to renew their practising privileges.
- All newly appointed permanent staff had an induction programme; however, a bank staff we spoke to had not received this, and had not completed mandatory training. They told us they had read the policies and procedures online and had asked to be put onto the induction programme.
- Staff looking after children had paediatric immediate life support training (PILS) and some had advanced training (PALS) in this area. We saw paediatric staff assisting UCC staff with a child who had a complex medical problem and required bloods to be taken.

Multidisciplinary working

- The UCC worked closely with patients and children's GPs to ensure all follow up and concerns were communicated appropriately. This meant care for these patients was safe and continuous.
- Adult trained nurses felt able to ask paediatric nurses for help and advice in the UCC, and we saw evidence of this during our inspection.

Seven-day services

- The UCC was open from Monday-Friday 8am – 8pm and Saturday 8am – 6pm.
- The pharmacy department could keep the department open out of hours to provide support to patients and staff. There was a 24 hour on-call service.

Access to information

- Policies and procedures were accessible to all staff via the intranet and staff showed us how they would access these.
- The RMO told us that if he had concerns about a patient he could ask Consultants in the OPD consulting rooms for their advice and this worked well.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff we spoke to lacked knowledge about the Mental Capacity Act 2005 and the deprivation of liberty safeguards.
- One senior member of staff explained they would ask the doctor to see the patient if they had any concerns. However, most members of staff were unclear about their responsibilities in relation to the Mental Capacity Act 2005. They were unable to describe the correct procedures for obtaining consent from someone with limited capacity.
- Paediatric staff told us they would employ different methods of gaining consent depending on the child's age. They described certain judicial rulings that governed consenting older children such as Gillick competencies and Fraser Guidelines.

Are urgent and emergency services caring?

Good

We rated the service as good for caring. This was because:

- Patients and their families were positive about the way staff treated people. Patients said the care they received was person centred and staff were helpful.
- Patients told us they were active partners in their care and felt fully involved in decisions around treatment.
- People's emotional needs were valued by staff and were embedded in their care and treatment.

However;

- There were issues around confidentially for patients when registering at the urgent care center (UCC) as screens in reception meant they had to talk loudly to be heard. Staff told us they had raised this with senior managers.

Good

Urgent and emergency services

Compassionate care

- Patient feedback was generally positive across the areas we inspected.
- Patients and their families described staff as "polite and efficient".
- We observed receptionist being kind and courteous to patients. We observed nursing staff were empathetic and supportive to patients undergoing minor operations.
- Scores for Patient-led assessment of the care environment (PLACE) for BMI Blackheath were generally the same as or higher than the England average. However for privacy dignity and wellbeing it was lower than the England average. PLACE is a National Programme, which assesses the service environment from a non-clinical perspective, for the purpose of improving services.
- The OPD and UCC Friends and Family postcard result for February 2016 indicated 99.5% of patients would recommend the service.
- During our inspection we noted UCC patients had to speak loudly for the receptionist to hear them. We spoke to a patient who expressed concerns about this. This could compromise privacy and dignity of patients. Receptionists told us they had raised this issue with the manager of the department but they had not received any feedback on a possible solution.

Understanding and involvement of patients and those close to them

- Patients and families told us they felt involved at every stage of their appointment. They were able to ask questions and understood the information they were given.
- Patients and families told us they felt they had enough time to talk to doctors and nurses about their treatment, making them feel at ease.
- Fees were visible throughout the department and discussed during consultation so patients knew how much their consultations were likely to cost.

Emotional support

- We observed staff giving emotional support to patients and their families. They were encouraged and supported through treatment by ensuring both patients and relatives were given up to date information.
- We saw that children attending UCC were spoken to in a friendly manner and staff tried hard to ensure they felt at ease.

Are urgent and emergency services responsive to people's needs?

(for example, to feedback?)

Good

- We rated the service as good for responsive. This was because:
- Staff planned and delivered services in a way that met the needs of the local population. UCC opening times had been extended to allow people to access the service more easily.
- There were low numbers of complaints throughout the service. Patients could complain or raise concerns and were treated compassionately if they did. Staff dealt with complaints in an open and transparent manner.

Service planning and delivery to meet the needs of local people

- The UCC catered for minor illness and injury six days a week. It was open from Monday to Friday 8am to 8pm and Saturdays 8am to 6pm.
- Since our previous inspection the hospital had developed its children's services. It provided paediatric trained nurses to assist with paediatric patients attending the UCC.

Access and flow

- Staff told us the busiest periods for the UCC were weekends and evenings. They told us that the department was becoming busier and they were seeing more regular patients.
- Patients attending the UCC would book in at the UCC reception. Administrative staff took the patients details and their reason for attending.
- Staff completed audits on patient waiting times in the department. They showed most patients were seen within the 15 minute target. When they were not it was usually due to an emergency in the department. If they were not seen within 15 minutes they were refunded their fee.

Good

Urgent and emergency services

- If a patient needed an unplanned admission from UCC, there was a pathway for staff to refer to. It included the use of the emergency admission pack, which we saw during inspection. It included an observations chart, reservations form and the referral letter from the RMO or consultant. This was part of the standard operating procedure for both adult and children.
- The inclusion criteria for the UCC included minor injury or illness for children and adults aged three years old and above. The hospital acknowledged that it may have patients with major illness and injury who attended and had protocols to follow if this did happen. We saw that people living with a recent history of active psychiatric disorders were not seen or cared for at the hospital and would be admitted to a local NHS hospital.
- Staff completed an emergency transfer pack if a patient was transferred to another hospital from the UCC. This included a transfer letter written by the doctor, a full set of observations, and a reservations form. If well enough, they could be taken by their family or a taxi. If not, an emergency ambulance would be called to transport the patient.

Meeting people's individual needs

- Staff told us they had training in caring for patients living with dementia and a learning disability. We saw that 93% of staff within the BMI Blackheath hospital had received this training within the last year and the target was 90%.
- If a person living with dementia or a learning disability was identified when booking an appointment reception staff would alert the UCC staff.
- Translation services were provided through a telephone language line service. Staff told us they would use this if necessary, but it was rarely required. Leaflets in patient care areas were not translated into other languages.
- There was a hearing loop in place for those with hearing difficulties.
- The chaperone policy was visible in all waiting and treatment rooms and staff told us this could be accessed on the intranet.
- There were parking spaces for those with mobility issues and for patients in a wheelchair. Patient using a wheelchair who attended UCC could be seen in the doctor's room which had easy access.
- In the UCC there was a specific paediatric phlebotomist to take blood test for children, as they were experienced in this area, making the patients feel more at ease.
- Patient leaflets were readily available throughout the UCC areas.

Learning from complaints and concerns

- Information on how to complain was visible in the waiting areas. Staff understood what to do it a patient wanted to make a complaint.
- We saw that staff should send an acknowledgement within two days of receiving the complaint and a full response within 20 working days. We saw 100% of complaints were dealt with within 20 days.
- There was one complaint about the UCC between April 2015 and March 2016.
- Staff told us complaints were dealt with by senior managers. There was a paper form to complete for all complaints including informal complaints. We saw these during our inspection.
- If the complaint could not be resolved informally a full investigation would take place. This would involve the patient's consultant and the Quality and Risk Manager when required.

Are urgent and emergency services well-led?

Good

We rated well –led as good for the service. This was because;

- The leadership structure for UCC was overseen by the Director of Clinical Services. There was a Clinical Manager for outpatients who managed consulting rooms and UCC.
- Staff were focused on providing patient centred care and ensuring a good patient experience. Staff told us managers were visible and they felt well supported.
- There had been improvements since the last inspection in February 2015 and staff told us they felt valued. Managers listened to their suggestions for improvement and change.
- The leadership and governance aimed to improve practice and regular governance meetings took place. Action plans were completed following these meetings and followed up by Heads of Department and the Quality and Risk Manager. Staff told us they had regular learning opportunities from incidents.

- Staff told us their practice was benchmarked against other BMI hospitals and they would receive feedback on patient comment cards.
- Staff enjoyed working at the BMI Blackheath and felt there was a strong ethos of teamwork and patient centred care.

Leadership / culture of service

- The leadership structure for UCC was overseen by the Director of Clinical Services. There was a Clinical Manager for Outpatients who managed consulting rooms and UCC.
- Staff we spoke to told us they felt valued and appreciated as team members. Managers were visible during our visit and staff felt able to discuss issues and concerns openly. One staff member told us the Executive Director had thanked them directly for their hard work on the department's audits.
- Staff were able to tell us who their managers were and also who the senior hospital managers were. They told us they were supportive and felt there was a culture of openness.
- Junior staff were offered the chance to complete a leadership course. This was competency based and would help them progress their career. Several staff had completed the course and found it interesting and helped them gain new leadership skills.

Vision and strategy for this this core service

- Staff discussed changes for the UCC. They told us there was a plan to move the UCC to the main hospital building so patients could be easily admitted. There were plans to increase the amount of medical admissions and possibly build an ambulatory care area to admit more UCC patients if required.

Governance, risk management and quality measurement for this core service

- The UCC and OPD had a joint daily lunchtime meeting which staff from both departments attended. They discussed issues such as broken equipment, staff shortage and incidents. These minutes were kept in a book in the nurse's office so everyone could read them. Staff told us this was useful as they could be kept up to date with issues at all times.
- There were monthly governance meetings within the hospital. These were attended by the OPD and UCC manager and the executive team including the director of clinical services. We saw recent meeting minutes, which included discussion of all incidents across the month, complaints and new clinical developments. They were well attended by senior staff.
- Feedback from the governance meetings for UCC staff took place in the 1pm meetings and recorded in a communications book so staff could refer back to information if they needed to.
- A children and young person's committee had been set up since our last inspection. Attendees included the quality and risk manager and the executive director. Discussions included further staff training in learning disability and audits needing to be completed. Senior staff told us they hoped to get other BMI hospitals to attend this in the future.
- Medical staff we spoke to sat on the Medical Advisory Committee (MAC). They met every two months and discussed issues such as consultant applications for practising privileges, feedback from the clinical governance meetings and the top five hospital risks. This allowed consultants to understand the wider issues in the BMI group and learn from incidents and complaints.
- We saw a hospital wide risk register which documented operational, leadership, clinical and governance risks including staff training, implementation of a new incident reporting system and equipment maintenance. Staff we spoke to told us the risks within their area and about the use of the risk register.
- The UCC Clinical Manager told us their practice was benchmarked against other BMI hospitals which included UCC. We saw the Blackheath hospital was low in the ranking of other hospitals and the manager told us areas of improvement included billing practises.
- Staff told us a new online system was due to be implemented allowing incidents and risks to be electronically recorded. This would allow easier information sharing of risks and ensure improved patient safety.

Public and staff engagement

- Staff we spoke with told us about the employee of the month award. This was given for good patient feedback or nomination from other team members. Staff told us it was motivating to receive the award and encouraged good team work. The OPD daily team meetings helped the UCC staff to feel well integrated into the team.

Good

Urgent and emergency services

- Staff felt supported in their roles and several staff members had further study paid for to improve their knowledge and skills in caring for patients.
- Patients completed a comment card following their appointments. Comments on these included “excellent care” and “professionalism is of a very high standard”.

Staff told us they got feedback on these surveys through managerial feedback and the imaging department felt proud they had received a high satisfaction score from patients.

Innovation, improvement and sustainability

- Staff told us there had been positive changes since the last inspection. These included better nurse staffing, changes in the flooring and room décor.

Good

Surgery

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

Information about the service

Surgery was the primary inpatient activity of BMI Blackheath. It carried out orthopaedic, gastroenterology, gynaecology, plastics, neurosurgery, oncology, urology, oral, vascular, ophthalmology, and ear nose and throat (ENT). It did not carry out high risk complex surgery. There were 6,756 visits to theatre, 1,956 inpatient attendances and 5,515 were day cases between April 2015 and March 2016. Of these admissions most were orthopaedic (1,382) followed by urological surgery (853) and gynaecology (506).

Information about services for children and young people, critical care and endoscopy are included in this report.

The hospital had three theatres with a six bedded recovery area and a six bay endoscopy unit. There were two wards comprising of 58 beds, one dedicated to day surgery patients, and another had a mix of medical and surgery patients who stayed at least overnight or longer. The 58 beds included, a two bed level 2 critical care unit that met Faculty of Intensive Care Medicine (FICM) standards.

It had two pre-operative assessment clinic rooms and a booking and admissions office.

There was a service provided for medical patients which consisted of beds on meridian ward. There were no medical patients on the wards at the time of our inspection.

We inspected all areas, spoke with 15 patients, two relatives, 32 members of staff including consultants, the registered medical officer (RMO), nurses of all levels, administrative staff, and senior members of staff such as service managers.

Summary of findings

Overall we rated the service as 'good' because:

- The hospital had made changes since our last inspection to bring their high dependency unit up to Faculty of Intensive Care Medicine (FICM) level 2 2013 Critical Care Standards.
- Resources and staffing for children services had improved.
- Staff were aware of the safeguarding policies and their responsibilities if they suspected or witnessed abuse.
- Patients received care that was evidence based and informed by best practice guidance.
- All of the patients we spoke with were positive about the care and treatment they had received and we observed appropriate interactions between patients and staff.
- The hospital had implemented a rolling programme to replace all carpets with hard flooring.

However;

- Although the hospital had made improvements since the last inspection in February 2015 some areas required further work.
- The arrangements for decontamination in the endoscopy unit were not in line with best practice guidance.
- Feedback and learning from incidents varied.
- Staff did not always adhere to infection prevention and control policies.

Good

Surgery

- There was a lack of information to benchmark the service against other similar units although data we received showed the service was performing well such as readmission and mortality rates.

Are surgery services safe?

Requires improvement

Are surgery services safe?

We rated safe as requires improvement because:

- Learning from incidents was not always shared with all staff.
- The endoscopy unit did not conform to best practice in relation to infection prevention and control. For example, there was no clear demarcation between clean and dirty areas in the decontamination room.
- Some areas of the wards were carpeted which was not in line with Health Building Notice requirements (HBN00-09, Infection control in the built environment).
- We observed some staff not adhering to good hygiene practice.
- There were no hand washing sinks in patient rooms which made it difficult for staff to comply with hand hygiene measures.
- Access to the theatre was via a sliding door. This entry system was not secure and allowed unauthorised access.

However:

- The critical care unit had implemented changes to bring it in line with Faculty of Intensive Medicine (FICM) standards for intensive care units.
- World Health Organisation (WHO) surgery safety surgery checklists were completed in all the records we reviewed.
- The hospital had increased the number of paediatric trained nurses.
- There were processes for assessing and responding to risk including a service level agreement with an NHS trust to transfer patients should their condition deteriorate.
- The hospital had introduced a rolling programme to replace all the carpets.

Incidents

Good

Surgery

- There had been a total of 293 clinical incidents reported in the twelve months before our inspection, of which 179 occurred within the surgery and inpatient department. There were 12 non clinical incidents related to surgery. Three incidents resulted in moderate harm, 139 low harm and in 104 there was no harm.
- Staff were clear about how to report an incident. The hospital confirmed that incidents were reported on a paper form which was recorded and managed electronically by the Quality and Risk department. Feedback we received stated that all incidents were reported to a manager before the documentation was completed. The hospital informed us that they planned to transfer all incident reporting to an electronic system by the end of 2016.
- There were mixed reviews from theatre and endoscopy staff about feedback and shared learning from incidents. Some staff were able to describe an incident and the learning they received. However, some said they only heard about an incident and the outcome if they were directly involved in the incident or they asked for feedback.
- Senior theatre staff said they attended team meetings where they reviewed any serious incidents as well as incidents from other BMI hospitals.
- Theatre sisters told us that if there was an incident within the theatre department, it was the responsibility of the theatre sister to investigate, and report the findings back to the Executive Director or the Director of Clinical Services. They told us feedback was only shared with those directly involved with the incident.
- The hospital confirmed that feedback from incidents was given to theatre staff on a monthly basis during team meetings, training and personal development.
- Some staff were unable to tell us about changes or learning from a recent incident.
- We reviewed an investigation of a serious clinical incident. Although an investigation was carried out to identify contributing factors and make recommendations, the investigation was not robust. Staff witness statements had not been taken, and the incident was not formally reported on the hospital system until the hospital received a complaint from the patient. The surgery took place in January 2016 and no incident was reported by staff who attended the procedure. The investigation concluded by identifying an area of practice that had caused the injury to the patient and required improvement. No further details were provided to show the learning or procedural changes that had taken place as a result of this incident.
- Theatre staff told us about changes following an incident involving instruments that had gone missing when they were sent for decontamination. To resolve this problem, the department took photographs of the equipment sent to the decontamination unit. They were then able to check the returned equipment against the photograph when they received the items back.
- 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. Theatre staff did not understand the meaning of the duty of candour and were not able to describe the steps that should be taken if something went wrong. The Deputy Theatre Manager was able to explain it fully.

Safety thermometer

- Performance figures on the safety thermometer displayed on wards showed it was rare for a patient to come to harm.
- Hospital records showed compliance for venous thromboembolism (VTE) screening was 100% from April 2015 to March 2016. There were three reported cases of hospital acquired VTE during the previous year. The medical staff we spoke with said most consultants follow the VTE hospital guidance; however one consultant had modified the treatment provided.

Cleanliness, infection control and hygiene

- The hospital reported seven surgical site infections (SSIs) from April 2015 to March 2016, two E-Coli, four staphylococcus aureus and one pseudomonas aeruginosa. These were investigated and the details were recorded and provided by the hospital.
- The hospital had conducted two hand hygiene audits during 2016. The first showed a compliance rate of 90%, however the second reported a 70% compliance rate. Areas had been identified by the hospital to improve compliance with a short action plan.

Good

Surgery

- There had been no cases of Methicillin-resistant Staphylococcus aureus (MRSA), Methicillin-sensitive Staphylococcus aureus (MSSA) or clostridium difficile (C. difficile) in the last two years. MRSA screening compliance for theatres was 69%. This figure was low, however we were not provided with any action plans to increase compliance.
- The hospital historically had a poor pre-assessment attendance percentage, however this had improved since the last inspection. Patients that were taken from another hospital, trust, or those that attended their pre-assessment via a telephone consultation were treated as if they had MRSA until it was proven otherwise, to protect patients and staff.
- Patients that had MRSA or those considered to be a risk, were placed last on the theatre list for their procedure and remained in the theatre for their post- operative recovery period. Once the patient had recovered, they were taken back to their room and the theatre was deep cleaned over night, ready for use the next day.
- The hospital conducted a series of infection prevention and control (IPC) audits. The August 2015 result for cleanliness of mattresses showed that 51% were not classed as acceptable to pass the audit. When the hospital found that a mattress was not fit for use, it was removed and replaced.
- Hospital records showed the compliance rate for use and disposal of sharps was 91%. For example the critical care unit audit for May 2016 showed that a non-sharps item had been put in the sharps bin. During the inspection the lids of sharps bins were closed and labelled.
- The hospital provided evidence of adherence to cleaning rotas and outcomes. However, there was no data for monitoring the use of personal protective equipment (PPE) and correct disposal of waste.
- We saw evidence that the water temperatures were checked and monitored daily and that the water was tested for bacteria.
- Most staff we observed did not use hand gels prior to entering and exiting patient rooms on the ward. Gel dispensers were appropriately placed and had signage to remind people to use them. All staff we observed were bare below the elbows.
- The hand washing audit for theatres for January and March 2016 showed there was on average 80% compliance with hand hygiene protocols. Issues highlighted in the audit were staff not being bare below the elbows and not washing their hands before and after contact with a patient.
- There were posters on the doors showing the 'five moments of hand washing', to remind staff and visitors the importance of infection control.
- In theatre we saw that an anaesthetist did not wear gloves when inserting a cannula into a patient or during the placement of an airway. They also touched a needle that they used to inject the patient. This behaviour was not challenged by the anaesthetist's colleagues. Following the inspection the hospital informed us that they had policies recommending that staff should wear gloves.
- Staff were able to explain the different types of waste bin used within the hospital and knew what items they were used for. The bins were labelled appropriately and the temporary lids were closed.
- Since the last inspection the hospital Infection Prevention and Control (IPC) Lead had been made a full-time post and there was a ward-based IPC link nurse. However, the IPC link nurse told us they did not have enough time to carry out this role effectively. There was no link infection IPC nurse for theatres.
- Housekeeping staff cleaned the operating theatres at night. A deep clean was conducted every six months, although the theatres were able to request this at any time if they felt it was appropriate.
- The hospital had isolation procedures in place, although we did not observed these being used at the time of our inspection. Staff were able to describe how patients transferred from another hospital or care home and those who were at high risk were placed in isolation until an MRSA test had been completed.
- Some areas on the wards had carpet and fabric chairs which was not in line with the Department of Health's Health Building Notice requirements (HBN00-09, Infection control in the built environment). The hospital had a rolling programme to replace all carpets which had been removed from all public areas in the main

hospital. Nineteen ward rooms had carpets replaced with hard flooring. This was noted on the risk register which stated in May 2016 that the replacement of carpets in rooms was on going.

- There were no dedicated hand wash basins in patient bedrooms for staff or visitors and no hand washing facilities within the ward corridors. Staff based at the hospital informed us that all staff and visitors either used the en suite basin in the bedrooms or the washing facilities in the sluice room. Treatment rooms did have hand wash basins but they were not standard utility sinks with mixer taps. None of these conformed to IPC guidance (Health Building Note 00-09: Infection control in the built environment March 2013 3.41 and 3.42). The issue of clinical sinks was recorded on the risk register but it was not clear if this included the lack of wash basin in patient rooms.
- Endoscopies were carried out within the endoscopy unit, except where a patient required a general anaesthetic. These cases were seen within theatres. Any endoscopes used within the theatre department were sealed in a box after use and transported on a trolley back to the endoscopy unit for decontamination.
- The endoscopy unit had a decontamination room that was used for both clean and dirty equipment. There was no clear demarcation between the dirty and clean areas. There was a sign on the wall that stated 'clean' and another that stated 'dirty'; however there was no colour coding or other physical barrier to separate the areas.
- Management had told us that a wall would be introduced to separate the cleaning and rinsing areas but this had been proposed for over a year. We did not see any evidence of progress for this.
- There was only one sink to wash and rinse the endoscopes which was not in line with best practice guidance. HTM 01-06 (Health Technical Memorandum 01-06 Decontamination of Flexible Endoscopes – March 2016) guidelines stated a double sink should be used to prevent cross contamination. Following our inspection, the hospital told us they had replaced the single sink with a double sink as per guidelines.
- At the time of our inspection, there was only one decontamination technician responsible for both clean and dirty areas. There were no changing facilities for the technician handling the endoscopes to enable them to change their scrubs or personal protective equipment. This created a risk of cross contamination. Following the inspection the hospital recruited further staff to the endoscopy department after our inspection to ensure there were enough staff to care for patients and that there were at least two decontamination staff within the endoscopy department.
- Since our last inspection in February 2015 the hospital had built a hatch for the endoscopes to pass through from the theatre to the decontamination room to the washer disinfector.
- The hospital was aiming to achieve Joint Advisory Group (JAG) accreditation. Action plans had been put in place following an independent review of the endoscopy unit in August 2016. This included timescales and named person responsible for completion of the action.

Environment and Equipment

- Logs showed that equipment servicing was up to date.
- Curtains in double rooms and the recovery bays appeared clean and had been changed in line with policy. The curtains within the theatre were also changed and up to date.
- Resuscitation trolleys had up to date checks with all the appropriate equipment available and checks were carried out daily.
- Staff said if equipment required repair, once this was reported the item was fixed quickly. Major and specialist pieces of equipment used within the theatres was hired on a contractual basis.
- Equipment and space in theatres was appropriate and since our last inspection a portable ventilator had been made available for patients requiring transfer to an intensive care unit in another hospital.
- The senior management team informed us that they did not have a contingency plan for decontamination of endoscopes if the machines broke down. This was contrary to the information provided by staff. They informed us that they would send used endoscopes to a sister hospital for decontamination.
- Linen was appropriately stored on shelves and in wrapped in boxes.

- Supplies of air mattresses and VTE stockings were in place for patients who needed them. If a mattress was needed that was not on site, staff told us that one would arrive within a few hours.
- Pressure relieving equipment was available in theatres for cases where a patient had a pressure ulcer or poor skin integrity. We were also informed that this equipment was available for any person undergoing a procedure that lasted more than 45 minutes to help lower the risk of pressure ulcers.
- We saw equipment checklists were present in all theatre areas. These were used by staff to ensure all necessary theatre equipment was available on a daily basis. Blankets, fluids, emergency intubation, difficult airway trolley and resuscitation equipment were available in the recovery area and within the endoscopy unit. These had been checked and audited. Theatres met Association of Anaesthetists of Great Britain and Ireland) (AAGBI) guidelines and this was an improvement noted from our previous inspection.
- The theatres sluice was used for storage which limited the available space. There were six recovery area bays within the theatre department. Of the six bays available, five were clear and available for use, whilst the sixth bay was used for storage. This did mean there was less available space, however the five available bays were free from clutter and non essential equipment.
- Staff told us that emergency call bells in theatres were tested daily, however there were no telephones within the anaesthetic room or operating theatre. Staff were concerned by this as they had no way to contact a porter and instead had to rely on a porter already being in the area. This had the potential to cause delays to patient care. The previous HDU had been extended to conform to FICM standards for a level two unit. There were two rooms that were larger in size and both had negative air pressure. A glass wall and a curtain separated the two rooms to provide privacy. The layout allowed for the curtain to be drawn between the two rooms whilst still allowing the nurse to observe both patients at the same time. This unit had immediate access to equipment that could give certain test results, such as blood gases and electrolyte levels, to enable appropriate treatment to be delivered as required. There were no patients within the unit at the time of our visit.
- The hospital was able to show us that they had a bariatric operating table specifically for this surgery.
- Daily facility and equipment checks were conducted in theatres which picked up any unclean or damaged areas and if waste had not been emptied. All clean equipment had an 'I'm clean' green sticker attached to it.
- Staff were trained to use the equipment on site such as syringe drivers and infusion pumps. However we saw no evidence of regular medical device training in either theatres or for the critical care unit.
- On the wards, if a room had been vacant for four days or more, the taps were run. There were regular checks for legionella.
- The theatres were not secure. They were easily accessible to staff and the public.

Medicines

- We saw evidence that medicines were managed appropriately by staff and drug charts were completed. Information supplied by the pharmacist showed that medicines were only ordered to agreed stock levels.
- We saw that staff checked and recorded fridge temperatures daily and that temperatures recorded were within the accepted range.
- Within theatres, controlled drug cupboards were fixed to walls and placed within rooms that were also locked. We saw that all medicine trolleys inspected were locked. The last controlled drugs audit took place in April 2016 and this showed 100% compliance across all wards and theatres throughout the hospital.
- Medicines were available within the theatre and recovery areas in case of a reaction to anaesthesia. Emergency drugs were available and staff checked daily to ensure they were up to date.
- The last safe and secure storage of medicines audit in May 2016 found some compliance concerns. They included oral medications had not been labelled to record the date of opening, and a medicine fridge had been left unlocked. The pharmacy department also found that patient medication prescriptions had not

been securely locked away. However, during our inspection we found all three theatres, the recovery area, pharmacy and endoscopy unit to be compliant. The HDU was found to be compliant.

- During our inspection we observed oral medications that were correctly labelled and stored within the theatres and on the wards.
- Medicines were stored outside the theatre in large metal cabinets that were locked via a padlock. They were stored behind a partitioning wall, out of sight. During our inspection, one of the drug cabinets was left open and unlocked just outside the theatre. We asked the Deputy Theatre Manager about this and they said they thought the cupboard should be more secure with alternative locking mechanisms
- Within theatres, controlled drugs were locked away in a double cabinet and the theatre lead for that day was in charge of the key.
- The last missed dose audit in December 2015 showed some omissions but, these were mainly from patients who had refused medicines on inpatient wards, or the consultant had removed the medicine for a specific time period.
- There was no medicines reconciliation audit as all medicines brought in were checked by the pharmacist on their daily round. There was no pharmacist interventions audit (assessment of pharmacist prescribing on patients) as all interventions were recorded on the inpatient prescription chart.
- During our inspection we found some theatre staff believed that medicines used within theatres requiring disposal were supposed to be flushed away via the sink. This was not in line with national guidelines or hospital policy. We brought this to the attention of the Deputy Theatre Manager. They explained that staff had been trained and shown the correct protocol for medicines disposal. They randomly selected three members of staff and asked them to describe the disposal procedure. They were able to explain this correctly.
- The ward round identified patients discharged on that day or the next and the pharmacist department prepared medicines for patients to take away.
- There was a total of 50 incidents reported for the medical and oncology services between April 2015 and March 2016. 29 of these were clinical and 21 were non clinical.

Records

- Most of the paper patient records we reviewed were complete with up to date pre-operative assessments, nursing assessments, care plans and observation charts. They included surgical notes and post-operative care plans.
- Patient records were stored appropriately behind the nurse's station in a locked cabinet.
- Consultant and operation notes were copied and left with the hospital to ensure the patient notes were available in their entirety when the consultant was off site.
- We reviewed a child's operation note on Paragon ward which was completed with the correct signatures, observations and consent form.

Safeguarding

- There was a corporate safeguarding vulnerable adults and children policy with defined responsibilities at national, regional and hospital level as well as a flow chart for how to report concerns. The hospital policies were up to date, reflecting the corporate policy for local responsibilities including the necessary local authority information.
- All staff we spoke with both in theatre and on the ward were aware of how to raise a safeguarding alert and knew the appropriate internal procedure for doing so. They were also aware of, and could name the lead for adult safeguarding. The hospital told us all staff had attended training in safeguarding as part of their induction.
- Information provided to us by the hospital showed that 89% of staff on the wards had safeguarding training and oncology staff were 100% compliant with safeguarding training.
- Staff were able to provide an example of a safeguarding incident that they had been involved with.

- All paediatric nurses and urgent care staff were trained to level three, which is in line with the "Safeguarding children and young people: roles and competences for health care staff intercollegiate document" 2014.
- When children's appointments were booked for clinic or surgery, the paediatric nurse ensured level three trained staff were available for the duration of the child's stay.

Mandatory Training

- Most theatre staff were up to date with their mandatory training with compliance at 82%, and ward staff at 85%. This was against a target of 100% and included basic life support, fire training, infection prevention and control
- All new staff had to go through the BMI corporate induction training programme and received a '90 day pack'. This explained to the new employee what they should expect in their first 90 days of their employment.
- Managers monitored staff compliance with mandatory training through an online training system. Each individual had a personal training account and received alerts by email when a training module was due to be completed. However staff told us that not everyone had access to their emails and this meant some staff had to be reminded in person to update their training.

Assessing and responding to patient risk

- The hospital used the National Early Warning Score system (NEWS) and patient scores were appropriately recorded and escalated if there was a concern. Staff were able to explain the procedure if a patient deteriorated.
- The anaesthetist and theatre recovery team on site held the cardiac arrest bleep in theatres. The cardiac arrest team was led by the Resident Medical Officer (RMO) and they met daily to discuss roles, should the resuscitation team be required. The RMO also held the bleep on the wards. The RMO was available 24 hours, seven days a week.
- The hospital theatre department conducted practice medical emergency scenarios for staff every month. They set the cardiac arrest team alarm off and ran the scenario with the staff that arrived. Staff were unaware that it was a training scenario until they arrived at the scene. Over the past three months a variety of different scenarios were rehearsed including a child choking.
- The RMO informed us that they were always able to reach the patient's consultant for advice if required. If the consultant was on leave, they informed the hospital, and a note was put on the ward noticeboard. The consultant would arrange for a colleague to be their cover.
- In most instances, patients who deteriorated would be stabilised by the RMO or consultant and transferred to a local NHS hospital. A service level agreement (SLA) was in place for transfers which included the criteria for when a patient would be transferred, staff responsibilities, and that the consultant anaesthetist would accompany the patient to the NHS hospital.
- Theatre staff were trained in retrieval skills to ensure a patient's airway could be stabilised before they were transferred to another hospital. Equipment was available in the event of a patient who was difficult to intubate.
- There was an emergency theatre on-call rota if a patient required emergency surgery. Every day the ward staff were made aware of the on-call staff via a paper slip given to them by the theatre department.
- A haemorrhage protocol was in place and a scenario audit was undertaken which showed overall competence but some areas for improvement including staff training.
- The hospital now had a level two critical care unit in line with FICM standards.
- All staff were trained in basic life support (BLS). Some senior nurses and members of staff were trained in immediate life support (ILS) and anaesthetists, the RMO and consultants were trained in advance life support (ALS). There were several members of staff trained in ALS on the hospital premises at any one time. A rota of senior nurses was available to all ward staff to provide advice as required.
- We observed the five safer steps to surgery including the World Health Organisation (WHO) checklist were completed appropriately. A wipe clean briefing sheet on how to complete the WHO checklist was displayed and used with every patient, showing each step including

team briefing, sign in, time out, closure count, sign out and debrief. The WHO checklist template was appropriate with identified staff responsible for each part of the checklist.

- An audit of the WHO (World Health Organisation) checklist in January 2016 found 92% compliance and in April 100% compliance.
- Pre-assessment nurses were able to given an example of a cancelled procedure for medical reasons. On the day of surgery the anaesthetist was not happy with the patient's blood sugar level, therefore the surgery was postponed for safety reasons.
- At the time of our inspection, within theatres, all staff wore the same colour caps. Different colour caps are used to quickly identify qualified practitioners or other members of the team and their roles quickly and easily. The Deputy Theatre Manager informed us that new colour coded caps were about to be introduced within the department for ease of identification.
- There were monthly mortality and morbidity meetings carried out within the hospital to identify trends that may need to be addressed or investigated. All the deaths or incidents that occurred were discussed fully at these meetings and if appropriate they were also investigated and reported.

Nursing staffing

- There were sufficient nursing staff to meet the acuity and dependency of the patients admitted for surgery and endoscopy, although further staff were required to cover sickness and more complex patients, as well as for the decontamination of endoscopes. A corporate nursing tool was used to calculate acuity and dependency and this was worked out 48 hours before each shift. At the time of our inspection, the majority of staff within the endoscopy unit were regular bank staff who worked alongside three members of permanent staff. We were shown evidence after our inspection that the hospital had employed further staff within this department for safety and decontamination purposes.
- Since the last inspection the hospital had increased the number of paediatric trained nurses from one to five. They worked across the hospital in the urgent care centre, wards and outpatient department.
- The hospital used an electronic rostering system. The same person who did the rostering would also write the roster on a designated white board within theatres as a quick and easy reference guide for all staff and to avoid confusion.
- When a patient was admitted to the HDU, the hospital told us that there were always two nurses to look after them. At the time of our inspection there were no patients in the HDU and therefore this could not be observed. There was a designated lead nurse for HDU and regular bank staff were used to staff the department as they were familiar with the environment and hospital protocol.
- The average percentage of bank and agency staff used between April 2015 and March 2016 within theatres was 5.8%.
- The use of agency nurses and HCAs on the ward was below average when compared to 17 other independent acute hospitals we hold this type of data for.
- In theatres, the majority of staff were permanent and at the time of our inspection there were two vacancies. One vacancy was for a nurse and another for an HCA, both within the recovery suite. The vacancies were being recruited to at the time of our inspection. .
- There was a newly appointed lead nurse for the endoscopy unit who had been in post for one week at the time of our inspection.
- Handovers included the nurses on shift and the RMO. Each named nurse for each patient from the previous shift handed over each of their patients. This included a full medical and social history including plans for the shift such as tests, medicines or discharge. However, patients commented that they were attended to by different nursing staff every day, therefore there was a lack of continuity. They also said that the member of nursing staff did not always know all the details of their condition or surgery, and patients found this inconvenient.

Medical Staffing

- The hospital had over 300 consultants who worked for the hospital via practising privileges and attended the hospital depending on whether they had patients there.

Good

Surgery

- RMOs were supplied by an agency. They were recruited after checks on their experience and qualifications had taken place. Some of the RMOs were recruited from abroad and attended a one week intense transitional training course to UK standards. This training included advanced life support for paediatrics and adults.
- There were three RMOs within the hospital. They were on duty 24 hours a day for a week at a time.
- When a patient was admitted to the HDU, an additional RMO with appropriate airway skills was deployed to the hospital via an agency. They covered the period that the patient remained within the unit. The hospital was clear that there was no problem in getting an RMO from the agency, and until they arrived the consultant cared for the patient.
- When the RMO was disturbed during the night, this information was passed to the day shift who allowed time for the night RMO to have adequate rest.
- Four consultants covered the critical care unit. There was also a lead consultant. Each consultant took it in turns to cover a week at the hospital and was on call and available at all times during that week.
- The general hospital RMOs had a variety of experience and had completed further training with the agency to enable them to carry out the role appropriately.
- The RMO conducted a round every 12 hours with the charge nurse to review all patients who had stayed overnight. Their remit was to ensure patients were comfortable and to prescribe additional pain relief. They only intervened medically if a patient had a problem such as a bleed post-surgery, and this was discussed with their consultant. The patient's pathway and care plan was managed by their consultant.
- Consultants were always required to be available by phone or have a named alternative contact if they were unavailable. Hospital staff told us it was very rare for a consultant to not answer their phone.
- Anaesthetic consultants stayed on site until the patient had recovered from their surgery. There was an anaesthetist on call overnight in case of any issues.
- All patients we spoke with said they had seen their consultant both before and after their procedure. All endoscopy patients were seen after their procedure and discharged by their consultant.
- There was a 10am ward round with the RMO and nursing staff. There was a handover at 7pm between the nurses in charge of the shifts.

Major incident awareness and training

- Generators were tested monthly and serviced six monthly.
- Emergency drills were conducted. The theatre staff that we spoke with during our inspection said that they had never taken part in one of the resuscitation scenarios and some were not aware that these took place.
- Staff were aware of what to do in the event of a fire and were we told that a previous drill had been carried out where evacuation was done by compartments (between each set of fire doors).
- A corporate appropriate business continuity plan was in place defining responsibilities from a national to hospital level. BMI Blackheath Hospital had specific action cards in place for different scenarios such as loss of utilities, loss of staff, and loss of communication infrastructures with actions to take in their event.

Are surgery services effective?

Good

Are surgery services effective?

We rated effective as good because:

- Some local audits took place and the hospital participated in some national audits. In areas we could benchmark, the hospital performed well, such as readmissions.
- Patients received care that was informed by evidence based guidelines.
- Patient's nutritional needs were assessed and staff followed fasting protocols.
- Patients had their pain assessed and recorded and received effective pain relief.

- Staff working in the high dependency unit maintained their competency by working closely with the theatre department when they were not busy.

However:

- Mental capacity assessments were not always undertaken for patients who may have lacked capacity. .

Evidence-based care and treatment

- Most policies and procedures we reviewed were up to date and in line with current guidance. The policy for pre-operative assessment was due for review in February 2015 and this had not been completed, however there was an up to date National Institute for Health and Care Excellence (NICE) policy for 'Routine Pre-operative Tests for Elective Surgery' available.
- Management told us that the hospital's policies and procedures were reviewed by a steering group which included management representatives of services including theatres. New guidance and updates such as NICE guidelines were reviewed at clinical effectiveness meetings.
- There were protocols in place for post-operative care, pain management and sepsis.
- Physiotherapy assistants worked with a physiotherapist to assess patients and measure their movement before and after their operation. They liaised with local NHS services to provide assistance and care once the patient left the hospital.
- There was no occupational therapist (OT) at the hospital. The hospital told us that they assess the patient for occupational therapy requirements during surgical pre-assessment. Referral was via the physiotherapist team once the patient had been admitted and their needs assessed.
- Antibiotic protocols were missing from the walls within the theatre. Although the hospital were using these, they were not visible. The hospital immediately printed and laminated the antibiotic protocol and placed it on the walls in all theatres ready for use.

Pain relief

- Pain assessments were undertaken and scores were recorded in patient records.
- Nursing staff had received training and were aware of how to manage epidurals and syringe fluids in theatres if a patient required them to reduce their pain.
- A pain team was available which was led by an anaesthetist who could be called by staff in the event the RMO could not manage a patient's pain.
- Staff discussed pain relief with the RMO who could refer to the patient's anaesthetist for further advice if necessary.
- For those patients at the end of life pain relief could be administered by a time released syringe driver. This was prescribed by the consultant as required.
- All patients we spoke with during our inspection informed us that their pain was managed appropriately and that pain relief was always available if required.
- We noted that children had been given appropriate pain relief following surgery and parents told us their child's pain had been managed well. We saw a pain management care plan that had been implemented by a paediatric nurse to assess children's pain score.

Nutrition and hydration

- All patient records that we viewed had a completed malnutrition universal screening tool (MUST). All the patient notes we reviewed showed completed fluid balance charts, and weight charts.
- A nil by mouth policy was in place and observed. There was access to an external dietitian when required. If a patient had been fasting prior to surgery the theatre were very proactive in notifying the ward and the patient if there was a delay. The patient was then given intravenous fluids to keep them hydrated.
- Ward staff followed guidance on fasting before operations. When the patient had more than two hours before their surgery, including times when their procedure was rescheduled to later in the day, staff gave patients sips of clear fluid.

Patient Outcomes

- Unplanned readmission rates were low at 10 patients between April 2015 and March 2016 within 28 days for a related condition.This was below average compared to other similar hospital.

Good

Surgery

- The rate of surgical site infections was low, however the rate of infection for primary hip arthroplasty, primary knee arthroplasty and breast surgery were higher than the England average of NHS hospitals. Between April 2015 and March 2016 there were seven surgical site infections recorded out of 3,238 surgeries that took place. These surgeries were anything from hip and knee arthroplasty to urology and vascular surgery.
- Patient outcome measures (PROMS) showed the hospital performed average to poor. However, these were based on low numbers of patients, both NHS and privately funded. Otherwise, patient outcomes were not measured by the hospital.
- There were 15 unplanned returns to theatres in the last year. There was no data available to compare this with similar hospitals.
- For the period April 2015 to March 2016 there were eight unplanned transfers of an inpatient to an NHS hospital. The rate of unplanned transfers had been stable over the same period. Data held about the hospital confirmed that the number of such transfers was comparable 'to units of a similar size.
- The hospital had participated in several BMI Quality audits including: critical care, breast cancer, bowel cancer and inpatients. However, these audits only gave raw information and did not benchmark.

Competent staff

- During our inspection we were shown the corporate and local induction packs. This included information such as a protected training, mentoring, practical training and mandatory e-learning. Some staff had not updated their competencies.
- All the nurses that worked in the critical care unit were qualified to provide level three care.
- For the period April 2015 -March 2016, 80% of inpatient staff had an appraisal and in theatres it was 25% of staff. Most of the staff we spoke with told us they had had their appraisals.
- Consultant revalidation was part of the requirement for maintaining their practising privileges. If a consultant wanted to carry out a new procedure, this had to be agreed as part of their practising privileges.
- Practising privileges were reviewed on an annual basis requiring evidence of their GMC registration, professional indemnity insurance, criminal record check (DBS), appraisal, Hepatitis B status, and registration with the Information Commissioners Office. We saw evidence that practising privileges had been suspended, not renewed or revoked due to poor outcomes, lack of documentation or lack of surgical activity. Appropriate terms and conditions were in place to ensure those who were granted practising privileges adhered to policies and procedures.
- The Deputy Theatre Manager told us the HDU staff worked theatres during quiet times to ensure their skills were kept up to date.
- Endoscopy decontamination staff were in-house trained and not certified to decontaminate endoscopes by an authorised provider. We were informed that members of the theatre team were also responsible for decontamination of endoscopes when endoscopy staff were not available. The new Lead Nurse and the Operating Department Practitioner (ODP) were certified and qualified in endoscopy decontamination. The hospital was aware that staff working within the decontamination suite should be trained and certified to carry out this procedure. They informed us that they have enrolled the decontamination staff on to an accredited course; however this was not until 2017. In the meantime, the hospital told us that the lead endoscopy nurse and the ODP would oversee, and take responsibility for, the decontamination of the endoscopes within the unit.
- Housekeeping staff received training and had competency checks, for example in handling chemicals and in waste disposal.
- Junior staff within theatres rotated between different specialities to give them experience of different types of surgery.

Multidisciplinary working

- During our inspection we saw evidence of multidisciplinary team (MDT) working within the ward areas. Doctors and nursing staff told us they worked well together.
- A weekly meeting between all heads of department took place.

- There were daily meetings between radiology, pharmacy and physiotherapy staff.
- Pharmacists from neighbouring BMI hospitals met regularly and worked closely with the BMI the chief pharmacist.
- We observed a handover from the lead nurses from day shift to night shift. This included information from the physiotherapist about assisting a patient to get out of bed. We observed the RMO reviewing patients at this time so that he had an overview of the inpatients.

Seven-day services

- The pharmacy department was open Monday to Friday from 8.30am to 5pm and on Saturdays from 8.30am to 12.30pm. There were pharmacists on call out of hours to provide advice and if necessary, come into the hospital. Staff had access to the pharmacy and could dispense most drugs, except controlled drugs themselves, without needing the pharmacist. The RMO had access to pre packed take home medicines when the pharmacy was closed to ensure patients could still be discharged.
- Pathology services were available on-call 24/7.

Access to information

- Staff confirmed that GPs were sent a copy of the discharge summary and the patients received a copy as well. A more detailed letter was sent by the operating consultant to the GP regarding the outcome of the patient's surgery. The consultant completed the discharge summary. Ward staff checked this and gave it to the patient. Ward staff also send a copy to the GP.
- There was good access to corporate and local information electronically via the hospitals intranet. This included policies, meeting minutes and bulletins.
- There was an information folder on the ward for staff to refer to about end of life care. However, the staff saw very few patients who required end of life care.
- When the hospital cancelled a patient for medical reasons a nurse looked to see if there was an explanation for not identifying this at pre-assessment. There were regular pre-assessment meetings with the booking administrator, the ward manager, the pre-assessment nurse and the pathology service.
- Any children who had surgery had a follow up phone call with the nursing sister to ensure any concerns or questions were answered quickly.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- All the patient records we reviewed showed that patients had consented to their surgical procedure. We saw that staff got consent first at the pre-operative assessment stage, and again before the operation, on either the same day or the day before. Within theatres, we saw a patient who had undergone a procedure without having signed their anaesthetic consent form. The patient informed us that they had verbalised consent with the anaesthetist, however the form remained unsigned.
- Staff told us it was rare for additional forms to be used as patients normally had capacity. There was an appropriate corporate Mental Capacity Act (MCA) 2005 and Deprivation of Liberty Safeguards (DoLS) policy in place that provided an appropriate capacity assessment form. A member of ward staff was able to tell us about a time when he had been involved in a situation that required knowledge of the MCA 2005.
- Nurses told us that mental capacity was assessed by pre-assessment nurses and that there had been very few patients who had dementia or other conditions that limited their capacity to make decisions. The RMO explained how he followed the two stage process to assess decisions about treatment, if the patient did not want to have the recommended care.However, we looked at the records of a patient whom nurses had noted was confused, but there was no MCA assessment on file. Nursing staff had carried out a risk assessment for the use of bed rails for the patient, but there was no DoLS assessment or record about.
- We asked to look at records of patient who had died at the hospital, and were told there had been seven deaths. We looked at the records of two patients who had died at the hospital. A Do not attempt cardiopulmonary resuscitation (DNACPR) form was completed and signed by a consultant, but the family were not consulted about this until three days later. Another patient, who was near the end of life while in hospital, but died elsewhere did not have a DNACPR form completed.

Good

Surgery

- Paediatric staff told us they would employ different methods of gaining consent dependent on the child's age. They described certain judicial rulings that governed consenting older children such as Gillick competencies and Fraser Guidelines.

Are surgery services caring?

Good

Are surgery services caring?

We rated caring as 'good' because:

- Patient feedback was consistently positive. This included individual interviews, questionnaires and surveys.
- Observations of care were positive and ensured privacy and dignity.
- Staff kept patients informed about their care and involved them in making decisions.

Compassionate care

- Between October 2015 and March 2016, for the NHS Friends and Family Test (FFT) the hospital achieved between 96% and 100% for NHS patients. For privately funded patients it was between 97% and 99%. The percentage shows the number of respondents who would recommend the service to their family and friends. However, the response rate was low, ranging from 26% to 60% over the same time period.
- The hospital had a patient satisfaction group that reviewed the results of the questionnaires and any action plans on a monthly basis.
- The hospital conducted a patient satisfaction survey which covered May 2015 to May 2016. This showed average scores of 76% for excellence and an average of 97% for satisfaction. The response rate was over 90% and the questions covered a range of services including accommodation, arrival, consultants, nursing care, catering, discharge and overall experience.
- Patient feedback during the inspection was positive. All the patients we spoke with commended staff saying they were friendly and nice.
- We observed staff maintained patient privacy and dignity and they were friendly towards patients. Patient doors were kept closed during treatment conversations to ensure privacy and dignity.
- Patients said staff were helpful, caring and understanding, which made them feel more relaxed and confident with their treatment and stay within the hospital.
- The Patient Led Assessment of the Care and Environment (PLACE) audit for February to June 2015 showed that in all areas other than privacy, dignity and wellbeing (83% for the hospital and 87% for the England average), the hospital scored above the England average.

Understanding and involvement

- During our inspection, we spoke with 15 patients and two relatives. They said they were kept informed and up dated regularly about their care and treatment and up to date. Some of the patients had undergone an endoscopy whilst we were on site and had said that their procedure was explained fully, staff were reassuring throughout, and good information was given for after the procedure for aftercare purposes.
- One family told us the anaesthetist and consultant had come to see them after their child's operation to explain that the procedure had gone well. This was very reassuring and allowed them to ask questions about the procedure.
- Patients were encouraged to ask questions regarding their care and we observed staff either answering these or getting a more appropriate staff member to do so.
- Patients told us they were kept up to date regarding their care including explanations about their procedure and the risks and benefits and this was recorded in their notes.

Emotional support

- Nurses told us that they were always available to provide additional support to patients when a consultant had to deliver distressing news.
- Staff told us that patients were encouraged to change into their own clothes 24 hours after surgery as this had been found to provide comforting familiarity, especially for patients living with dementia.

Good

Surgery

- The senior nurse and the breast nurse had set up a support group for patients who had undergone breast surgery. This provided an opportunity for patients to share their experiences with other patients with similar conditions.

Are surgery services responsive?

Good

Are surgery services responsive?

We rated responsive as 'good' because:

- The number of people who had a pre-operative assessment had improved since the previous inspection.
- Patients were generally able to access care and treatment within national waiting times.
- The high dependency unit could care for patients requiring level 2 care.
- The hospital had improved resources and support for children since the previous inspection.
- All areas of the hospital were accessible by wheelchair.

However:

- Some patients felt there could be more information available about their procedure.
- Staff had not received training on how to care for adults living with dementia or people who had a learning disability.
- Some staff were unaware who the dementia champion was.

Service planning and delivery to meet the needs of local people

- Patients told us that they were able to arrange admissions times in agreement with their consultants. Both consultants and the hospital were able to accommodate admissions at weekends and late in the evening.
- Referral to treatment times (RTT) for patients starting treatment within 18 weeks of referral were mostly above 90% from April 2015 to March 2016. During the period July through to November the average was 84.75%. From December 2015 to March 2016 the RTT was at an average of 98%. The NHS no longer uses this measure, however the hospital continued to use this to monitor its own progress with NHS patients only.
- Cancellation to surgery on the day of the procedure was 0.85%.
- Staff told us that patients were able to be pre-assessed face to face, by telephone or at the hospital on the morning of their procedure, depending on the type of surgery and any pre-existing conditions or risk factors.
- The critical care unit had future plans to have four level three beds rather than two level two beds, and the hospital had recruited four intensivists in preparation.
- The hospital had recently been awarded an NHS contract to provide bariatric services to meet local demand. The Deputy Theatre Manager told us that there had been a thorough risk assessment to ensure the service could be provided safely and effectively. Bariatric equipment was available for these patients and we were shown the bariatric operating table.

Access and flow

- Normal theatre hours were from 7.30am to 8pm Monday to Saturday and on one Sunday per month for bariatric surgery. Endoscopy hours were 7.30am to 9.30pm.
- Patients were informed about their surgery via an admission letter.
- A theatre administrator scheduled procedures and operations. They attended team briefings to be able to record any changes to the theatre list order, and estimate the time needed within the theatre for each patient.
- Any gaps within the theatre booking system were colour coded so that they could be utilised for alternative activities, such as training, or filled by a consultant.
- The day case ward was closed overnight as patients were only expected to be there during the day. On some occasions day patients had to be moved to the inpatient ward to be cared for overnight. The day case ward only remained open if there was a lack of bed space but this was rare.

Good

Surgery

- Utilisation of theatres was monitored and reviewed to show where gaps were. Patients were rarely operated on overnight as no patient was admitted for emergency surgery. Performance was reviewed monthly via a dashboard to show how well utilised theatres were.
- The number of patients that underwent pre-assessment was 69%.This rate was higher than the previously reported rate (56% in December 2014).
- The critical care unit opened in October 2015. Since the opening to the time of our inspection there had been 81 patients admitted and treated within the unit.
- Patient discharges were usually authorised by the admitting consultant however sometimes this was done by the RMO but only where the consultant was in agreement that the discharge was appropriate.
- Staff told us external occupational therapists and physiotherapists and social services were generally quick to respond but that there were occasional problems which resulted in a patient's discharge being delayed.
- Paediatric surgery was meant to be carried started no later than 3pm, as defined in the hospital's children and young people's standard operating procedure. However, an audit carried out by staff from 29 June to 12 July 2016 showed three children were taken to surgery after 3pm. Staff told us it was for non-clinical reasons and said they had alerted the head of department to this issue. All children were safely operated on and the anaesthetist visited the children post operatively.

Meeting people's individual needs

- Although we did not see evidence of any policies the hospital had on supporting patients with additional communication requirements, such as those living with mental health conditions or learning disabilities, staff told us that they did not have any patients who would need this support. Staff had not received training in caring for people living with dementia or people who had a learning disability.
- For people living with dementia the hospital told us there was a dementia champion on the ward. However, staff were unclear as to who it was and therefore, if a patient with dementia had been admitted, the ward manager was alerted.
- A local dementia assessment process had been agreed during October 2015 and was effective at the time of our inspection. If a patient had a medical history that included dementia, or the patient was over 75 years old, the hospital conducted a dementia risk assessment. This risk assessment was also available to younger patients if dementia was suspected.
- Booking staff notified staff on the ward if prior to admission if a patient was living with dementia. However, there was nothing on the front of the notes to alert the clinician that the patient was living with dementia.
- Staff told us they rarely used translators as family or friends normally attended if a patient did not speak English. A telephone translation service was used for consultations, or at times when a translator was needed at short notice. Advanced bookings were able to be made for face to face translation services within the hospital if and when required.
- During our inspection we observed an incident where a patient attended the hospital for an endoscopy. The patient did not speak English and required a translator. This had not been booked in advance and had to be rebooked for a later date.
- Information booklets about the hospital were available for patients. These included room facilities, meals, care expectations, health and safety, discharge and a patient guide which included information on charges, and complaints. Post-surgery advice leaflets were mainly provided to patients by the individual consultant rather than there being standardised hospital leaflets. Therefore it was not clear whether consistent advice was always provided to patients about their post-operative care.
- All the areas of the hospital were accessible by a wheelchair. Lifts were in place between levels and each part of the hospital was wide enough to accommodate a wheelchair.
- The hospital gave children a teddy bear in their room on return from theatre. They had specialist bed covers and pillow cases for children's beds to make them feel less nervous. Parents felt this was a very personal touch.

Good

Surgery

- The hospital told us children and their families were contacted seven days before an operation and asked if they wished to come and see and have a tour of the ward to relieve any concerns. However, a family we spoke with said they had not been offered this service.
- In most cases, children were discharged on the day of surgery. If this was not possible the hospital expected either the children's nursing sister to stay on shift or would use a bank paediatric nurse. Ward staff said that this had never happened and if the child was to stay overnight it would have been planned.
- Children's parents received a follow up phone call between 24-48 hours post discharge to ensure the child was recovering well and give advice for any concerns parents may have.
- Call bells were answered promptly and there was no limit on visiting times.
- Adult patients had a follow up telephone call post discharge to check on their progress.
- Patients commented the lack of leaflets and information available about their procedure.

Learning from complaints and concerns

- The hospital made available both its own and the NHS complaints procedure, depending if a patient was receiving NHS or privately funded care. If a patient was privately funded, their complaint was reviewed first by the hospital and then regionally if the patient was not satisfied. The targets were to acknowledge the complaint in two days and respond in 20 days. Most of the patients we spoke with were fully informed about the complaints procedure.
- Data provided by the hospital showed that all complaints were responded to within 20 days in the period from February 2015 to March 2016.
- The hospital had received 155 complaints for the period April 2015-March 2016 and this was statistically higher when compared to 18 other independent hospitals we hold data for. These were reviewed quarterly and improvements were discussed at team meetings. However these were not broken down by service although management told us most related to outpatients.
- Trends for complaints included unexpected charges when a patient's insurance did not cover the whole costs of their care. Recommendations to improve included improving discharge, communication with, social services, and review of consultants who ran late theatre lists.
- All patients received a patient guide which included a section covering the formal complaints procedure. Copies of the BMI leaflet entitled 'Please tell us' were located throughout the hospital. All patients were encouraged to complete a patient satisfaction survey during or after their admission or outpatient visit; they can complete a section asking for the hospital to contact them should they wish.
- Staff told us that they did their best to deal with issues and complaints at ward level.
- More formal complaints were handled in line with the hospital's policy. This would involve the Inpatient Manager undertaking an investigation and liaising with consultants if necessary.
- We reviewed a complaint and the investigation. There was learning to take from this incident, however there was no evidence that this learning had been put into practice or that it had altered practices or procedures.

Are surgery services well-led?

Good

Are surgery services well-led?

We rated well led as 'good' because:

- Leadership on the wards and in theatres had been strengthened and improved and staff spoke positively about the support and visibility of their managers staff. They said there was good team working.
- There was a clear clinical governance structure which included a range of committee meetings at both clinical and operation levels which review the quality and safety of care and. The structure had been strengthened with the introduction of a children's and young people's committee.
- The hospital had a dashboard to monitor performance which was reviewed both locally and regionally.

- Staff were aware of the hospital's aim to continuously provide a high quality service to patients.
- Staff described the culture as open and said they felt able to raise concerns. Information was shared with staff at team meetings and through hospital bulletins.

However;

- Issues identified in our previous inspection in February 2015, such as non-compliance of sinks and the endoscopy unit, were on the risk register but had not been addressed.
- Patient feedback and engagement was limited.

Leadership of service

- Since the last inspection the leadership had been improved and the hospital had been successful in recruiting to several long standing vacant posts. The leadership structure for the surgical team had been reviewed and was managed by the Director of Clinical Services and overseen by the interim Executive Director. This included the Theatre Manager and Deputy Theatre Manager. Endoscopy, Critical Care and the RMO were managed by the Associate Director of Clinical Services. Endoscopy had appointed a new lead nurse for the unit who reported to the Associate Director of Clinical Services.
- The Executive Director was the lead for the Medical Advisory Committee (MAC), executive team meeting and the hospital management team.
- The Director of Clinical Services was the lead for clinical governance meetings and the clinical management group.
- Some staff said managers and leads including the Executive Director and Clinical Services Director were visible. However, others said senior management could have been more visible and spent more time getting to know staff as it would make them feel more valued.
- Staff we spoke with told us both new and long standing senior staff were supportive and front line staff felt able to raise concerns.
- Staff commented on the ward manager's good leadership and said they treated all staff with fairness and respect. They encouraged staff development and acted as a mentor to nurses who were taking on more senior roles.

Culture within the service

- Staff reported a positive culture at the hospital with good team working. They told us they were happy to be working at the hospital and felt supported by the business. During our inspection we observed good morale and teamwork on the wards and in theatres.
- The staff survey results from May 2016 showed that the survey was completed by 67% of staff. All staff who responded said that they were proud to work for the hospital, 57% said they would recommend BMI Healthcare as an employer, 64% said they were satisfied working for BMI Healthcare and 72% said that they expected to still be working for BMI Healthcare in 12 months' time. The results of the survey showed that staff felt that they were not paid fairly for their job role when compared to other similar roles elsewhere, however, they enjoyed flexible working hours, good team spirit and a nice environment to work within.
- Staff told us they enjoyed working with each other and were able to talk openly with each other and rely upon their colleagues.
- Staff spoke positively about the high quality care and services they provided for patients and were proud to work for the hospital. They described the hospital as a good place to work and as having an open culture. The most consistent comment we received was that the hospital was a friendly place to work and people enjoyed working there.
- Nursing staff said they felt comfortable to challenge consultants if they felt it was appropriate and they received support from management to do this.
- Senior staff were supportive to more junior colleagues and would take concerns forward for staff if they did not feel confident to do so themselves.
- Senior theatre staff met twice a month for a clinical meeting and the whole team met every month. The

theatre sisters felt that it would be helpful for them to attend governance meetings as they filled out incident forms and report concerns. Senior staff took more junior staff into small groups to discuss any incidents or issues.

- Some staff said they wanted more engagement with management and more incentives and rewards.
- Unit managers felt they were involved in the many changes at BMI Blackheath.
- Examples of discussions at ward meetings included concerns raised within an audit to show that staff were not recording all the information expected on care plans. However, some nurses we spoke with had not attended a ward meeting.

Vision and strategy for this service

- The hospital had a vision which included providing advanced treatment, using modern technology, having a comfortable environment and friendly staff.
- Staff we spoke to were aware of the hospital's vision and told us that the focus was to provide a high quality service to patients.
- The executive team told us they planned to increase the number of patients using the hospital by admitting patients with more complex needs.
- There was a plan to refurbish and improve the facilities and at the time of the inspection the hospital had received planning permission to build a new endoscopy unit to replace the existing suite.
- The hospital had plans to expand the critical care unit to a four-bed unit and provide level three care as per FICM standards.
- Clinical governance meetings minutes from April 2016 discussed the increase in the amount of medical work undertaken at the hospital. It noted local NHS consultant's interest in providing medical care at the hospital and refurbishing rooms on the ward to allow space for this increase.
- There were plans for a new ambulatory care area to allow for more medical patients to be seen and treated at the hospital. Staff told us this was a work in progress.

Governance, risk management and quality measurement

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- The hospital had a risk register. The version dated May 2016 included issues identified on our previous inspection in February 2015 which had not yet been addressed such as carpets, sinks, and the non-compliance of the endoscopy unit. It stated that refurbishment of the endoscopy unit was planned for 2016 to achieve JAG accreditation.
- Senior staff had some awareness of the concerns we found related to the endoscopy unit, appropriate policies and procedures and the environment. They took prompt action following the inspection to address the areas concern about the endoscopy unit.
- The hospital had a dashboard to monitor performance which was reviewed both locally and regionally. This provided the leadership team with a comprehensive overview of several key performance and safety measures including staffing levels, agency use, incidents, wound infections, mortality, complaints and cancelled surgeries. Performance was reviewed by the senior leadership team at regional meetings and recommendations for improvement were tracked to ensure they were completed.
- The clinical governance structure included committee meetings at both clinical and operation levels including specific risk management, health and safety and clinical effectiveness meetings. These reviewed performance and daily operations at the hospital. A monthly children's and young person's committee has been established since our last inspection which provided oversight of clinical and operational performance specific to these services.
- Oversight at a regional level was provided by a clinical governance tracker and through regular performance meetings which included discussion of local audits.
- The pharmacy manager attended clinical governance meetings, the clinical practice group, and mortality and morbidity meetings.
- The Medical Advisory Committee met three monthly and items discussed included clinical incidents, complaints, accreditation and credentialing. I
- BMI had expectations of the way their services were managed. This promoted consistency, for example in risk management, and enabled comparisons between the hospitals.

Good

Surgery

- Staff meetings reviewed training, policies, previous meeting minutes, contracts, incident reporting, equipment, cleanliness, safer steps to surgery and any other issues staff wanted to raise.

Public and staff engagement

- Monthly bulletins were sent to staff which included both hospital and regional BMI information. These included learning from incidents, reminders and updates about guidance and procedures, and safety alerts. Staff were able to tell us about these.
- There was a comments and suggestions box for staff to use anonymously to encourage change and improvements.
- There was a poster on the wall with 'You said, we did'- this was a scheme that took suggestions and comments from staff and those that were implemented were showcased.
- During our last inspection, the executive team acknowledged that they wanted to improve patient communication. This included encouraging patients to feedback on the services, and setting up regular patient forums. We saw no evidence of this during our inspection.
- The NHS Friends and Family Test response rate was low, ranging between 26% and 60% from October 2015 to March 2016. Between 97% and 100% of patients and their relatives and friends would recommend the hospital. There were a wide variety of comments regarding the care and facilities provided within the hospital. Most of the comments indicated that patients were pleased with the level of care that they received, however some patients felt that the information they received was not always in enough detail.
- We saw evidence that front line staff were engaged in discussions about a variety of subjects including staffing levels, incidents, and training. Staff told us they had opportunities to raise any concerns or suggestions at regular meetings with their manager
- The hospital had an employee of the month scheme where a member of staff was recognised each month for their contribution or dedication.
- There was also a 'making a difference' award given to staff that had gone above and beyond their role or had done something outstanding for patients or another member of staff.

Innovation, improvement and sustainability

- It had been agreed with the local NHS hospitals that BMI Blackheath would carry out bariatric surgery, due to local demand. The surgery had been risk assessed and agreed with consultants, the quality and safety team, heads of department and the theatre team. Within their meetings they felt that they had covered all possible scenarios and eventualities of things that could go wrong and were satisfied that the surgery was safe and should go ahead.
- The endoscopy unit was due to be rebuilt in the near future. Planning permission had been agreed prior to our inspection.
- Theatre staff were encouraged to progress and develop. We met a number of staff that had trained to get to their current level of competence through the hospital and had been supported to do so.
- The Blackheath Hospital was moving towards opening an ambulatory care area within the main hospital. This would allow more medical patients to be seen and cared for from the urgent care centre. This was noted in the hospital managers' team meeting in April 2016 and several staff could tell us about these plans for expansion.

Good

Outpatients and diagnostic imaging

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

Information about the service

BMI The Blackheath Hospital Outpatients department (OPD) is in a four storey building called Winchester House. It has 22 consulting rooms, 2 minor surgery rooms, cardiology department, phlebotomy and diagnostic imaging. From April 2015 to March 2016 there were 50,200 outpatient attendances. The OPD offers a range of specialist clinics including orthopaedics, gynaecology, cardiology and ear nose and throat (ENT). There is a physiotherapy department within outpatients, which provides a range of therapies for post-operative and self–referral patients.

There is an outpatient's oncology service with a six bay chemotherapy day unit in the main hospital. The oncology service is open from Monday-Friday 9am to 5pm. The hospital treats around 40 cancer patients per month.

The diagnostic imaging department is located between the main hospital site and the outpatient building. They provide a range of imaging facilities including x-rays, computerised tomography (CT), and Magnetic Resonance Imaging (MRI) scanning. Radiographers provide a 24-hour service for inpatients.

For the period April 2015 to March 2016 there were 48,953 adult attendances.

The hospital also provides outpatient clinics for children aged 0-17 years old. From April 2015 to March 2016 there were 4745 attendances of children and young people in the OPD. They provide paediatric trained nurses to assist with clinics. Resident Medical Officers (RMOs) are trained in advanced paediatric life support.

We visited BMI The Blackheath Hospital during an announced inspection on 12 and 13 July. We spoke to 14 members of staff including managers, consultants, nurses and healthcare assistants. We spoke with six patients and two relatives. We looked at ten sets of medical records, and reviewed other information on display or provided to us.

Good

Outpatients and diagnostic imaging

Summary of findings

Overall, we rated OPD, and diagnostic imaging as good.

- BMI the Blackheath Hospital had improved on several areas of care provision following the last CQC inspection including new flooring in outpatient areas, carrying out audits and employment of specialist paediatric trained staff nurses.
- There were systems to ensure incident reports were investigated and lessons learned. Staff understood the duty of candour, although some staff felt it was the medical staff's duty to complete this, instead of the nursing staff. 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.
- We observed good infection prevention and control (IPC) practices but not all equipment, such as chairs, met IPC standards. New flooring was being installed and work was due to finish in August 2016 following recommendations during the last inspection. Clinical equipment was serviced, appeared clean and functioning. Daily monitoring of resuscitation equipment had taken place.
- The training information provided showed 89% to 100% of staff had attended mandatory training. Medical staff, employed by the hospital, had all training via their employment agency.
- Most staff had completed intermediate life support training and there were paediatric-trained staff to care for children under the age of 18. Staff told us they could ask for additional courses and managers would support them.
- We saw use of evidence based practice and national guidelines.
- Assessment of patient risk was completed and there was an admission exclusion criterion for patients whose conditions were acute or significantly complex. The services had protocols and guidelines to assess and monitor patient risk such as a new World health Organisation (WHO) surgical checklist for minor operations in outpatients. The WHO checklist is a simple tool designed to improve the safety of surgical procedures by bringing together the whole operating team to perform key safety checks during vital phases of surgical procedures.
- We saw consent was completed correctly, however, some staff did not know how to complete consent for patients who lacked capacity.
- Following the previous inspection there was evidence of local audits through the departments, and staff showed how these had driven improvement and change in the services.
- Staff provided dignified, compassionate and respectful care. Patients and their families were positive about the care they received at the BMI Blackheath Hospital. They told us they felt involved in their care and staff were very helpful.
- The service was meeting the 92% target for NHS referral to treatment time of 18 weeks most months. Privately funded patients rarely had a wait to see a consultant, and patients told us they had not experienced long waiting times.
- The BMI Blackheath Hospital was benchmarked against other BMI providers and staff told us they were attempting to improve their current low standing.
- Staff were positive about working in the service and felt encouraged to make suggestions for improvement. They showed us examples of new equipment they had received following these suggestions.
- Staff told us there was strong teamwork and managers were visible and easy to talk to.

Good

Outpatients and diagnostic imaging

Are outpatients and diagnostic imaging services safe?

Good

We rated the service as good for safety. This was because:

- The departments had systems to minimise patient risks, which were used by staff to ensure patient safety.
- There were effective incident reporting systems and staff felt confident in using them. They told us they received feedback from incidents through meetings and a written communication book.
- Staffing levels were adequate across all the services to meet patient need. Staffs' safeguarding concerns were completed appropriately and staff knew who to contact if there were any concerns of abuse for both children and adults.
- The environment was clean, tidy and equipment was fit for purpose.
- A new World Health Organisation (WHO) checklist had been created for patients undergoing minor surgery to ensure patients were as safe as possible during their procedure.
- The dedicated oncology suite in May 2014 achieved the Macmillan Quality Environment Mark which involved an external assessment of the environment.

However,

- Some chairs did not meet infection control standards as they could not be thoroughly cleaned in both the OPD and oncology suite. New flooring was being put into place and work was due to be completed in August 2016.

Incidents

- There were 39 incidents in the OPD and three in the diagnostic imaging department from April 2015 to March 2016.
- In the same period there were no serious incidents or never event across the services we inspected. 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 occurrence of a never event could indicate unsafe practice.
- Staff described the type of incidents they would report and showed us the paper system used to record incidents. These would then be entered onto a computer system by the Quality and Risk manager.
- Staff across OPD and diagnostic imaging told us they felt confident in reporting incidents and were encouraged to do so by senior staff.
- The OPD held a daily one o'clock meeting where they discussed any incidents, which had occurred in the department and learning from these. Heads of Department across the hospital met at 10am each morning to discuss any incidents they had in their department.
- The OPD had a folder with incidents and their outcomes so staff could refer to these for learning purposes if they could not attend the one o'clock meeting.
- A senior member of staff told us it would be up to the consultant to ensure duty of candour was upheld if required. Junior staff described the process of being open and honest with patients if something went wrong. Radiology staff had posters promoting duty of candour and explained what they would do if there was a patient incident in their area. The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support to that person.
- There had been no incidents reported to the CQC resulting from a patient undergoing a medical exposure to the Ionising Radiation (Medical Exposure) Regulation 2000 (IRMER) in the year prior to inspection.

Cleanliness, infection control and hygiene

- Clinical areas were visibly clean and tidy.
- A recent infection prevention and control (IPC) audit of the OPD showed there was poor flooring and décor and areas were cluttered. Since the last inspection new flooring was being installed in outpatient areas. This was on-going and completed rooms were fresh and bright with new paint.
- New chairs did not meet IPC standards as they had fabric covers in both the OPD and oncology suite. Staff told us they could be cleaned but the IPC lead nurse confirmed this was not the case. The BMI corporate team were aware of this but there was no current solution.

- Domestic staff we spoke to told us the consulting rooms and imaging rooms were cleaned daily. We saw checklists had been completed to indicate areas that had been cleaned.
- Hand hygiene audits were completed by all the departments we visited and junior staff were encouraged to assist with this. Bare below the elbows compliance was 100% and hand hygiene compliance was between 70% and 100%. The IPC lead nurse told us they were trying to carry out more teaching around hand washing to improve these numbers.
- There were hand washing facilities in each consulting room and hand gel in all patient areas. Personal protective equipment (PPE) including gloves and aprons was available for staff in all clinical areas.
- Children's toys were cleaned after each use and stored securely when not in use.

Environment and equipment

- There were resuscitation trolleys throughout the OPD, oncology suite and imaging departments. Adult resuscitation trollies were checked daily with no equipment noted as missing.
- There was a dedicated children's resuscitation trolley which was shared with the urgent care centre (UCC). This was checked daily and labels were used for easy access to the correct size of equipment appropriate to the size and age of children. If any children were having a minor operative procedure this was taken to the required consulting room or minor operative theatre.
- None of the staff we spoke to had concerns about accessing equipment. A senior member of staff in the OPD had implemented a tracing system for instruments used in minor operations, which had meant the equipment they received was more reliable.
- All equipment we checked was clean and stored appropriately. There was evidence of safety checks having been undertaken.
- One consultant used a laser machine, which they bought in to the department themselves. This had a full audit trail and regular checks, which we saw on inspection. There was a laser protection supervisor named on documentation and fire proof doors were in place. A recent audit by an NHS trust showed that there were no concerns with its usage and they were fully compliant with necessary regulations.
- The reception for OPD was open and patients and staff could communicate easily with others.
- Radiology staff had access to the appropriate protective equipment to carry out x-rays and scans. We saw radiation output testing results which showed equipment was safe for use. Warning lighting above the x-ray and scan rooms to indicate when the rooms were in use was in working order during our inspection.
- Oncology patients were cared for on a dedicated oncology suite which had six bays. In May 2014 the hospital achieved the Macmillan Quality Environment Mark which involved an external assessment of the environment. The assessment concluded that the environment was welcoming and modern with comfortable armchairs for patients and screens to maintain their privacy.
- There was an extravasation kit available if needed for those patients undergoing chemotherapy. Extravasation is when a chemotherapy medication or other drug leaks outside the vein onto or into the skin, causing a reaction.
- In oncology, the sink had shown positive for pseudomonas however this had been rectified in April 2016 and was now safe. Nursing staff told us there was on-going monitoring of this.

Medicines

- Prescription pads were kept locked away in the OPD. The keys to obtain the pads had to be signed out and back in again at the beginning and end of each shift.
- The OPD kept some pre-packed medications for patients to take home if required. The stock levels were recorded on a spread sheet and when the levels were low staff would order more stock. This meant the team knew which member was responsible for ordering and ensuring the medications arrived.
- Emergency drugs in the OPD were checked daily and fridges were locked and temperatures checked. No controlled drugs were kept within the department.
- We saw a medication error had prompted a change in the way medications in the outpatients department were stored to avoid the wrong drug being dispensed.
- Chemotherapy drugs were stored securely in the pharmacy, and transported to the suite as required. There was a new e-prescribing system for chemotherapy patients, which improved the reliability and safety of prescribing regimes.
- There was a chemotherapy spillage policy and we saw the spillage kit was easily available.

- There were appropriate processes in place for the disposal of chemotherapy drugs, overseen by the facilities manager.
- For oncology clinics held out of hours the pharmacy manager could keep the department open to provide local support if required. There was a 24 hour on-call service if staff needed help with medications.

Records

- During inspection we looked at 10 sets of patient's records for outpatients.
- These included modified WHO checklists for patients undergoing minor procedures.
- Medical records for NHS patients were kept in the medical records department and this was in a building near the outpatients department. A recent flood had destroyed some old records, which prompted consultants to destroy historic notes.
- Following the flood staff had moved all records to a secure room within the building. Locked bags were used to transport any notes moving around the hospital. Staff told us there was never any issue with providing patient notes at the time of their appointment.
- Records for privately funded patients were held by the Consultants. As part of their practising privileges they were expected to read and understand information governance policies. Staff told us the medical secretaries could keep notes and consultants should be registered with the Information Commissioners Office (ICO). This is an independent authority set up help data privacy for individuals.
- The physiotherapy department had previously had problems obtaining patients notes when they came for an appointment. This meant at times they were unsure of the consultant's instruction. This was rectified by communication with consultants, and in response the ward had started faxing operation notes and ward therapy notes to the outpatient physiotherapists. Consultants completed a referral form for those patients referred directly from outpatient's clinics.
- Notes were tracked via an online tracker ensuring traceability. Once notes were finished with they would be taken away to a secure off site storage location and scanned on to the computer.
- We looked at five sets of paper patient records in the chemotherapy suite. We saw that Consultants documented medical management plans. There was evidence of appropriate discussion about ceilings of treatment and care plans were in place. The names of the consultant and nurse reviewing the patient were clearly documented and notes were signed and dated.
- The notes indicated that all patients were assessed before starting chemotherapy, including a review of blood tests and a record of weight.

Safeguarding

- The hospital had up-to-date safeguarding policies and procedures for both children and adults. Staff knew the safeguarding leads in their areas and how to contact them.
- Staff we spoke to understood how to raise a safeguarding concern and they told us for adults they would complete a capacity assessment and contact the GP if there were any safeguarding concerns.
- OPD had not had any safeguarding referrals or concerns in the last 12 months.
- Safeguarding training was mandatory for all staff and all registered nurses were required to complete level two as a minimum. Information provided pre-inspection showed 96% of OPD staff were trained to level two. 100% of oncology staff were level 2 trained. All paediatric nurses were trained to level three, which is in line with the "Safeguarding children and young people: roles and competences for health care staff intercollegiate document" 2014.
- When children's appointments were booked for clinic the paediatric nurse ensured level three trained staff were available for the duration of the clinics.
- The hospital had a chaperone policy, which was visible in all patient care areas. Staff told us some clinics such as gynaecology would have a dedicated nurse so all patients could be chaperoned. We saw documentation of a chaperone being present during a consultation in several patients' notes.
- All staff we asked told us they would feel confident to challenge any concerning practices or behaviours.

Mandatory training

- Mandatory training for staff was a mixture of online e-learning and face to face sessions.
- Information we received pre-inspection showed between 89% and 100% of staff in the departments we inspected had completed their mandatory training up

to 16 May 2016. One staff member told us if they had to do it at home this would be paid time. Most staff told us they were given protected time to complete their mandatory training.
- Training was monitored online and each staff member had a password protected training account. This meant the staff could be alerted when a module was due to be completed. Managers had access to this and would remind staff if they had not completed their training.
- The resident medical officer (RMO) completed all mandatory training through their agency including advanced life support.

Assessing and responding to patient risk

- Receptionists told us they would try to identify any outpatients who were unwell on attending. They would call the nurse or RMO to see patients urgently. They gave examples of when this had happened. However, reception staff told us they had no training in identifying the deteriorating patient but would always ask the nurse in charge or RMO for advice if they were concerned.
- OPD had exclusion criteria for patients who were not appropriate to be seen in the department. It included those with acute major illnesses and very complex medical problems. These criteria ensured patients were seen safely by staff.
- The OPD met with staff across the building in the morning to allocate staff roles in the event of a cardiac arrest or patient emergency. This was visible on the board in the OPD staff room. Staff carried bleeps for such an emergency. Response times were audited during the daily checks.
- There was a bleep system set up in each consultation room so staff could alert others in case of an emergency.
- If a patient became acutely unwell during their time in OPD, imaging or oncology an ambulance would be called. We saw a policy for this during our inspection. Staff would stabilise the patient and then transport them to the nearby accident and emergency. Staff gave examples of this happening whilst we were on inspection and stated there was never a problem with ambulance waits. They told us they had good relationships with the local hospitals and would ring them to make them aware of the patient.
- Radiology had a specific safety checklist for CT and MRI scans to ensure patients were not given contrast if they had certain health problems. There were protocols to follow if patients did have medical problems and needed blood tests prior to their scan.
- Women of child bearing age were tested for pregnancy prior to any diagnostic procedures and this was documented in their notes.
- The OPD had designed a new World Health Organisation (WHO) checklist to provide safer care for patients undergoing minor operations. This had been put into practice in July 2016. The notes we looked at had completed this for each procedure and during the procedures we observed staff used the WHO checklist appropriately.
- There had been five cases of neutropenic sepsis recorded by the hospital since April 2016 until the time of inspection.
- The neutropenic sepsis policy was understood by nursing staff, who told us how they would respond promptly to signs of sepsis which might arise as a result of a patient's lowered immune system.
- We saw that there was a 24 hour on call phone which was held by one of three trained chemotherapy nurses. All of the nurses had specialist UK oncology nursing society (UKONS) triage training. All patients were encouraged to call the number if they showed signs on neutropenic sepsis. They were asked to present to the main hospital and once the patient arrives the RMO and nurse in charge would care for the patient.
- We saw a flow chart on the wall of the unit, which highlighted the pathway to follow if they suspected a patient had neutropenic sepsis. Consultants agreed to be available to follow up on signs of sepsis.
- Staff told us that the RMO or consultant would respond quickly if a nurse raised concerns about neutropenic sepsis. They could then admit patients for further observation and intravenous antibiotic administration if necessary.

Nursing staffing

- The OPD was staffed according to the number of clinics running. There was a minimum of one trained nurse on alongside a nursing sister. Healthcare assistants (HCAs) were used to assist in clinics.

Good

Outpatients and diagnostic imaging

- There were paediatric trained nurses on the ward and a bank staff of paediatric nurses when required, to ensure patient safety. There was five full time paediatric staff between the ward, OPD and UCC.
- There was no use of staff acuity tools. Senior staff told us staff turnover rates were high, 30% from April 2015 to March 2016 but were unsure why this was. This often left the unit needing to use bank staff to ensure patient safety. They told us they had not needed to use any agency staff until the week prior to our inspection.
- Bank and agency staff were given an induction in all the departments we inspected. There was no induction checklist for nurses but physiotherapy had a comprehensive competency based induction checklist.
- The chemotherapy suite was fully staffed by trained chemotherapy nurses. There were processes in place for staff from hospitals in south London to cover for each other in the event of more than one nurse being on leave or sick.

Medical staffing

- Each consultant worked in set clinics and saw each person on their specific list. Staff told us clinics rarely ran late and patients were seen in a timely manner.
- Radiologists had set slots each week and a breast care specialist attended twice per week to carry out mammography clinics, meaning patients only had to attend once to have all their tests done.

Major incident awareness and training

- Staff in the OPD told us the major incident policy was available on both the intranet and in paper form in the major incident folder which we saw.
- There were fire marshals available on each floor of the building and high visibility tabards were available for these staff. Each staff member understood their responsibility in evacuation in case of a fire.
- Senior staff told us they did not practice for terrorist attacks as they would not be able to admit patients in this instance.

Are outpatients and diagnostic imaging services effective?

Good

We report on effectiveness for outpatients below however we currently do not rate.

- We saw evidence based care was informed by national guidelines, policies and protocols.
- Diagnostic imaging provided a wide range of services with prompt reporting of images.
- Local audits were completed and staff showed us ways in which they had driven improvement, for example documentation for patients having minor operations had improved significantly since audits had been undertaken.
- Staff were offered courses to improve their clinical knowledge and skills. Revalidation for nurse was on-going and staff felt well supported in completing this. Revalidation for nurses is a new scheme set up by the Nursing and Midwifery Council (NMC) to ensure that nurses and midwives are practising safely and effectively.

However;

- Appraisal rates across OPD and imaging were low and senior staff told us they aimed to improve this year.
- Staff were unclear of their responsibilities in relation the Mental Capacity Act 2005. They could not describe the way to obtain consent for a patient who lacked capacity.
- There was no formal on call rota for radiologists.

Evidence-based care and treatment

- Clinical staff we spoke to were aware of relevant clinical guidelines in their areas including the National Institute for Health and Care Excellence (NICE). Radiologists followed guidelines from the Royal college of Radiologists.
- We found that equipment such as ultrasound and laser devices had been subject to recent and regular audit. The hospital told us the diagnostics and imaging department carried out a programme of ionising radiation (medical exposure) regulations (IRMER).
- Standard operating procedures we viewed were referenced with evidence of best practice and national guidelines.

Good

Outpatients and diagnostic imaging

- Guidelines were easily accessible on the hospital intranet or as a hard copy although staff were aware this may not be the most up to date version. We saw that policies and procedures referenced NICE.
- There was evidence of a wide range of local clinical audits. The OPD carried out documentation audits on the minor procedures pathway. Initially the team found minor procedure post-operative observations were not routinely carried out. In response the senior nurses carried out teaching on the importance of post-procedure observations and as a result, there was almost 100% compliance rate.
- Senior staff audited staff response times to emergency bleeps to ensure staff were responsive to emergencies. They initially checked the bleep system at the same time every month but, after discussion now completed the check at a random time and this had improved staff response times.
- Physiotherapy had completed audits to help consultants improve recovery treatments through the use of specialist equipment and how these affected recovery.
- Diagnostic reference levels (DRLs) for different scanners were available in each imaging room for staff to refer to if required and these were complaint with national dose levels. Reference levels give radiographers a guideline of how much radiation should be used for different parts of the body to achieve an adequate scan picture.
- Radiology had audited the number of x-rays that had to be retaken to assess if teaching needed to be carried out on patient placement for best imaging. The senior manager did not find there was a specific issue and told us they would continue to audit.
- Oncology consultants working at the trust worked for neighbouring NHS trusts and followed national guidance on chemotherapy treatment such as NICE and UK Oncology Nursing Society (UKONS).
- We saw that there were up to date policies in the chemotherapy suite, such as the extravasation and neutropenic sepsis policies. Nursing staff were able to tell us how they followed these policies.

Pain relief

- Patients were advised to contact their GP if they required further pain relief on leaving the department.
- Outpatients could contact their consultants directly if they were experiencing pain. Patients we spoke to said they had been given the number of the consultant's secretary or the consultants themselves if they had pain.

Patient outcomes

- Staff told us diagnostic test results were available in a timely manner and for all consultations. As the system was online results were available in a matter of minutes in most cases. This meant treatment could commence the day the patient saw their consultant if necessary. We did not see any evidence that they were recording the length of time it took to process test results.

Competent staff

- Nurses we spoke to were preparing for revalidation and had begun to prepare their portfolios. They had received feedback from consultants, peers and patients for evidence.
- Revalidation for nurses is a new scheme set up by the Nursing and Midwifery Council (NMC) to ensure that nurses and midwives are practising safely and effectively. Nursing staff, we spoke to felt well supported in preparing for revalidation.
- Medical revalidation for RMOs was managed through the agency with which they were employed.
- Consultants had to complete revalidation as part of their practising privileges. The human resources department followed up any issues of doctors who did not have revalidation.
- Appraisal rates for the outpatients department nurses April 2015- Mar 16 was 50% for both nurses and healthcare assistants. This was a low number of staff receiving appraisal. However, from April 16 to the time of inspection 55% of nurses and 25% of health care assistants (HCA) had received an appraisal. Senior staff told us they aimed to significantly improve the year's appraisal rate.
- Staff we spoke to said their appraisals were completed online in two stages. Their appraisal had allowed them to ask for further courses and discuss their progressions within the department. We saw some completed appraisals, which showed learning and improvements.
- Staff we spoke to had the opportunity to attend courses such as immediate life support and advanced life support to improve their ability to care of patients safely.

- RMO appraisals were completed by the agency with which they were employed and consultants had to provide evidence of appraisal to renew their practising privileges.
- All newly appointed permanent staff had an induction programme; however, a bank staff we spoke to had not received this, and had not completed mandatory training. They told us they had read the policies and procedures online and had asked to be put onto the induction programme.
- Staff looking after children in OPD clinics had paediatric life support training and some had advanced training in this area. We saw paediatric staff assisting UCC staff with a child who had a complex medical problem and required bloods to be taken.
- The physiotherapy department and RMO used 360 degree feedback to improve their practice. This is a system or process in which employees receive confidential, anonymous feedback from the people who work around them. The physiotherapy department had "Champions" in certain areas such as training and quality. These champions would teach other team members best practice and complete audits.
- All nursing staff in the oncology suite were trained chemotherapy nurses and had regular competency reviews.
- We saw that the RMO had mandatory training in the use of Chemotherapy agents for oncology patients.
- The senior oncology nurse, the breast cancer nurse and another nurse on the chemotherapy unit had attended advanced communication skills courses. This meant that they could give better support to patients and were available on the telephone when patients wanted to discuss aspects of their treatment or wanted someone to talk to.

Multidisciplinary working

- The physiotherapy department worked closely with consultants and had produced protocols for certain surgical procedures, such as knee and hip surgery rehabilitation. This allowed staff to provide continuity of care for patients and ensure they were working to best practice guidelines.
- Ward patients would have their operation notes and wound dressing requirements faxed to the physiotherapy and outpatients department. Patients could then be booked in for wound dressing changes prior to discharge by the outpatient's staff. Physiotherapists were aware of what rehabilitation patients required from their ward notes.
- The OPD worked closely with patients and children's GPs to ensure all follow up and concerns were communicated appropriately. This meant care for these patients was safe and continuous.
- We observed consultants and nurses working well together during minor operations in the outpatients department.
- We observed, and staff told us, of close working between the medical oncologists who worked at the hospital, the nursing team, the breast cancer nurse and the physiotherapist. Nurses said consultants were available at any time if they had concerns about a patient.

Seven-day services

- The radiology department was open from 08.30am -08.30pm Monday and Friday and 08.30am-1pm on Saturdays. Outside this time outpatients would go to the main hospital department. There was a 24 hour on call radiographer.
- There was no formal on-call radiologist rota. This may compromise patient safety if there was an unwell patient who required a scan report. The manager of the department told us meetings were underway to have a formal rota but this was ongoing. They told us there had never been a problem having a scan reported up to the time of inspection.
- The oncology service ran from 9am to 5pm during the week, with two evening clinics to make appointments flexible for patients.
- The pharmacy department could keep the department open out of hours to provide support to patients and staff undergoing or giving chemotherapy. There was a 24 hour on-call service.

Access to information

- Physiotherapy patients were sent information via an online system, which provided exercise videos and patient leaflets.
- Radiographers could access NHS scans and x-rays for patients on an online system. Radiologists could access the PACS system anywhere there was a computer allowing fast reporting of imaging.

Good

Outpatients and diagnostic imaging

- Policies and procedures were accessible to all staff via the intranet and staff showed us how they would access these.
- Patients received an information pack and a chemotherapy handbook, which was personalised for each patient and gave them information about their treatment and possible side effects.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff we spoke to lacked knowledge about the Mental Capacity Act 2005 and the deprivation of liberty safeguards.
- One senior member of staff explained they would organise a best interests meeting if there was a concern. However, most members of staff were unclear about their responsibilities in relation to the Mental Capacity Act 2005. They were unable to describe the correct procedures for obtaining consent from someone with limited capacity.
- Paediatric staff told us they would employ different methods of gaining consent dependent on the child's age. They described certain judicial rulings that governed consenting older children such as Gillick competencies and Fraser Guidelines.
- We examined six sets of notes and the consent forms we saw were all completed correctly.
- Consent for chemotherapy treatment was documented in the five sets of records we reviewed.

Are outpatients and diagnostic imaging services caring?

Good

- We rated the service as good for caring. This was because:
- Patients and their families were positive about the way staff treated people. Patients said the care they received was person centred and staff were helpful.
- Patients told us they were active partners in their care and felt fully involved in decisions around treatment.
- People's emotional needs were valued by staff and were embedded in their care and treatment. Breast cancer patients could attend a peer support group to talk about their experiences.

Compassionate care

- Patient feedback was generally positive across the areas we inspected.
- Patients and their families described staff as "polite and efficient". Parents told us they felt "impressed and spoilt" with the care their child had received.
- We observed receptionist being kind and courteous to patients. We observed nursing staff were empathetic and supportive to patients undergoing minor operations.
- Scores for Patient-led assessment of the care environment (PLACE) for BMI Blackheath were generally the same as or higher than the England average. However for privacy dignity and wellbeing it was lower than the England average. PLACE is a National Programme, which assesses the service environment from a non-clinical perspective, for the purpose of improving services.
- The outpatients Friends and Family postcard result for February 2016 indicated 99.5% of patients would recommend the service.
- We looked at patient feedback in the outpatient's physiotherapy department which included "I was always listened to" and "professionalism and care is of a very high standard".
- Some patients mentioned the reception staff could be heard talking amongst themselves about personal matters and were seen putting on makeup. This made patients feel uncomfortable at times.
- The hospital had increased the presence of a palliative care consultant. The consultant saw cancer patients with limited options for further chemotherapy to treat them for symptom management. He also became involved in conversations with patients and their families to explain when further chemotherapy was not in their best interest.

Understanding and involvement of patients and those close to them

- Patients and families told us they felt involved at every stage of admission or appointment. They were able to ask questions and understood the information they were given.
- Children and young people's families told us they were kept up-to-date regarding care and what the treatment would entail.

Good

Outpatients and diagnostic imaging

- Patients and families told us they felt they had enough time to talk to doctors and nurses about their treatment, making them feel at ease.
- Fees were visible throughout the department so patients had some idea of how much their consultations may cost.

Emotional support

- We observed staff giving emotional support to patients and their families. They were encouraged and supported through treatment by ensuring both patients and relatives were given up to date information.
- We observed nursing and medical staff giving reassurance to nervous patients undergoing minor procedures in the outpatient department. Paediatric trained staff were able to give emotional support to both children and their families. There were no counselling services available but patients could be referred back to their GP for this if necessary.
- The senior nurse and the breast nurse specialist had set up a support group for patients which had been well received by patients. We saw evidence of this in the "BMI Matters" newsletter.
- The feedback from the support group was very positive and noted things such as "a feeling of belonging to a group of lovely people" and that it was "supportive and interesting".
- Staff told us of one patient who they asked a priest to see in the last hours of life for emotional and spiritual support.
- Staff referred patients to a psychiatrist if they had further need for emotional support.

Are outpatients and diagnostic imaging services responsive?

Good

- We rated the service as good for responsive. This was because:
- Staff planned and delivered services in a way that met the needs of the local population. Clinics and physiotherapy clinic times had been extended to allow people to access the service more easily.
- NHS patients were mostly seen within the 92% target for 18 weeks referral to treatment time.
- Care and treatment was coordinated with other providers, including local hospitals.
- There were low numbers of complaints throughout the service. Patients could complain or raise concerns and were treated compassionately if they did. Staff dealt with complaints in an open and transparent manner.

Service planning and delivery to meet the needs of local people

- Since our previous inspection the hospital had developed its children's services. It provided paediatric trained nurses in the OPD.
- Physiotherapy had extended its opening hours from 9am-5pm to 730am to 6pm to cater to the local population as patients had said they would like to be able to attend before and after work.
- Staff we spoke to told us they aimed to accommodate all patients' needs when having oncology treatment. Staff told us they would come in early or stay late if required ensuring patients could have the appointment slot that was most convenient to them.

Access and flow

- OPD patients booked in at a separate reception area to UCC. Waiting times for patients to see their consultant once they had arrived in the clinic were not recorded by outpatient staff.
- We were told patients waited no longer than a week to be seen once their GP had referred them to their specific consultant. Some clinics such as neurosurgery had longer wait times as these clinics ran on a two weekly basis. We saw evidence some NHS ear nose and throat (ENT) patients were waiting over three weeks to see a Consultant due to the demand on the service.
- Staff we spoke to told us the maximum time a privately funded patient would have to wait for an appointment would be a week from GP referral although we did not see evidence supporting this. Patients we spoke to confirmed they had waited less than a week to be seen.
- OPD did record the number of "did not attend" (DNA) for NHS patients. Information provided to us showed 50% of clinics had exceeded the target of 5% of patients who did not attend their appointments in June 2016. Consultants told us if patients did not attend they would normally telephone them. NHS patients who DNA would be referred back to their GP if they had not given prior notice that they would not attend.

Good

Outpatients and diagnostic imaging

- NHS patients met the 92% target for Referral to Treatment within 18-weeks each month from April 2015-March 2016, except August and September 2015.
- There were exclusion criteria for patients wishing to have inpatient treatment following and OPD consultation. This included a Body Mass Index (BMI) greater than 41 and if there was a serious anaesthetic risk or active or recent psychiatric illness. These ensured patients were not given treatment or care where the hospital could not provide the required level of support.
- If a patient needed an unplanned admission from outpatients there was a pathway for staff to refer to. It included the use of the emergency admission pack, which we saw during inspection. It included an observations chart, reservations form and the referral letter from the RMO or consultant. An emergency ambulance could be called or family could take the patient to the hospital.
- The hospital provided a range of scans and x-rays including mammography (breast screening), DEXA scanning (bone density scans), CT and MRI scans, pathology and physiotherapy. Patients told us the choice of treatment was adequate and they could complete all treatments in one day, meaning they did not have to travel to the hospital multiple times.
- Most patients had blood tests the day before they came for oncology treatment so they did not have to wait for the results before receiving chemotherapy. Oncology consultants reviewed patients at every cycle of chemotherapy.

Meeting people's individual needs

- Staff told us they had training in caring for patients living with dementia and learning disability. We saw that 93% of staff within the BMI Blackheath hospital had received this training within the last year. Training targets were set at 90%.
- Staff told us they would help this patient group by asking their carer to come with them to appointments. Staff knew of no other changes they would make. One nurse told us they would ask the nurse in charge what to do if someone with dementia or a learning disability was booked into a clinic.
- We were told by reception staff there was no way of identifying this patient group at the time of booking appointments. If a person living with dementia or a learning disability was identified when booking an appointment, booking staff would inform reception.
- Translation services were provided through a telephone language line service. Staff told us they would use this if necessary, but it was rarely required. Leaflets in patient care areas were not translated into other languages.
- There was a hearing loop in place for those with hearing difficulties.
- The chaperone policy was visible in all waiting and treatment rooms and staff told us this could be accessed on the intranet. Clinics such as gynaecology had a one to one nurse for all consultations.
- There were parking spaces for those with mobility issues and for patients in a wheelchair.
- The radiology department had appropriate changing facilities and gowns for patients.
- Paediatric clinics were grouped together. To make the waiting room more child friendly, the paediatric nurse provided toys and books suitable for children.
- Patient leaflets were readily available throughout the outpatients and urgent care areas.
- Oncology services were patient focused and nursing and physiotherapy staff were developing new services to cater for different preferences. The physiotherapist provided exercises, acupuncture and reflexology for patients if they wanted these. It had been agreed that she would train to provide a lymphedema service, as the hospital had been unable to recruit to this post. An additional part-time physiotherapist would be appointed to give her more time for these additional duties.

Learning from complaints and concerns

- Information on how to complain was visible in the waiting areas. Staff understood what to do it a patient wanted to make a complaint.
- We saw that staff should send an acknowledgement within two days of receiving the complaint and a full response within 20 working days. We saw 100% of complaints were dealt with within 20 days.
- There were 66 complaints received about the OPD and three for imaging. Trends included complaints about consultants and delays in appointments and treatment.
- Staff told us complaints were dealt with by senior managers. There was a paper form to complete for all complaints including informal complaints. We saw these during our inspection.

Good

Outpatients and diagnostic imaging

- If the complaint could not be resolved informally a full investigation would take place. This would involve the patient's consultant and the quality and risk manager when required.

Are outpatients and diagnostic imaging services well-led?

Good

- We rated well –led as good for the service. This was because;
- The leadership structure for Outpatient Department (OPD) and imaging was overseen by the Director of Clinical Services. There was a Clinical manager for OPD who managed consulting rooms and Urgent Care Centre (UCC). The operations manager managed the OPD appointments team alongside their team leader.
- The Oncology service was managed by the Clinical Services Inpatient Manager and Director of Clinical Services.
- Staff were focused on providing patient centred care and ensuring a good patient experience. Staff told us managers were visible and they felt well supported.
- There had been improvements since the last inspection in February 2015 and staff told us they felt valued. Managers listened to their suggestions for improvement and change.
- The leadership and governance aims to improve practice and regular governance meetings took place. Action plans were completed following these meetings and followed up by heads of department and the quality and risk manager. Staff told us they had regular learning opportunities from incidents.
- Staff told us their practice was benchmarked against other BMI hospitals and they would receive feedback on patient comment cards.
- Staff enjoyed working at the BMI Blackheath and felt there was a strong ethos of teamwork and patient centred care.

Leadership / culture of service

- The leadership structure for OPD and imaging was overseen by the Director of Clinical Services. There was a Clinical Manager for outpatients who managed consulting rooms and UCC. The Operations Manager managed the OPD appointments team alongside their team leader.
- Staff we spoke to told us they felt valued and appreciated as team members. Managers were visible during our visit and staff felt able to discuss issues and concerns openly. One staff member told us the executive director had thanked them directly for their hard work on the department's audits.
- Staff were able to tell us who their managers were and also who the senior hospital managers were. They told us they were supportive and felt there was a culture of openness.
- Junior staff were offered the chance to complete a leadership course. This was competency based and would help them progress their career. Several staff had completed the course and found it interesting and helped them gain new leadership skills.
- The oncology service was overseen by the director of clinical services and then the specialist oncology sister and oncology nurse specialist. The clinical governance team were an overall part of the service to ensure patient safety.

Vision and strategy for this this core service

- Staff discussed changes for OPD including an increase in the amount of medical admissions and possibly building an ambulatory care area.
- Paediatric staff had a vision of having paediatric specific consulting rooms, and had discussed this with senior managers who staff told us were responsive to this idea.
- Some staff told us about plans to increase the number of NHS patients using the service and there were meetings across BMI to determine how this could be done.

Governance, risk management and quality measurement for this core service

- The OPD had a daily lunchtime meeting which staff from both OPD and UCC departments attended. They discussed issues such as broken equipment, staff shortage and incidents. These minutes were kept in a book in the nurse's office so everyone could read them. Staff told us this was useful as they could be kept up to date with issues at all times.
- There were monthly governance meetings within the hospital. These were attended by the OPD, Imaging and

Physiotherapy managers and the executive team including the Director of Clinical Services. We saw recent meeting minutes, which included discussion of all incidents across the month, complaints and new clinical developments. They were well attended by senior staff.

- Feedback from the governance meetings for OPD staff took place in the 1pm meetings and recorded in a communications book so staff could refer back to information if they needed to. Diagnostic imaging staff had regular meetings and would feedback any issues to staff.
- A children and young person's committee had been set up since our last inspection. Attendees included the Quality and Risk Manager and the Executive Director. Discussions included further staff training in learning disability and audits needing to be completed. Senior staff told us they hoped to get other BMI hospitals to attend this in the future.
- Medical staff we spoke to sat on the Medical Advisory Committee (MAC). They met every two months and discussed issues such as consultant applications for practising privileges, feedback from the clinical governance meetings and the top five hospital risks. This allowed consultants to understand the wider issues in the BMI group and learn from incidents and complaints.
- The OPD clinical manager told us their practice was benchmarked against other BMI hospitals. This included staffing levels, billing rates and number of procedures carried out. We saw the Blackheath hospital was low in the ranking of other hospitals and the manager told us areas of improvement included billing practises.
- We saw a hospital wide risk register which documented operational, leadership, clinical and governance risks including staff training, implementation of a new incident reporting system and equipment maintenance. Staff we spoke to told us the risks within their area and about the use of the risk register.
- Staff told us a new online system was due to be implemented allowing incidents and risks to be electronically recorded. This would allow easier information sharing of risks and ensure improved patient safety.
- We saw that the oncology ward sister attended the hospital clinical governance meetings. We saw minutes for these and noted discussions around cancer care teaching and rectifying problems about contacting on call oncology staff.

Public and staff engagement

- Staff we spoke with told us about the employee of the month award. This was given for good patient feedback or nomination from other team members. Staff told us it was motivating to receive the award and encouraged good team work. The OPD Daily team meetings helped them to feel integrated with the UCC.
- Staff felt supported in their roles and several staff members had further study paid for to improve their knowledge and skills in caring for patients.
- Patients completed a comment card following their appointments. Comments on these included "excellent care" and "professionalism is of a very high standard". Staff told us they got feedback on these surveys through managerial feedback and the imaging department felt proud they had received a high satisfaction score from patients.
- The senior oncology nurse and Breast Care Nurse had set up a support group for patients with cancer. This gave patients the chance to discuss any problems they were having and get support from their peers. This was discussed in the MAC meeting in March 2016 and stated that it was receiving excellent feedback from users.
- A cancer care education day was held for staff in May 2016 to increase knowledge and confidence in nursing patients with cancer.
- The cancer support group was named via a competition which was won by a member of the group.

Innovation, improvement and sustainability

- Staff told us there had been positive changes since the last inspection. These included better nurse staffing, changes in the flooring and room décor.
- Staff gave us several examples of changes they had implemented to improve patient care. This included ordering a light for the minor operations theatre in outpatients.
- A paediatric nurse had designed and implemented a pain management chart using faces for children to express their pain rating. This had not previously been in place and its effectiveness was being audited at the time of our inspection.
- The physiotherapy department had asked managers for several pieces of equipment to improve the recovery of

patients. They had received this equipment and there were comments that patients had found the equipment very helpful. They have also helped with consultants audit data.

- Physiotherapy staff completed peer review forms for each staff member to drive improvement and praise good practice. We saw consultant's feedback on the service and the change in some treatments following this feedback.
- The Oncology Unit had Macmillan Environmental Accreditation. This is a detailed quality framework used for assessing whether cancer care environments meet the standards required by people living with cancer.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

Action the hospital MUST take to improve

Take action to mitigate the risks in endoscopy.

Action the provider SHOULD take to improve

Action the hospital SHOULD take to improve

Ensure all staff comply with infection prevention and control policies.

Ensure learning from incidents is consistently shared with staff and incidents reports are available for outpatients and the urgent care centre.

Be clear in their policies where they have deviated from national guidelines with regards to pregnancy testing female patients prior to surgery.

Increase the screening levels of MRSA compliance to targeted levels as set out in policy and procedure.

Ensure hand washing facilities on the wards are compliant with infection prevention and control guidance.

Produce infection prevention and control audits with quantifiable data to enable comparisons to take place and identify areas of good practice and those that require improvement.

Ensure theatre staff are aware of the correct disposal of wasted medications.

Review access to the operating theatre to make secure

Formalise and embed the triage system in the urgent care centre.

Review the secure locking system for medicines cupboards in theatres.

Formalise and embed the triage system in the urgent care centre.

Consider how it could introduce a system for staff to recognise if patients attending the urgent care centre are at risk or deteriorate while waiting to see the doctor.

Ensure that staff have a good understanding of the Mental Capacity Act2005 and how to care for and consent patients who may not have capacity to do so themselves.

Increase the uptake of appraisals for staff for all staff groups in all areas.

The hospital should benchmark itself against similar services to monitor its performance and identify areas of good practice or those that require improvement.

Ensure patients' privacy is protected when booking in at the urgent care centre.

Consider how access to occupational therapists could be improved.

Ensure staff have access to training about caring for patients living with dementia or learning difficulties and are aware of the dementia champion.

Continue to work to improve patient engagement.

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
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **The hospital had not taken all the necessary action to mitigate the risks in endoscopy.** **The hospital must take action to mitigate risks to patient safety in the endoscopy unit.**