BMI The Clementine Churchill Hospital

Quality Report

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

Ratings

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

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

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

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

Summary of findings

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

Overall summary

BMI The Clementine Churchill Hospital is operated by BMI Healthcare Limited. The hospital has 121 beds. Facilities include five operating theatres, an endoscopy suite, a minor procedures unit, six-bed level two and three critical care unit, outpatients and diagnostic imaging facilities.

The hospital provides surgery, medical care, critical care, outpatients and diagnostic imaging. The hospital provides services to adults and young adults over the age of 16; both private and NHS patients, as well as a paediatric non-interventional outpatients' service.

We inspected this service using our comprehensive inspection methodology. We carried out an unannounced inspection on 3 September 2019 to 5 September 2019 for outpatients, medical care and surgery and an unannounced inspection of critical care and diagnostic imaging services on 29 and 30 October 2019.

To get to the heart of patients' experiences of care and treatment, we ask the same five questions of all services: are they safe, effective, caring, responsive to people's needs, and well-led? Where we have a legal duty to do so we rate services' performance against each key question as outstanding, good, requires improvement or inadequate. Throughout the inspection, we took account of what people told us and how the provider understood and complied with the Mental Capacity Act 2005.

The main service provided by this hospital was surgery. Where our findings on surgery for example, management arrangements also apply to other services, we do not repeat the information but cross-refer to the surgery service level. Where our findings for outpatients and diagnostic imaging also apply to services for children and young people, we do not repeat the information but cross-refer to the outpatients and diagnostic imaging sections of the report.

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

- The service had enough staff to care for patients and keep them safe. Staff had training in key skills, understood how to protect patients from abuse, and managed safety well. The hospital controlled infection risk well. Staff assessed risks to patients, acted on them and kept good care records. They managed medicines well. The hospital managed safety incidents well and learned lessons from them. Staff collected safety information and used it to improve the service.
- At our last inspection, we identified various concerns related to infection prevention and control (IPC). At this inspection we found that IPC had improved across services and staff took measures to reduce the risks of infection. Surgical wards no longer had carpeted flooring and were now compliant with infection control guidance. All areas of the intensive care unit were visibly clean and free from dust. This had improved since the last inspection.
- Staff provided good care and treatment, gave patients enough to eat and drink, and gave them pain relief when they needed it. Managers monitored the effectiveness of the service and made sure staff were competent. Staff worked well together for the benefit of patients, advised them on how to lead healthier lives, supported them to make decisions about their care, and had access to good information. Key services were available seven days a week.
- The endoscopy service had received Joint Advisory Group on gastrointestinal endoscopy (JAG) accreditation in March 2019.
- Staff treated patients with compassion and kindness, respected their privacy and dignity, took account of their individual needs, and helped them understand their conditions. They provided emotional support to patients, families and carers.
- The hospital planned care to meet the needs of local people, took account of patients' individual needs,

Summary of findings

and made it easy for people to give feedback. People could access services when they needed it and did not have to wait too long for treatment. The hospital had dementia champions who could provide staff with advice and support to help care for patients living with dementia.

- At our last inspection we were told by staff that they had difficulty accessing diagnostic imaging services. At this inspection we were told by staff that they did not experience difficulty accessing these services and there were protected slots for inpatients.
- Leaders ran services well using reliable information systems and supported staff to develop their skills. Staff understood the service's vision and values, and how to apply them in their work. Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. Staff were clear about their roles and accountabilities.

However:

- In outpatients, we found patient notes were filed untidily, were not always complete and were difficult to follow.
- In diagnostic imaging, here was no clear signage warning people of the MR controlled access area and no additional locked door separating the waiting area from the controlled access area. This meant there was a risk that unauthorised persons could access the MR controlled access area. This was on the department's risk register.
- In diagnostic imaging, not all staff competencies and patient group directions were fully signed by the relevant staff members.
- The service was not meeting all of the building standards for critical care services. This was on the department's risk register. However, it should be noted this requirement is for new units only.
- We were not assured in the event of an outreach call and/or emergency resuscitation call the intensive care unit would have appropriate medical cover. This was due to the unit's resident medical officer (RMO) holding multiple roles. There was also no documented escalation procedure in place to show how the ward was medically covered if the RMO was called out.
- We were not assured there was appropriate medical cover on the intensive care unit at all times. In addition, consultants were working over 24 hour periods which was against national guidelines.
- We noted that for two of the five notes we checked in critical care, we could not identify if a daily ward round had happened. Therefore, we were not assured ward rounds were happening for all patients.
- Agency usage in critical care was above the recommended 20% in some months. This was on the department's risk register.
- Physiotherapy and pharmacy were not able to attend daily ward rounds on the intensive care unit due to staffing issues, which was not compliant with Guidelines for the Provision of Intensive Care Services. The pharmacy team also did not have a suitable post graduate qualification for critical care pharmacy.
- The intensive care unit still did not have a follow up clinic where patients could reflect upon their critical care experience and be assessed for progress which was not in line with the Guidelines for the Provision of Intensive Care Services.
- We found that the BMI practising privileges policy and the BMI care of the deteriorating patient policy did not align. The hospital was following the BMI practising privileges policy which stated that consultants and anaesthetists retained responsibility for their patient for the patient's entire clinical pathway. However, the BMI care of the deteriorating patient policy stated that there should be an anaesthetist rota in place. Both policies had been reviewed in January 2019, but the discrepancy had not been picked up. The hospital subsequently informed us that this discrepancy had not been identified by the corporate provider's National Clinical Governance Board who were responsible for these policies. The hospital had also not identified or escalated this discrepancy to the corporate governance board but told us that they had escalated the issue of the anomaly following our inspection.

Summary of findings

Following this inspection, we told the provider that it must take some actions to comply with the regulations and that it should make other improvements, to help the service improve. We also issued the provider with a requirement notice. Details are at the end of the report.

Nigel Acheson, Deputy Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Medical care (including older people's care)	Good	Medical care services were a small proportion of hospital activity. We rated this service as good because it was safe, effective, caring and responsive and well led.
Surgery	Good	Surgery was the main activity of the hospital. Staffing was managed jointly with medical care. We rated this service as good because it was safe, effective, caring, responsive and well led.
Critical care	Good	Critical care services were a small proportion of hospital activity. The hospital has a six-bed intensive care unit providing level two and level three care. We rated this service as good because it was safe, effective, caring, responsive and well led. We rated safe as requires improvement.
Services for children & young people	Good	Services for children and young people were a small proportion of hospital activity within the outpatients and diagnostic imaging service. We rated this service as good because it was safe, effective, caring, responsive and well led. We did not have sufficient evidence to rate effective and caring.
Outpatients	Good	The outpatients department was one of the main services of the hospital's activity. We rated this service as good because it was safe, effective, caring and responsive and well led.
Diagnostic imaging	Good	Diagnostic imaging was one of the main services of the hospital's activity. We rated this service as good because it was safe, effective, caring, responsive and well led.

Summary of findings

Contents

Good

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Services we looked at:
Medical care (including older people's care); Surgery; Critical care; Services for children & young people; Outpatients; Diagnostic imaging

Summary of this inspection

Background to BMI The Clementine Churchill Hospital

BMI The Clementine Churchill Hospital is operated by BMI Healthcare Limited. It is a private hospital in Harrow, London. The hospital primarily serves the communities of the north west London area but also accepts patient referrals from outside this area.

The hospital has 121 beds and provides a range of services including surgical procedures, surgical and medical inpatient care, endoscopy, outpatients and diagnostic imaging services. The hospital provides services to adults and young adults over the age of 16; both private and NHS patients, as well as a paediatric non-interventional outpatients' service.

The hospital has five theatres, a minor procedures unit, 23 outpatient consulting rooms, a Joint Advisory Group on gastrointestinal endoscopy (JAG) accredited endoscopy suite and a level two and three critical care unit.

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

Our inspection team

The team that inspected the service comprised CQC inspectors and specialist advisors with specialisms in medical care, surgery, critical care, outpatients and diagnostic imaging. The inspection team was overseen by Nicola Wise, Head of Hospital Inspection.

Information about BMI The Clementine Churchill Hospital

The hospital has three wards and is registered to provide the following regulated activities:

- Diagnostic and screening procedures
- Family planning
- Surgical procedures
- Treatment of disease, disorder, or injury

During the inspection, we visited two wards, Downing and Epping. Chartwell ward was not in use at the time of our inspection due to low activity. We spoke with staff including registered nurses, health care assistants, reception staff, medical staff, operating department practitioners, and senior managers. We also spoke with patients.

There were no special reviews or investigations of the hospital ongoing by the CQC at any time during the 12 months before this inspection.

Activity (March 2018 to February 2019):

- In the reporting period March 2018 to February 2019 there were 2,307 inpatient cases and 7,777 day case episodes of care recorded at the hospital; of these 39% were NHS-funded and 61% other funded.
- 7% of all NHS-funded patients and 32% of all other funded patients stayed overnight at the hospital during the same reporting period.
- There were 31,572 outpatient total attendances in the reporting period; of these 73% were other funded and 27% were NHS-funded.
- The top three surgical procedures performed in the reporting period were: injection aspiration, into joint, cyst, bursa with image guidance (1107 procedures); multiple arthroscopic operation on knee (463 procedures); ultrasound phacoemulsification of cataract with lens implant (410 procedures).

Summary of this inspection

- The hospital had 345 doctors under the rules of practising privileges. The hospital employed 73 registered nurses, 34 healthcare assistants including operating department practitioners and 149 other staff.

Track record on safety:

- No never events
- Clinical incidents (April 2018 to March 2019): there were 1098 clinical incidents reported; 806 were categorised as no harm, 278 were categorised as low harm, 12 were categorised as moderate harm and two were categorised resulting in death.
- There were five serious injuries reported from April 2018 to March 2019.
- There were no incidents of hospital acquired meticillin-resistant staphylococcus aureus (MRSA), meticillin-sensitive staphylococcus aureus (MSSA), E.coli or clostridium difficile.
- Between December 2018 and May 2019, the hospital received 67 complaints.

Services accredited by a national body:

- Joint Advisory Group on gastrointestinal endoscopy (JAG) accreditation

Services provided at the hospital under service level agreement:

- Pathology and histology
- Microbiology
- Decontamination services
- Theatre services
- Resident medical officer provision
- Interpreting services

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

Good

Our rating of safe improved. We rated it as Good because:

- Services had enough staff to care for patients and keep them safe.
- Staff had training in key skills, understood how to protect patients from abuse, and managed safety well.
- Staff assessed risks to patients, acted on them and kept good care records. At our last inspection, we had concerns that staff were not assessing patients after a fall. During this inspection, we found the hospital had improved this process.
- Services managed medicines well.
- Services managed safety incidents well and learned lessons from them. Staff collected safety information and used it to improve the service.
- The phlebotomy environment was newly renovated and now provided ample space for safe working.
- We found that infection, prevention and control had improved across services and staff took measures to reduce the risk of infection.
- Surgical wards no longer had carpeted flooring and was now compliant with infection control guidance.
- All areas of the intensive care unit were visibly clean and free from dust. This had improved since the last inspection.
- At our last inspection we were told by staff that they had difficulty accessing diagnostic imaging services. At this inspection we were told by staff that they did not experience difficulty accessing these services and there were protected slots for inpatients.

However:

- In outpatients, we found patient notes were filed untidily, were not always complete and were difficult to follow.
- In diagnostic imaging, there was no clear signage warning people of the MR controlled access area and no additional locked door separating the waiting area from the controlled access area. This meant there was a risk that unauthorised persons could access the MR controlled access area. This was on the department's risk register.
- The service was not meeting all of the building standards for critical care services. This was on the department's risk register.
- We were not assured in the event of an outreach call and/or emergency resuscitation call the intensive care unit would have

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appropriate medical cover. This was due to the unit's resident medical officer (RMO) holding multiple roles. There was also no documented escalation procedure in place to show how the ward was medically covered if the RMO was called out.
- We were not assured there was appropriate medical cover on the intensive care unit at all times. In addition, consultants were working over 24 hour periods which was against national guidance.
- We noted that for two of the five notes we checked in critical care, we could not identify if a daily ward round had happened. Therefore, we were not assured ward rounds were happening for all patients.
- Agency usage in critical care was above the recommended 20% in some months. This was on the department's risk register.

Are services effective?

Good

Our rating of effective improved. We rated it as Good because:

- Staff provided good care and treatment, gave patients enough to eat and drink, and gave them pain relief when they needed it.
- Managers monitored the effectiveness of the service and made sure staff were competent. New staff received a comprehensive week-long hospital induction and completed competency booklets.
- Staff worked well together for the benefit of patients, advised them on how to lead healthier lives, supported them to make decisions about their care, and had access to good information.
- Key services were available seven days a week.
- The endoscopy service had received Joint Advisory Group on gastrointestinal endoscopy (JAG) accreditation in March 2019.
- Adherence to and understanding of NICE guidelines was embedded and evidenced through the use of audit programmes to benchmark practice. The service provided care and treatment based on national guidance and evidence-based practice
- Staff understood how and when to assess whether a patient had the capacity to make decisions about their care.

However:

- Physiotherapy and pharmacy were not able to attend daily ward rounds on the intensive care unit due to staffing issues, which was not compliant with Guidelines for the Provision of Intensive Care Services. The pharmacy team also did not have a suitable post graduate qualification for critical care pharmacy.

Summary of this inspection

Are services caring?

Good

Our rating of caring stayed the same. We rated it as Good because:

- Staff treated patients with compassion and kindness, respected their privacy and dignity, took account of their individual needs, and helped them understand their conditions.
- Staff provided emotional support to patients, families and carers.
- Staff took time to interact with patients and those close to them in a respectful and considerate way. We observed staff greet patients appropriately and introduce themselves by name.
- BMI friends and family test scores were consistently high in all services.
- Patients spoke positively about the care they received and how they were treated on the ward. Patients told us staff were respectful and provided them with space to ask questions about their care.

Are services responsive?

Good

Our rating of responsive stayed the same.We rated it as Good because:

- The service planned care to meet the needs of local people, took account of patients' individual needs, and made it easy for people to give feedback.
- People could access the service when they needed it and did not have to wait too long for treatment.
- The hospital had dementia champions who could provide staff with advice and support to help care for patients living with dementia.
- Staff told us they would ensure they respected cultural preferences for example, they told us they always checked if a patient needed a female interpreter.

However:

- Patient information leaflets were not on display in different languages or formats but were available on request.
- The critical care service still did not have a follow up clinic for patients following discharge from the hospital which was not in line with Guidelines for the Provision of Intensive Care Services.

Are services well-led?

Good

Our rating of well-led stayed the same.We rated it as Good because:

- Leaders ran services well using reliable information systems and supported staff to develop their skills.
- Staff understood the service's vision and values, and how to apply them in their work.

Summary of this inspection

- Staff felt respected, supported and valued. They were focused on the needs of patients receiving care.
- Staff were clear about their roles and accountabilities.
- The service engaged well with patients, staff and the community to plan and manage services and all staff were committed to improving services continually.
- There were clear lines of management in all services.
- Staff reported an open and honest culture and told us they felt able to raise concerns with their manager.
- The senior management team were visible throughout the hospital and were actively involved in the daily management of services.

However:

- We found that the BMI practising privileges policy and the BMI care of the deteriorating patient policy did not align. The hospital was following the BMI practising privileges policy which stated that consultants and anaesthetists retained responsibility for their patient for the patient's entire clinical pathway. However, the BMI care of the deteriorating patient policy stated that there should be an anaesthetist rota in place. Both policies had been reviewed in January 2019, but the discrepancy had not been picked up. The hospital subsequently informed us that this discrepancy had not been identified by the corporate provider's National Clinical Governance Board who were responsible for these policies. The hospital had also not identified or escalated this discrepancy to the corporate governance board but told us that they had escalated the issue of the anomaly following our inspection.
- We found one risk which was not on the critical care service's risk register. The resident medical officer held multiple roles including outreach and resuscitation at the same time which meant that in the event of an emergency this could leave the intensive care ward with no medical cover.

Detailed findings from this inspection

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Medical care (including older people's care)	Good	Good	Good	Good	Good	Good
Surgery	Good	Good	Good	Good	Good	Good
Critical care	Requires improvement	Good	Good	Good	Good	Good
Services for children & young people	Good	Not rated	Not rated	Good	Good	Good
Outpatients	Good	N/A	Good	Good	Good	Good
Diagnostic imaging	Good	N/A	Good	Good	Good	Good
Overall	Good	Good	Good	Good	Good	Good

Good

Medical care (including older people's care)

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

Information about the service

Medical care services were a small proportion of hospital activity. The majority of medical care provided by the hospital was elective endoscopy. The hospital also accepted general medical admissions.

The hospital's endoscopy unit was located on Marlborough Suite. The unit had two consulting rooms, two procedure rooms, eight recovery bays and a discharge room. The endoscopy unit was accredited by the Joint Advisory Group on Gastrointestinal Endoscopy. General medical admissions were nursed on Downing Ward, a 26-bedded medical and surgical ward.

From August 2018 to July 2019, the hospital performed 2,907 endoscopy procedures and had 269 medical admissions.

During this inspection, we visited Downing Ward and Marlborough Suite. We spoke with three patients and 19 members of staff including medical and nursing staff, healthcare assistants, pharmacy and therapy staff. We observed care and looked at a wide range of documents including medical records, policies, standard operating procedures, meeting minutes, action plans, prescription charts, risk assessments and audit results. Before our inspection, we reviewed performance information from, and about, the hospital.

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

Good

The main service provided by BMI The Clementine Churchill Hospital was surgery. Where our findings for surgery also apply to medical care, we do not repeat the information but cross-refer to this section of the report.

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

Mandatory training

- **The service provided mandatory training in key skills to all staff and made sure everyone completed it.**
- Mandatory training was comprehensive and met the needs of staff. Staff completed several mandatory training modules as part of their induction and were required to update them in line with the hospital's training matrix.
- Mandatory training included safeguarding, dementia awareness, care and communication of the deteriorating patient and infection control. Training was delivered through a combination of online assessment and practical training days.
- The hospital set a target of 90% for the completion of mandatory training. As of August 2019, training compliance for Marlborough Suite was 98% and training compliance for Downing Ward was 95%.

- Managers monitored mandatory training and would notify staff when their training was due for renewal. Staff were positive about the training they received and were supported to attend additional training, if relevant to their role.
- Consultants worked at the hospital under practising privileges and, as a result, were not required to complete the hospital's mandatory training. Consultants were however required to provide annual evidence to the medical advisory committee that they had completed mandatory training at their main place of work.
- Resident medical officers (RMOs) were managed via an external agency. The agency provided RMOs with a comprehensive mandatory training programme.

Safeguarding

- **Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and knew how to apply it.**
- Staff received training specific for their role on how to recognise and report abuse. Safeguarding training was part of the hospital's mandatory training programme and included information on Prevent. Prevent is a government-led training programme, designed to stop individuals from getting involved in, or supporting, terrorism or extremist activity. Although the hospital did not provide medical care to young people under the age of 18, staff were required to complete safeguarding training for both vulnerable adults and children.
- The hospital set a target of 90% for the completion of safeguarding training for staff working on Marlborough Suite and Downing Ward. As of August 2019, safeguarding training rates for staff met hospital targets for safeguarding children level 1 and level 2, safeguarding adults level 1 and level 2 and prevent. Only one member of staff was eligible to complete level 3 training but, as of August 2019, this had not been completed.
- Staff knew what the term safeguarding meant and how to recognise signs of abuse. Staff had a good understanding of child sexual exploitation and female genital mutilation.
- Staff could explain the safeguarding referral and knew how to contact the hospital's safeguarding team for advice. The hospital's safeguarding team had developed a 'safeguarding pack' to support staff with all aspects of safeguarding. The pack contained various documents including safeguarding flowcharts, local authority and lead contact numbers, safeguarding policies and procedures.

Cleanliness, infection control and hygiene

- **Since our last inspection, infection prevention and control had improved. Staff used equipment and control measures to protect patients, themselves and others from infection. They kept equipment and the premises visibly clean.**
- All areas visited were visibly clean and tidy. Cleaning records were up-to-date and demonstrated that the departments were cleaned regularly.
- At our last inspection, we identified various concerns related to infection prevention and control (IPC). For example, we observed staff walking into infectious rooms without personal protective equipment (PPE) or washing their hands. During this inspection, we found IPC had improved and staff took measures to reduce the risk of infection. For example, hand sanitiser points were widely available to encourage good hand hygiene practice and we saw staff washing their hands before and after contact with patients. All staff used personal protective equipment, such as aprons and gloves, when providing care. On Marlborough Suite, staff used personal protective equipment in 'dirty' areas and removed this before moving to 'clean' areas of the room.
- Staff cleaned equipment after patient contact and labelled equipment to show when it was last cleaned. Endoscopes were cleaned immediately after use and in line with guidance from the Department of Health (Health Technical Memorandum 01-06: Decontamination of flexible endoscopes). Used endoscopes were passed from the procedure room to the decontamination room through hatches to reduce the risk of contamination. Staff used a system to track and trace equipment at each stage of the decontamination process.
- The hospital screened all appropriate patients for bacterial infections such as meticillin-resistant

Staphylococcus aureus (MRSA). In addition, all patients who had recently been abroad were screened for carbapenem-resistant Enterobacteriaceae (CRE) or carbapenemase-producing Enterobacteriaceae (CPE). Staff would inform the IPC lead when there was an infected patient in the hospital. Staff used isolation signs to advise staff and patients that isolation or precautions were needed. An external company was used to deep clean patient bedrooms following an infection.

- Water quality sampling was carried out regularly to measure the level of bacteria in the water. Following a test that identified macrobacterium in the water, we saw evidence that the service had took appropriate action to address the risk. The endoscopy lead had attended a week-long water quality course. The hospital had also invested in a reverse osmosis machine to purify water. Since the machine instalment, all water checks showed bacteria levels were within acceptable ranges.
- IPC department link practitioners completed monthly IPC audits, overseen by the hospital's IPC lead. The IPC lead also completed a quarterly IPC superior patient care audit. Audit results were shared with department leads and discussed at team meetings. The IPC audit completed in March 2019 found both Downing Ward and Marlborough Suite to be 100% compliant with all IPC standards.

Environment and equipment

- **The design, maintenance and use of facilities, premises and equipment kept people safe. Staff were trained to use them. Staff managed clinical waste well.**
- Throughout the inspection, we found that ward areas and corridors were spacious and free from clutter. Fire exits were clear and fire extinguishers were available, if required.
- Since our last inspection, the service had seen a significant reduction in the number of medical inpatients. This was mainly due to the closure of the hospital's urgent care centre. As a result, the hospital had closed the medical ward and medical patients were now nursed alongside surgical patients on Downing Ward. Downing Ward had 26 single patient rooms, each with en-suite facilities.
- The hospital had plans to expand the sluice room on Downing Ward in order to improve the layout. At the time of our inspection, the sluice sink was immediately behind the sluice door. This was a risk to staff who could be hit by the door whilst washing their hands. Staff were aware of this risk and took care when opening the sluice door.
- The hospital's endoscopy unit was located on Marlborough Suite. The unit had two consulting rooms, two procedure rooms, eight recovery bays and a discharge room. Marlborough Suite housed a decontamination unit which had achieved accreditation by the Joint Advisory Group on Gastrointestinal Endoscopy in March 2019.
- The service had suitable facilities and enough equipment to meet the needs of patients. Staff had access to specialist equipment to support the needs of bariatric patients.
- The service had processes to ensure equipment was maintained and tested for electrical safety, ensuring it was fit for purpose and safe for patient use. We checked a range of medical equipment and found all equipment had been safety tested and was within the stated date for review.
- We also checked the expiry dates of consumable equipment, including needles and syringes. We found all items had expiry dates clearly marked on them and were within date.
- Downing Ward and Marlborough Suite each had an emergency trolley, for staff to use in the event of a cardiac arrest. Staff checked resuscitation equipment against an equipment checklist to ensure essential equipment was available and in working order. Staff used tamper evident tags to alert staff if the resuscitation equipment had been used. The top of each trolley was checked daily and the rest of the trolley was checked weekly or after each use. In both areas, we found satisfactory checks had been completed for the previous three months (June to August 2019).
- Staff disposed of clinical waste safely. We saw appropriate facilities for the disposal of clinical waste and sharps (such as needles) in clinical areas. There were different coloured bins to clearly identify categories of waste, in line with current waste management legislation.

Good

Medical care (including older people's care)

Assessing and responding to patient risk

- **Staff completed and updated risk assessments for each patient and removed or minimised risks. Staff identified and quickly acted upon patients at risk of deterioration.**
- The hospital had a strict admission criterion to ensure the service only admitted patients if staff could meet their needs. For example, the service did not accept acute cardiac patients or patients with an acute airway condition. In endoscopy, patients were assessed for their suitability prior to treatment.
- Staff completed risk assessments for patients admitted onto Downing Ward. Risk assessments included assessing the risk of falls, malnutrition and pressure ulcers. At our last inspection, we had concerns that staff weren't re-assessing patients after a fall. During this inspection, we found the hospital had improved this process. For example, the service had introduced a post-fall checklist, to be completed by the resident medical officer. Staff would also review a patient's care plan post-fall and make appropriate amendments to their falls risk assessment.
- Staff used the national early warning score two (NEWS2) to assess patient deterioration. The NEWS is a tool, used by staff, to quickly determine the degree of patient illness, based upon six cardinal vital signs and patient observation. Staff received training on how to use the tool and how to respond when a patient deteriorated.
- Staff identified and responded quickly to patients at risk of deterioration. If a patient deteriorated, nursing staff would seek medical support from the resident medical officer (RMO). Depending on the patient's severity, the RMO would either contact the patient's consultant, bleep the hospital's critical care outreach team or contact the emergency services.
- Staff had been trained to respond to a cardiac arrest while waiting for the ambulance to arrive. All healthcare assistants had completed basic life support training, all nursing staff had completed intermediate life support training and all resident medical officers had completed advanced life support training.
- Staff we spoke with understood the signs and symptoms of sepsis and knew how to respond if they identified concerns. BMI had a service level agreement (SLA) with the local NHS hospital. Any patient with suspected or recognised sepsis, as identified using the NEWS2, would be transferred, via ambulance, to the local NHS hospital for management and review.
- All patients received discharge information from the consultant and a discharge information sheet. The sheet explained to patients what symptoms to look out for and what to do if they had concerns. The sheet also had a phone number for patients to contact the ward or endoscopy suite for advice.
- The World Health Organisation's Five Steps to Safer Surgery is a surgical safety checklist made up of five steps. Staff were required to complete the WHO checklist for all endoscopy procedures. We observed three endoscopy procedures. We observed all staff to be fully engaged with the WHO checklist and comply with all five steps. Specifically, we observed staff complete a briefing before the induction of anaesthesia, sign in, time out, sign out and debrief.
- The service audited 25 endoscopy procedures per month to ensure staff were completing the WHO checklist correctly. The endoscopy lead practitioner also completed ad hoc observational audits. Audit results from March to July 2019 showed that Marlborough Suite staff were 100% compliant with all aspects of the WHO checklist.
- Staff shared key information to keep patients safe when handing over their care to others. All staff used the Situation, Background, Assessment, Recommendation (SBAR) technique to facilitate prompt and appropriate communication.
- Staff had access to mental health support, provided by staff from a local mental health hospital. BMI staff could access support 24 hours a day, seven days a week, for risks associated with a patient's mental health.

Staffing

- **The service had enough staff with the right qualifications, skills, training and experience to keep patients safe. Managers regularly reviewed and adjusted staffing levels and skill mix, and gave bank and agency staff a full induction.**
- Staffing levels and skill mix were planned and reviewed so that patients received safe care and treatment. On

Downing Ward, staff used a safer staffing tool to assess patient acuity and dependency, and to ensure nursing establishments reflected patient needs. Staffing was also reviewed at the daily bed meeting. Service leads described how staffing levels had improved since the closure of the medical ward. All staff who had worked on the medical ward, now worked on Downing Ward.

- On Marlborough Suite, endoscopies were performed by consultants, with support from two endoscopy nurses and an endoscopy healthcare assistant. The endoscopy lead practitioner managed the team scheduling to ensure each operating list had the correct staffing levels and skills mix.
- We observed that staffing levels met the needs of patients and the demands of the service. Staffing levels were displayed in each department we inspected. Endoscopy staffing exceeded recommendations made by the British Society of Gastroenterology.
- At the time of our inspection, the service had three nurse vacancies; two on Downing Ward and one on Marlborough Suite.
- From May 2018 to April 2019, the hospital reported a staff turnover rate of 1.8%. Within the same time period, the hospital reported a staff sickness rate of 4.7%. The data above includes staff working on Downing Ward, Epping Ward, Marlborough Suite and in theatres.
- To ensure safe staffing levels were met, the service used bank and agency staff. Agency staff received a local induction before working on a ward. The service tried to use the same agency staff to promote continuity of care for patients.

Medical Staffing

- **The service had enough medical staff with the right qualifications, skills, training and experience to keep patients safe.**
- Medical cover was provided by consultants and the resident medical officers (RMOs). All consultants worked for the hospital under a practising privilege arrangement. Practising privileges is a system which independent organisations use to allow a person to practice in their service. The hospital monitored the suitability of consultants annually, including their ongoing training, appraisals and competencies. We reviewed a sample of staff files and found that consultants have provided the hospital with all the required information.
- All medical patients were reviewed by their consultant daily. Staff would contact the consultant if there were any changes to the patient's condition. At the time of our inspection, the hospital had 100 medical care consultants with practising privileges.
- The service had two RMOs who provided clinical support to medical patients. RMOs worked split shifts from 8am to 4pm, 4pm to 12am, and 12am to 8am. RMOs were based on-site, ensuring patients had access to medical input 24 hours a day, seven days a week. Overnight the RMOs were supported by the duty night sister.

Records

- **Staff kept detailed records of patients' care and treatment. Records were clear, up-to-date, stored securely and easily available to all staff providing care.**
- Staff used paper records to record patients' care and treatment. Records were stored securely, in lockable cupboards.
- At our last inspection, we found that patient records were not always complete, particularly nursing assessments. During this inspection, we found patient records had improved. Patient notes were clear and comprehensive and included detailed risk assessments. Within the records, we saw evidence of good communication and multidisciplinary team (MDT) working.
- Discharge summaries were sent to the patient's GP to ensure continuity of care within the community.
- The service regularly audited patient records to ensure they were completed appropriately. For example, in December 2018, the hospital conducted an audit to assess whether patient records were completed in-line with hospital policy. The audit found 93% of records contained dated, timed and signed entries. As a result of the audit, an action plan was developed, and staff identified as non-compliant received verbal feedback.

- For our detailed findings on records please see the safe section in the surgery report.

Medicines

- **The service used systems and processes to safely prescribe, administer, record and store medicines.**
- The hospital's pharmacy service was available Monday to Friday, 8.30am to 8pm, Saturdays, 9.30am to 2pm, and an on-call service on Sundays. Out of hours, staff could contact an on-call pharmacist. The service provided medicine reconciliation, clinical advice and preparation for discharge.
- At our last inspection, we found medicine administration records were not always legible and did not always match prescriptions. During this inspection, we found medicine documentation had improved. We reviewed a sample of prescription charts and found that they had all been verified by a pharmacist. Charts showed allergy statuses and venous thromboembolism (VTE) risk assessments had been completed and, if required, the relevant low molecular weight heparin (LMWH) was prescribed. Staff reviewed patient's medicines regularly and provided specific advice to patients and carers about their medicines.
- The pharmacy team also conducted a programme of audits across the hospital to ensure medicines were safely managed. All prescribing was appropriate and in line with hospital policies and guidelines. Pharmacy staff completed medicines reconciliation in a timely manner.
- Medicines were stored securely. Staff stored medicines in a locked cupboard or fridge, in a secure clinical room. Some prescription medicines are controlled under the Misuse of Drugs legislation (and subsequent amendments). These medicines are called controlled drugs (CDs). In line with national guidelines, all CDs were locked securely and stored separately from other medicines.
- Staff checked and recorded the medicines fridge and room temperatures daily, to ensure medicines were stored at the correct temperature. On Downing Ward, we saw daily checks had been completed for the last three months (July to September 2019). We saw evidence that when an irregular temperature was recorded, staff took appropriate action.
- During our inspection, we undertook a random check of medicines and controlled drugs (CD). All medicines and CDs checked were accounted for and within their expiry date.
- The service had systems to ensure staff knew about safety alerts and incidents, so patients received their medicines safely. The pharmacy team produced a medicines management newsletter, which provided staff with information about medicines incidents, alerts and updates. The team also attended the daily "comm cell" meeting to disseminate any medicine information to the clinical services managers, who in turn would disseminate to staff.

Incidents

- **The service managed patient safety incidents well. Staff recognised incidents and near misses and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support. Managers ensured that actions from patient safety alerts were implemented and monitored.**
- Incidents were reported using the hospital's electronic reporting system. All staff knew what incidents to report and how to report them. Staff could give examples of the recent incidents they had reported. For example, staff described how they had logged an incident on the system following a delayed discharge.
- From April 2018 to August 2019, the medical service reported 37 incidents, of which 26 were categorised as 'no harm,' nine were categorised as 'low harm,' one incident was categorised as 'moderate harm' and one incident was not categorised. The moderate harm incident related to a patient fall on Downing Ward. Following the incident, learning points were identified and actioned.
- In the same reporting period, the service reported not having any never events. Never events are serious incidents that are wholly preventable, where guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and should have been implemented by all healthcare providers.

Good

Medical care (including older people's care)

- Managers investigated incidents thoroughly. Following an investigation, key learning would be identified and presented to the clinical governance committee. Key learning would also be discussed at the patient safety and quality meeting and at team meetings.
- Staff gave examples of local changes in practice following an incident. For example, following a patient fall on Marlborough Suite, patients in recovery were now wheeled to the bathroom in a patient wheelchair.
- 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. Staff understood the duty of candour and could give examples of when it would need to be applied.

Safety Thermometer

- **Staff collected safety information and used it to improve safety.**
- Downing Ward collected safety information for all patients and used this information to improve the service. The types of safety information the hospital monitored included falls, catheter urinary tract infections (UTI), pressure ulcers and venous thrombosis (VTE) assessments.
- The safety information of NHS patients was submitted formally via the NHS safety thermometer. The thermometer is a monthly snapshot audit, used to record the prevalence of patient harm and to provide immediate information and analysis for frontline teams to monitor their performance in delivering harm free care.
- From September 2018 to August 2019, the hospital reported that all NHS medical patients had been assessed for VTE, no patients had acquired a pressure ulcer or UTI and no patients had had a harmful fall.

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

Good

The main service provided by BMI The Clementine Churchill Hospital was surgery. Where our findings for surgery also apply to medical care, we do not repeat the information but cross-refer to this section of the report.

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

Evidence-based care and treatment

- **The service provided care and treatment based on national guidance and best practice.**
- Staff had access to policies and guidance through the hospital intranet and in paper format. The policies we saw were version controlled, ratified and included clear dates for review. Staff followed policies to plan and deliver high quality care, according to best practice and national guidance.
- The quality and risk manager reviewed hospital policies to ensure they were in accordance with the latest national guidance, including National Institute for Health and Care Excellence (NICE) guidance. Clinical services managers were alerted to any new policy changes and would disseminate the changes to their team. All new policies were also displayed on the BMI e-learning system for staff to review.
- There were several evidence-based pathways for staff to follow for specific conditions. For example, patients with suspected sepsis would be placed on to the Sepsis Six pathway, before being transferred to the local NHS hospital.
- The endoscopy lead practitioner attended a BMI endoscopy steering group which met every two months. The group discussed clinical practice and shared learning. The endoscopy lead practitioner had also visited other BMI endoscopy units to share good practice.

Nutrition and hydration

Good

Medical care (including older people's care)

- **Staff gave patients enough food and drink to meet their needs and improve their health.**
- Staff recognised the importance of good nutrition and hydration as an essential part of patient care. Staff accurately completed patient fluid and nutrition charts. Staff used the malnutrition universal screening tool (MUST) to monitor patients at risk of malnutrition. Patients had access to a dietitian to support their nutritional and hydration needs.
- Catering staff were able to accommodate special dietary needs, including food allergies and needs relating to religion and culture. Food allergies were clearly documented in patient records.
- Endoscopy patients were given an information leaflet which explained how they should prepare for their appointment. For some patients, this included advice on when they should stop eating and drinking before their procedure. Once fully recovered, all patients were offered something to eat and drink.

Pain relief

- **Staff assessed and monitored patients regularly to see if they were in pain and gave pain relief in a timely way. They supported those unable to communicate using suitable assessment tools and gave additional pain relief to ease pain.**
- Staff assessed patients' pain and gave pain relief in line with individual needs and best practice. Staff used a face scale to assess the pain in patients who could not verbalise.
- We reviewed a sample of patient records and prescription charts and found that staff prescribed, administered and recorded all pain relief accurately.
- Patients told us their pain was well managed and that nursing staff administered pain relief in a timely manner.
- The pharmacy team provided pain management advice and support to staff and patients, helping people to manage their pain as best they can.

Patient outcomes

- **Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for patients. The endoscopy service had been accredited.**
- Managers carried out a comprehensive audit programme. Local audits were used to measure outcomes for patients and drive improvements to the service. Audits included completion of patient records, cleaning, hand hygiene compliance, equipment availability and management, venous thrombosis (VTE) assessment compliance, completion of the national early warning score (NEWS2), medicine management and compliance with the WHO checklist.
- The service audited readmission rates and unplanned transfers. From August 2018 to July 2019, two medical patients were re-admitted within 28 days of discharge. Within the same time period, two medical patients were transferred to the local NHS hospital following patient deterioration.
- Downing Ward displayed various audit results, allowing patients, visitors and staff to view their performance monthly.
- In addition to local audits, the endoscopy service was accredited. The endoscopy service had received Joint Advisory Group on gastrointestinal endoscopy (JAG) accreditation in March 2019. JAG is a national organisation, which assesses details of how endoscopy services are delivered and monitored. Endoscopy services provide evidence to JAG and once the required standards are achieved, the unit is awarded JAG accreditation.
- The endoscopy service participated in the National Endoscopy Database (NED). The NED was developed by JAG, with support of several other societies and colleges, to facilitate quality assurance, benchmarking, service evaluation and research. In addition, the endoscopy service benchmarked its outcomes against other BMI services. For example, from October 2018 to September 2019, the service audited bowel preparation, rating the preparation from excellent to unacceptable. The service achieved an excellent/good score for 63.7%

of procedures. This score was slightly worse when compared to the other BMI endoscopy services (71.6%). Audit results were monitored and discussed at the hospital's endoscopy user group.

Competent staff

- **The service made sure staff were competent for their roles. Managers appraised work performance and held supervision meetings with staff to provide support and development.**
- Staff were experienced, qualified and had the right skills and knowledge to meet the needs of patients.
- All new staff were required to attend a five-day hospital induction. The induction included various face-to-face training and information on the vision and structure of the hospital.
- Following the induction, staff worked as a supernumerary for two weeks and were required to complete several competencies dependant on their role. Competencies included intravenous therapy and blood transfusion. On Marlborough Suite, staff completed competencies recommended by the JAG. All competencies required sign off by a senior staff member.
- All consultants under practising privileges received an induction pack which included details on what was required of them to practise at BMI.
- The hospital had suitable arrangements for staff supervision and appraisal. Staff identified their learning needs and development opportunities through their yearly appraisal.
- As of September 2019, 100% of staff on Marlborough Suite had completed their appraisal. On Downing Ward, 13% of staff had completed their appraisal and 87% of staff were on track to complete their appraisal before the deadline (end of October 2019).
- Nursing staff and consultants told us they were supported with their revalidation through clinical supervision.
- The hospital provided staff with the training to deliver effective care, support and treatment. Additional training opportunities were publicised at team meetings and on staff notice boards. Staff had the opportunity to discuss training needs with their line manager and were supported to develop their skills and knowledge. For example, on Downing Ward, staff participated in yearly cardiac arrest simulation training.
- Each department had elected department 'links' who received additional training in their chosen speciality and attended working groups and conferences. 'Links' provided their colleagues with training, advice and support on various topics including venous thrombosis (VTE), falls and sepsis.

Multidisciplinary working

- **Doctors, nurses and other healthcare professionals worked together as a team to benefit patients. They supported each other to provide good care.**
- The medical service was delivered by a multidisciplinary team (MDT) of doctors, nurses, healthcare assistants, pharmacists, physiotherapists and occupational therapists. All members of the MDT were involved with assessing, planning and implementing patient care and treatment. Staff could also make patient referrals to a wider multidisciplinary team, including a dietitian and a speech and language therapist.
- Staff held regular and effective multidisciplinary meetings to discuss patients and improve their care. For example, Downing Ward had three daily safety huddles to discuss patient care. These were attended by nurses, healthcare assistants and therapy staff. We attended a daily safety huddle during our inspection and observed good MDT working. All staff in attendance contributed to discussions around patient care, treatment and discharge.
- Staff had strong working links with external services and agencies. For example, staff from the local NHS hospital had provided BMI staff with training on specialist topics such as parenteral nutrition.

Seven-day services

- **Key services were available seven days a week to support timely patient care.**
- Medical inpatient services were available 24 hours a day, seven days a week. The endoscopy unit operated Monday to Friday, 7am to 7pm.

Good

Medical care (including older people's care)

- Consultants visited Downing Ward daily. In addition, a resident medical officer (RMO) was based on-site 24 hours a day, seven days a week. An on-call critical care outreach team provided emergency cover.
- With the exception of magnetic resonance imaging (MRI) and single-photon emission computed tomography (SPECT CT), all diagnostic services on-site were available 24 hours a day, seven days a week. MRI was available 8am to 8pm, Saturday and Sunday. SPECT was available 9am to 5pm, Monday to Friday.
- The pharmacy service was available Monday to Friday, 8.30am to 8pm, Saturdays 9.30am to 2pm and an on-call service on Sundays. Outside of these hours, staff could contact an on-call pharmacist. Physiotherapists and occupational therapists were available on the wards seven days per week.

Health promotion

- **Staff gave patients practical support and advice to lead healthier lives.**
- Staff supported medical patients to live healthier lives and manage their own health, care and wellbeing. Patients had access to information leaflets which promoted a healthier lifestyle. Leaflets included smoking cessation support, obesity and healthy eating.
- On Marlborough Suite, patients received a discharge information pack which included information on how to enhance the recovery process.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- **Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients' consent. They knew how to support patients who lacked capacity to make their own decisions.**
- Staff gained consent from patients for their care and treatment in line with legislation and guidance. We observed staff explaining procedures to patients, identifying possible risks and seeking their consent. We observed endoscopy staff confirming patients' consent to procedures and confirming the patient's details before the endoscopy procedure was carried out.
- We saw patient records contained consent forms and, if appropriate, Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) forms. All consent documentation was clear and recorded appropriately.
- Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. When patients could not give consent, staff made decisions in their best interest, taking into account the wishes of the patient's family and friends.
- The Mental Capacity Act (2005) is designed to protect patients who may lack capacity, to make certain decisions about their care and treatment. Information about the Mental Capacity Act (2005) and associated Deprivation of Liberty Safeguards (DoLS) was covered as part of staff induction. Staff were also required to complete consent training. As of August 2019, 100% of staff on Marlborough Suite and Downing Ward had completed consent training.
- Although the service had had very few patients under a DoLS application, staff were able to explain the process for submitting an application and ensured best interest decisions were made in accordance with legislation.

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

Good

The main service provided by BMI The Clementine Churchill Hospital was surgery. Where our findings for surgery also apply to medical care, we do not repeat the information but cross-refer to this section of the report.

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

Compassionate care

- **Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.**
- At the time of our inspection, there were no medical patients on Downing Ward. We were therefore unable to observe any interactions between Downing Ward staff and medical patients. We were, however, able to observe care and speak to patients on Marlborough Suite.

Good

Medical care (including older people's care)

- We found staff to be courteous, professional and kind when interacting with patients. Staff took time to interact with patients and those close to them in a respectful and considerate way. We observed staff greet patients appropriately and introduce themselves by name.
- Staff respected patient confidentiality and privacy and were discreet when providing care. On Marlborough Suite, there were dedicated male and female recovery bays to help maintain patient dignity. On Downing Ward, all patients were nursed in single rooms. We observed staff knock and seek permission before entering patient rooms. Patients could request a chaperone and chaperone posters were displayed across the hospital.
- From patient records, we saw evidence that staff understood and respected the personal, cultural, social and religious needs of patients and how they may relate to their care needs.

Emotional support

- **Staff provided emotional support to patients, families and carers to minimise their distress.**
- Staff gave patients and those close to them help, emotional support and advice when they needed it. Downing ward displayed information about local support services available.
- Staff understood the emotional and social impact that a person's care, treatment or condition had on their wellbeing and on those close to them. Staff supported patients who became distressed in an open environment and helped them maintain their privacy and dignity. We observed staff providing reassurance to anxious patients before their endoscopy treatment. Quiet rooms were available for staff to take patients and their relatives when they had received upsetting news. For patients with mental health needs, staff had access to mental health liaison support from a local hospital.
- Upon discharge, patients were given a telephone number to contact the service if they had any concerns.
- The hospital had a chaplain who offered emotional support to all faiths and was available on-call 24 hours a day, seven days a week.

Understanding and involvement of patients and those close to them

- **Staff supported and involved patients, families and carers to understand their condition and make decisions about their care and treatment.**
- Staff provided patients with relevant information, both verbal and written, so they could make informed decisions about their care and treatment. Staff talked with patients, families and carers in a way they could understand, using communication aids where necessary.
- Patients told us they were aware of the next steps in their treatment, and that follow up appointments were made quickly and within a reasonable timescale. On Marlborough Suite, we observed staff interacting with patients before, during and after their treatment. At each stage, staff checked the patients understanding of the information they were given.
- Relatives and carers were treated as important partners in the delivery of care. On Marlborough Suite, staff advised patients to bring a friend or family member to their treatment to support them getting home.
- Patients and their families could give feedback on the service and staff supported them to do this. Patient feedback was positive. The patients we spoke with said that staff treated them well and were caring. Displayed patient thank you cards showed that patients felt they had been treated with compassion.
- Patients could provide feedback on the service through various ways, including the hospital's friends and family test. The test asks patients if they would recommend the services they have used to their friends and family. In July 2019, the hospital response rate was 55.5%, based on 218 responses. This response rate was higher than the England average of 26.1%. Of those who responded, 98% of patients would recommend the service to their friends and family.
- Information on the cost of procedures was provided at the point of booking. Patients told us that conversations about finances were done so with sensitivity and that they had all the information they needed before deciding to proceed.

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

Good

Medical care (including older people's care)

Good

The main service provided by BMI The Clementine Churchill Hospital was surgery. Where our findings for surgery also apply to medical care, we do not repeat the information but cross-refer to this section of the report.

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

Service delivery to meet the needs of local people

- **The service planned and delivered care in collaboration with local services.**
- The service worked collaboratively with local healthcare services to improve patient care and access. The quality and risk manager and the director of clinical services attended a quarterly quality meeting with the local clinical commissioning group to discuss patient outcomes, incidents and complaints. In addition, the executive director and the director of operations attended a quarterly contract performance meeting with the local clinical commissioning group.
- The facilities and premises were appropriate for the services being delivered. The endoscopy unit was well-equipped and complied with national guidelines. The layout of Downing Ward meant that all areas were accessible for people using a wheelchair or walking aids.
- Staff knew about and understood the standards for mixed sex accommodation and knew when to report a potential breach. Mixed sex breaches are identified by the CQC as a breach of same sex accommodation, as defined by the NHS Confederation. From April 2018 to August 2019, the medical service reported no mixed sex breaches.

Meeting people's individual needs

- **The service planned services to meet individual needs and preferences. Staff made reasonable adjustments to help patients access services. However, patient information leaflets were not available in different languages or formats. Following the inspection, we were told that leaflets in different languages were available on request.**
- Staff used the hospital's admission criteria to ensure the service only admitted patients if staff could meet their needs. The service did not treat complex patients, such as psychiatric patients, but did treat some patients with multiple co-morbidities, in line with the admission criteria.
- On Marlborough Suite, pre-admission screening was used to identify any additional needs. On Downing Ward, nursing staff assessed the additional needs of patients on admission.
- Staff had access to interpreting services for patients who did not speak English. In addition, a loop recorder was available to support patients who were hard of hearing.
- There was a range of information leaflets available, providing patients with information on treatment and aftercare. However, patient information leaflets were not available in different languages or formats. Following the inspection, we were told that leaflets in different languages were available on request.
- Staff recorded specific dietary needs at the patient's pre-operative assessment or on admission. Menu options were available for patients who required special diets, for religious or cultural reasons.
- The hospital had specialist equipment to support the needs of bariatric patients.
- Although the service did not often treat patients living with dementia or a learning disability, staff described how they would try to plan services to meet their individual needs. The hospital had a dementia lead who could provide staff with advice and support to help care for patients living with dementia. Staff were also required to complete dementia awareness training. As of August 2019, 87.5% of staff on Marlborough Suite and 100% of staff on Downing Ward had completed the training.

Access and flow

- **People could access the service when they needed it and received the right care promptly.**
- Staff followed a hospital admissions policy to ensure only suitable patients were admitted on to the wards.

Good

Medical care (including older people's care)

Patients were admitted under the care of a named consultant. Consultants visited the ward daily and provided a 24 hour on-call service, as and when required.

- All medical inpatients were nursed on Downing Ward and there were no medical outliers. From August 2018 to July 2019, the hospital had 269 medical admissions. At the time of our inspection, there were no medical patients on Downing Ward.
- Discharge planning began on admission. The service ran daily safety huddles, where staff discussed the bed plan for the day, patients ready for discharge and any issues that could present a challenge for timely discharge. The hospital had a discharge coordinator to help support discharge planning. All inpatients required a review by either a consultant or resident medical officer (RMO) before discharge. Patients could be discharged at weekends, providing the RMO deemed it safe to do so. Delayed discharges were rare. All patients discharged from Downing Ward received a follow-up telephone call 48 hours after discharge.
- On Marlborough Suite, patients were either referred by their GP or BMI consultant. Patients referred by their GP could book a convenient date and time for their procedure using the NHS e-referral system. Private patients could book appointments through the hospital or via the website. The endoscopy lead practitioner held a daily staff huddle to discuss the operation list for the day. From August 2018 to July 2019, the hospital performed 2,907 endoscopy procedures. Patients usually spent between 30 to 60 minutes in recovery before being discharged by a registered nurse.
- Waiting times from referral to treatment were in line with good practice. All NHS patients were seen within 18 weeks of referral, in accordance with the NHS Constitution.

Learning from complaints and concerns

- **It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learnt with staff.**
- Patients, relatives and carers knew how to complain and raise their concerns. Complaints leaflets and posters, describing the hospital's complaints procedure, were displayed in patient areas.
- Staff followed an up-to-date complaints policy, which provided guidance on how to manage complaints efficiently. Staff logged all complaints and concerns onto the electronic incident recording system.
- All complaints required an acknowledgement letter within three working days and a full written response within 20 working days. If a complaint could not be concluded within 20 working days, a holding letter was sent explaining the reason for the delay and confirming a new final response date. From October 2018 to August 2019, the medical service received 16 complaints.
- The hospital acknowledged, investigated and closed all 16 complaints in line with their complaints policy. Managers investigated complaints and identified themes.
- There were procedures for the sharing and learning from complaints across the service. Complaints were discussed both locally at safety huddles and team meetings, and at a senior level at the clinical governance committee. Staff gave examples of changes in the service following patient feedback and complaints. For example, agency induction training was reviewed following a complaint about an agency nurse's clinical practice.
- The hospital provided patients with information on how to progress a complaint with the Independent Healthcare Sector Complaints Adjudication Service (ISCAS) and the Parliamentary and Health Services Ombudsman (PHSO) if they were not satisfied with the hospital's internal complaints process.

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

Good

The main service provided by BMI The Clementine Churchill Hospital was surgery. Where our findings for surgery also apply to medical care, we do not repeat the information but cross-refer to this section of the report.

Good

Medical care (including older people's care)

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

Leadership

- **Leaders had the integrity, skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff. They supported staff to develop their skills and take on more senior roles.**
- The hospital's medical service had clear lines of management. The service was overseen by two clinical services managers who reported to the director of clinical services. On a day-to-day basis, the inpatient service was managed by a senior sister and the endoscopy service was managed by the endoscopy lead practitioner.
- The department was managed by visible, experienced and enthusiastic leaders. Service leads had good oversight of the activity, performance, staffing and safety in their department. They were knowledgeable about their service and strived to continuously improve it. For example, the endoscopy lead practitioner had visited other BMI endoscopy units to learn and to share good practice.
- Staff spoke positively about their local leadership. They described feeling valued and supported in their role. Clinical services managers felt well supported by the senior management team.
- Staff had access to leadership skills and development opportunities. For example, the hospital offered a ward management course to senior nurses looking to develop their leadership skills.

Vision and strategy

- **The hospital had a vision for what it wanted to achieve and a strategy to turn it into action, developed with stakeholders. Leaders and staff understood and knew how to apply the vision and strategy.**
- The hospital had a clear vision, aligned to the BMI Healthcare Corporate Vision, and a strategy to turn the vision into action. The hospital's five-year business development plan had been developed by the senior management team. The BMI strategy for 2015-2020 identified eight objectives which included information, efficiency, growth, communication, patients, facilities, people and governance and these were underpinned by a clinical and non-clinical strategy. Objectives of the strategy included to promote an honest, open and blame-free culture where risks were identified and addressed at every level and escalated appropriately.
- Staff were aware of the hospital vision and strategic objectives, including their role in achieving them.
- For our detailed findings on vision and strategy please see the well-led section in the surgery report.

Culture

- **Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service promoted equality and diversity in daily work and provided opportunities for career development. The service had an open culture where patients, their families and staff could raise concerns without fear.**
- Staff reported an open and honest culture. Staff felt able to raise concerns with their manager, and we observed leaders had an open-door policy. The senior management team were visible throughout the hospital and were actively involved in the daily management of services.
- Staff felt valued and well supported in their role. Staff told us that there were opportunities for further learning and development. For example, for staff interested in becoming a registered nurse, the hospital ran a nursing associate course. Several members of staff described how they had developed and progressed within the organisation, including the executive director.
- The hospital had appointed a 'freedom to speak up guardian'. Guardians promoted an open culture, allowing staff to speak up about concerns easily.

Governance

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

- Staff were clear about their roles and understood what they were accountable for. Staff demonstrated a good awareness of governance arrangements and knew how to escalate their concerns.
- Information was escalated from ward to board through safety huddles, team meetings and heads of department meetings. The senior management team and clinical services managers held a daily "comm cell" meeting to discuss expected admissions and discharges, incidents, complaints and any other hospital business. "Comm cell" meeting minutes were emailed to all staff, as were patient safety alerts and lessons learnt from incidents.
- Both staff on Marlborough Suite and Downing Ward had regular team meetings, in which issues and general communications were shared and discussed. The clinical services managers attended team meetings and would then escalate any concerns at the heads of department meeting. Meeting minutes from January to August 2019 showed that incidents, staffing and risks were routinely reviewed by staff at all levels.
- Service leads monitored how the endoscopy service was performing through the endoscopy user group. The group discussed audit results and patient outcomes and composed of the senior management team, endoscopy consultants, endoscopy lead practitioner and the clinical services manager.

Managing risks, issues and performance

- **Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and identified actions to reduce their impact.**
- Marlborough Suite and Downing Ward each had their own risk register, maintained by the clinical services manager. Each risk was given a rating, review date, responsible individual and set of control measures. Risks included Downing Ward sluice and the bacteria levels in water quality samples.
- Progress was regularly recorded on the risk register, demonstrating active management of risks. Staff, including service leads, were aware of the risks in their service area and knew what mitigations were in place to reduce the risk. Risks were monitored and reviewed at both a senior level, via heads of department meetings, and at ward level, via team meetings.
- The service collected performance data through quality and safety reports, which were presented to the clinical governance committee. The committee was attended by the senior management team, clinical leads and the clinical services manager for each department. The quality and safety reports gave the senior management team an overview of how each service was comparing to key quality indicators.
- There was a programme of clinical audit across the service, which meant senior staff could monitor compliance with safety standards. Where audits had been carried out, there was evidence that service leads had used the results to implement improvements and changes to the service.

Managing information

- **Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were integrated and secure. Data was submitted to external organisations as required.**
- Staff collected, analysed and managed information using secure electronic systems, with security safeguards. For example, staff used computer privacy screens and log in access codes.
- Service leads monitored quality and risk information through a number of systems, such as governance meetings, local audits and quality reports.
- Staff told us they were able to access the information they needed to ensure they provided safe and effective care.
- There were named persons responsible for the timely submission of data to external bodies, for example, to participate in the National Endoscopy Database.

Engagement

Good

Medical care (including older people's care)

- **Leaders and staff actively and openly engaged with patients and staff to plan and manage services. They collaborated with partner organisations to help improve services for patients.**
- Patients could provide feedback on the service through various means including the hospital's friends and family test. Both positive and negative comments from the test were discussed at "comm cell" meetings and at team meetings. Staff told us about actions that had been taken following patient feedback. For example, following a comment about communication, staff were reminded to clearly communicate to patients when there had been any changes to their care plan.
- Inpatients were also contacted 48 hours after discharge to find out how they rated their care and treatment. All comments from the calls were documented and any concerns would be escalated to the clinical services manager to follow-up.
- On Marlborough Suite, staff provided patients with a questionnaire upon discharge. The questionnaire was endoscopy-specific, as recommended by the JAG. The results of the questionnaire were shared at the endoscopy user group and any actions were added to an action plan.
- Staff were engaged in the planning and delivery of the service. Staff attended team meetings and safety huddles to share ideas, opinions and feedback their concerns. They were encouraged to suggest and help implement developments.

Learning, continuous improvement and innovation

- **All staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them**.
- Staff sought new ways to improve services for patients. For example, the hospital's dementia lead had set up a falls group to improve falls assessments, management and intervention.
- Staff were committed to continuous learning. For example, on Downing Ward, staff participated in yearly cardiac arrest simulation training.

Good

Surgery

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

Information about the service

Surgery is the main inpatient activity within the hospital. No children are treated in the surgical service. Specialities include orthopaedics, spinal, gynaecology, ear nose and throat, ophthalmic, cosmetic and general surgery.

The top three surgical procedures performed in the reporting period were: injection aspiration, into joint, cyst, bursa with image guidance (1107 procedures); multiple arthroscopic operation on knee (463 procedures); ultrasound phacoemulsification of cataract with lens implant (410 procedures).

In the reporting period March 2018 to February 2019 there were 2,307 inpatient cases and 7,777day case episodes of care recorded at the hospital; of these 39% were NHS-funded and 61% other funded.

There are five theatres within the main operating department each with an adjacent anaesthetic room which operates from 7.30am to 8pm. The main theatres have access to a ten-bedded recovery bay. There are two theatres in the minor procedures unit which also operate from 7.30am to 8pm and there is a dedicated two-bedded recovery bay.

The hospital has three wards: Chartwell, Downing and Epping. During our inspection Chartwell ward was not in use due to low activity. Downing ward has 26 single rooms with en-suite facilities and accommodates medical and general surgery patients. Epping ward is the orthopaedic and spinal ward and accommodates 29 patients in single rooms with en-suite facilities.

There is a pre-operative assessment clinic on the ground floor of the building which comprises three clinic rooms and a staff office. Telephone pre-operative assessments are offered to patients who are assessed as appropriate for a telephone assessment.

We visited all clinical areas including theatres, recovery, the minor procedures unit and pre-operative assessment clinic during our inspection.

During our inspection we spoke with 29 members of staff including consultants, anaesthetists, nurses and allied health professionals. We spoke with the surgical leadership team and the hospital senior management team. We also spoke with five patients and one relative. We checked 10 patient records, the ward environment and equipment.

Are surgery services safe?

Good

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

Mandatory training

- **The service provided mandatory training in key skills to all staff and made sure everyone completed it.** The hospital provided a structured induction and mandatory training programme for staff.
- Staff received their mandatory training through face-to-face sessions and online courses. All new staff received a week-long induction to complete the courses. Temporary (agency) staff received a local induction which included orientation on the wards.
- The hospital set a target of 90% for completion of mandatory training courses. Mandatory training rates

for theatre staff as at September 2019 were 98% and 95% compliance for staff in pre-operative assessment. Training compliance in the reporting period for recovery staff was 96.7%, 95% on Downing ward and 99% on Epping ward.

- The mandatory training programme included information governance, equality, diversity and human rights, basic life support, dementia awareness, moving and handling, fire safety, protecting people at risk of radicalisation (PREVENT) care and communication of the deteriorating patient, consent, infection prevention and control and medicines management.
- Staff confirmed that it was easy to access the online learning platform and they received email updates when refresher training was due and could request protected time to complete these updates. Managers had access to monthly training records and monitored staff training compliance.
- Consultants with practising privileges were not required to complete training through the hospital's system. However, they were required to provide evidence that to the hospital that they had completed their training at their main place of work. We saw that their mandatory training compliance was monitored through a database which alerted the hospital when any training was due.
- Resident Medical Officers' (RMO) training compliance was managed through an agency but they told us they also had access to the hospital's online training system. Copies of the RMOs' training records were submitted to the BMI The Clementine Churchill Hospital by the agency so that the provider could have sight of and monitor training compliance.

Safeguarding

- **Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.**
- We reviewed the hospital's safeguarding adults and safeguarding children policies which were in date and available on the hospital's intranet and reflected the intercollegiate document. The policies detailed individual responsibilities and processes for reporting and escalation of concerns. The policies covered topics such as types of abuse, confidential counselling services and the Mental Capacity Act 2005.
- We also saw a safeguarding flowchart on the staff information board of relevant telephone numbers and contact details of the safeguarding lead in the staff room on the ward.
- Staff we spoke with had good awareness and knowledge about female genital mutilation (FGM) which was part of mandatory training within safeguarding and knew how to escalate concerns to the senior nurse and safeguarding lead. Staff also told us they had taken part in the preventing radicalisation of vulnerable people programme (PREVENT).
- The hospital set a target of 90% for safeguarding training. Staff were trained to level three in both adult and child safeguarding. Compliance rates in theatres, wards and recovery were consistently above 90%. However, in pre-operative assessment, compliance rates were below the hospital target at 66.7% for safeguarding adults level 1, 50% for safeguarding adults level 2, 66.7% for safeguarding children level 1 and 50% for safeguarding children level 2. We were told this was due to long term sickness and low staffing levels in the team. After the inspection we were told that the pre-operative assessment team comprised one sister, one registered nurse and one healthcare assistant. We were told that the sister had now completed all requirements for both children and adult safeguarding levels 1 to 3, the registered nurse had completed safeguarding adults level 1 and 2 and was due to complete safeguarding children level 3 and the healthcare assistant had completed both adult and children level 1 and 2 as required. The safeguarding lead for the hospital was level 4 safeguarding trained.
- All staff we spoke with demonstrated a good understanding of safeguarding vulnerable adults and children. Staff were able to identify the potential signs of abuse, the process for raising concerns and what would prompt them to make a referral. We were given examples of concerns they had identified and where referrals were made. Staff knew how to escalate concerns to the senior nurse and safeguarding lead.

Cleanliness, infection control and hygiene

Good

Surgery

- **Since our last inspection we saw improvements in infection, prevention and control (IPC). Staff used equipment and control measures to protect themselves and others from infection. They kept equipment and the premises visibly clean.**
- Surgical wards, theatres, pre-assessment clinic areas and the minor procedures unit were visibly clean and free of clutter. Hand sanitisers were available in all areas including at the point of entry to patient rooms on the wards. However, we did not see signage informing visitors to use hand sanitisers.
- Throughout our inspection all staff were observed to be 'bare below the elbow' and adhered to infection control procedures, such as hand washing and using hand sanitisers when entering and exiting wards and bed spaces. There was easy access to personal protective equipment (PPE), such as aprons and gloves the entrances to patient rooms. We witnessed staff using PPE effectively. Patients we spoke with were satisfied with the level of cleanliness of their patient rooms.
- At our last inspection we noted that there was carpeted flooring in the corridors which was not compliant with infection control guidance. At this inspection, carpeted flooring had been replaced with hard flooring and was now compliant with infection control guidance. The hospital was also in the process of installing clinical handwash basins on the wards.
- We inspected a sample of patient rooms and en-suite bathrooms and found them to be visibly clean. At our last inspection we found some mattresses were stained and damaged. At this inspection, we checked a sample of mattresses and saw that they were in good condition. We were told that the wards had an audit in August 2019 with the IPC lead which led to the replacement of 28 mattresses. We inspected various items of equipment including hoists, raised toilet seats, blood pressure cuffs and bed tables and found a good level of cleanliness.
- At our last inspection we noted gaps in the daily cleaning checklist for housekeeping staff. At this inspection we observed housekeepers working throughout the day following protocols and observed a detailed schedule of cleaning tasks to maintain the cleanliness of the ward. We noted at this inspection that there were no gaps in the documentation and that the checklist was monitored on a daily basis. We viewed a cleaning schedule on the wards for housekeepers with information on the type of cleaning task, such as the hard flooring and frequency for the area to be cleaned. We saw a form at the back of patients' observations chart in the patient's rooms which was used by the housekeepers and filled out and signed after every time the room was cleaned. Nurses we spoke with told us that the housekeepers regularly informed them when a room had been cleaned but that the form was also useful to refer to.
- The hospital now had an IPC lead who completed monthly IPC audits for each department. The results were shared with department leads and discussed at team meetings. The wards, theatres and minor procedures unit also had a dedicated IPC link nurse. The hospital had access to a consultant microbiologist at a local NHS trust who also contributed to the annual IPC report. The annual IPC report was completed by the director of clinical services who was the hospital's director of infection prevention and control (DIPC), the quality and risk manager and the IPC lead.
- We observed staff washing their hands and using hand sanitisers on the surgical wards. We looked at the hand hygiene audit for theatre from March 2019. The audit checked 76 items including before patient contact, after contact with bodily fluids/procedure, and after patient contact. The audit looked at registered nurses, healthcare assistants and medical staff. The service scored 76 out of 76 and was therefore 100% compliant. In the same reporting period, the minor procedures unit was 99% compliant, Epping and Downing ward were 100% compliant.
- Staff cleaned equipment after patient contact and labelled equipment with green 'I am clean' stickers to show when it was last cleaned.
- The decontamination of surgical equipment was completed off-site at a BMI facility. Staff told us that this worked well and they did not encounter any issues with the service. There was a system in place to track and trace equipment at each stage of the decontamination process.
- During our inspection there were no patients who were being barrier nursed; however nurses told us that if

there was a patient who required barrier nursing, there would be signs alerting staff on the door of the patient's room to alert staff and visitors of infection risk and to use the appropriate PPE.

- All patients were swabbed for meticillin-resistant staphylococcus aureus (MRSA) during their pre-operative assessment.Staff would inform the IPC lead when there was an infected patient in the hospital and the information would be highlighted in the patient's notes. Those patients with colonisation (on the skin but not infected) or infection such as MRSA would be allocated to the end of the theatre list to allow for the a deep clean of theatres before the next patient accessed the theatre the next day.
- There were no reported cases of MRSA and no reported cases of clostridium difficile in the reporting period.
- We saw that policies on the hospital intranet which showed that the surgical service was compliant with the National Institute for Health and Care Excellence (NICE) guidance relating to the prevention of surgical site infections. The hospital reported surgical site infections from hip and knee replacement surgery to Public Health England. From March 2019 to October 2019 there had been one surgical site infection which was investigated to be a community attributed superficial site wound infection.

Environment and equipment

- **The design, maintenance and use of facilities, premises and equipment kept people safe. Staff managed clinical waste well.**
- The hospital had two wards for surgical patients on the first floor of the building. Downing ward cared for general surgical patients and Epping ward cared for spinal and orthopaedic surgical patients. All patients were cared for in private single rooms with en-suite facilities. All patient rooms had a call bell and emergency buzzers in the main patient bedroom area and the en-suite bathroom.
- On the ground floor, there were five operating theatres and a 10-bed recovery bay. Four of the five theatres had laminar flow. Laminar flow theatres aim to reduce the number of infective organisms in the theatre air by generating a continuous flow of bacteria free air. Access to theatres was by keypad locked door. There was also a patient transfer lift from theatre to wards and the intensive care unit on the first floor.
- The minor procedures unit was located near outpatients and comprised of two theatres and a two-bed recovery bay. At our last inspection we saw that one theatre was used for storage. At this inspection we saw that theatres were clear of clutter and not used for storage purposes
- Medicines rooms were locked to prevent unauthorised entry. Linen cupboards and storage rooms were appropriately stocked and tidy.
- Emergency trolleys were available on each ward and in theatres. Pre-operative assessment clinic area and the minor procedures unit had access to the resuscitation trolleys in outpatients. We checked the emergency trolleys on wards and theatres and found that they were secured with a plastic snap lock, so it was clear if someone had accessed the resuscitation equipment. Equipment on the top of emergency trolleys were checked daily and equipment in the drawers were checked on a weekly basis with expiry dates documented on the record check sheets which were signed to confirm checks had been made. We checked various consumables, such as cannulas, masks and syringes and found that they were sealed and in date.
- We saw evidence that equipment had been serviced and calibrated regularly. We checked various items of equipment such as defibrillators, glucometer and blood pressure monitors and found they had been safety tested. We saw that safety checks had been completed and logged for anaesthetic machines. At our previous inspection we found some equipment in use within the department had not been safety tested. At this inspection we found equipment had safety test stickers and they were in date.
- Oxygen tanks were stored securely and were in date. We inspected three sharps bins and found them to be correctly labelled and not filled above the maximum fill line.
- We checked consumable equipment cupboards and found that all items we sampled were in date and packaging was intact, indicating it was sterile and safe for use in patient care.

- Waste management was handled appropriately, with different colour coding for general waste, and clinical waste. All clinical bins were seen to be operated with lids and were not overfilled. Waste management and removal including those for contaminated and hazardous waste was in line with national standards.
- The hospital had access to bariatric equipment such as a bariatric operating table, bariatric wheelchairs and patient rooms with wider doors.
- The IPC lead conducted patient equipment audits. The audit checked 16 items including cleaning schedules, use of detergent and disinfectant wipes, use of PPE. Audit results for March 2019 showed compliance of 94% for the minor procedures unit, 94% for theatres, 100% for Downing ward and 94% for Epping ward. Actions were noted within audits where areas of improvement were identified, for example to remind staff to use green 'I am clean' stickers after equipment had been cleaned.
- The hospital continued to have a service contract for equipment which was hired in theatres.
- Equipment faults could be reported electronically and monitored by staff.
- At our last inspection we found that resident medical officers (RMOs) used empty patient rooms on another ward to rest when on duty overnight or between shifts. RMOs now had their own allocated rest room.

Assessing and responding to patient risk

- **Staff completed and updated risk assessments for each patient. Staff identified and quickly acted upon patient at risk of deterioration.**
- Staff we spoke with were aware of escalation protocols for deteriorating patients and the use of national early warning scores (NEWS2). We checked patients' NEWS charts and found them to be correctly filled in and we saw evidence that appropriate escalation had taken place where a patient had scored a high NEWS score. NEWS2 was audited as part of the health documentation audit. Results from the March 2019 audit showed 100% compliance.
- The use of the World Health Organisation (WHO) five steps to safer surgery checklist was embedded in practice and we saw that staff consistently used this in theatres. The latest audits as at March 2019 showed 97% compliance for WHO checklist completion.
- In theatre we observed staff members wearing different coloured surgical caps in order to clearly identify the role of each person in theatre. Blue surgical caps indicated qualified staff, white were for visitors, green identified healthcare assistants and the theatre leader wore a yellow cap.
- During our inspection, we observed an anaesthetic practitioner check a patient in without using the checklist in the booklet provided and therefore did not fill the paperwork in at the time of checking in the patient. We raised this with the theatre manager who immediately spoke to the staff member and also raised the issue at the afternoon briefing and reminded staff to the checklist and fill it in in real time mode and not to do this retrospectively.
- Staff we spoke with said they had received training in sepsis and the sepsis six care bundle which consists of three tests and three treatments management of patients with presumed or actual sepsis. There was a sepsis board on the ward with information on escalation, contact numbers and flowcharts for staff to follow as well as a sepsis folder at the nurse's station which all staff were required to sign once they had read the documents on sepsis within the folder. Staff used the situation, background, assessment and recommendation (SBAR) tool for escalation.
- Patients were assessed in the pre-operative assessment clinic by a nurse prior to their surgery. This was conducted face to face or over the telephone depending on certain criteria. The service did not treat complex patients, such as psychiatric patients, but did treat some patients with multiple co-morbidities, in line with the admission criteria. The service had strict admission criteria and did not accept bariatric patients with a body mass index (BMI) of 40 or greater and patients with complex co-morbidities where patients were NHS funded in line with their standard contract. The service followed National Institute for Health and Care Excellence (NICE) recommendations for pre-operative tests.

- We saw evidence in patient notes that risk assessments had been completed. For example, patient notes recorded falls risk assessments, malnutrition risk assessments and moving and handling risk assessments. Notes showed that patients were assessed for VTE risk on admission and 24 hours after admission in patient documentation. Venous thromboembolism (VTE) risk assessments were completed for all patients by nurses and VTE audits for the reporting period showed 100% compliance. This was an improvement since the last inspection where we found that 50% of patient had VTE risk assessments completed. We saw that on risk assessments where the VTE score was high, it was signed off by a consultant to show that the consultant had checked this.
- The service used the Waterlow pressure ulcer prevention score tool to assess patients' risk of developing a pressure ulcer. However, the service did not have access to a tissue viability nurse as the post was currently vacant. The clinical services manager told us that the hospital was recruiting to the post and there were staff who had taken tissue viability courses and were able to support patients. They told us that hospital also had access to pressure relieving mattresses but that if a patient had very serious pressure ulcers, they would not be admitted on to the ward at this hospital.
- Patients received a discharge information pack when they were discharged from the hospital. The pack included information such as symptoms to look out for and a 24-hour telephone number to the wards if they had any concerns or needed advice post-discharge.
- All nursing staff had completed immediate life support training, all healthcare assistants had completed basic life support training and resident medical officers (RMO) had completed advanced life support training.
- If a patient deteriorated, nursing staff would escalate for support from the resident medical officer (RMO). The RMO would contact the patient's consultant, bleep the hospital's critical care outreach and resuscitation team or arrange for transfer to a local NHS hospital depending on the severity of the patient. There was an on-call team which included a radiographer, theatre team and senior staff who were supported through an on-site duty nurse who covered 24 hours day seven days a week. The on-call theatre team were available for emergency returns to surgery out of hours.
- There was 24-hour access to diagnostic imaging (with the exception of MRI and single-photon emission computed tomography (SPECT CT). There was access to an on-call radiographer and a break in policy to theatres which would be coordinated by the theatre manager.
- While there was no formal on-call anaesthetist rota, the hospital followed its practising privileges policy which stated that consultants and anaesthetists retained responsibility for their patient for the patient's entire clinical pathway. Consultants were required to be contactable by telephone and available to attend their patient at all times in the event of an emergency. Anaesthetists and consultants informed the hospital of who would be covering them if they were not able to attend to their patient. The hospital was able to demonstrate examples of occasions where consultants were called in and diagnostics were undertaken out of hours.
- We were told by an anaesthetist that if the hospital required an anaesthetist at short notice, there was a text messaging system where anaesthetists were contacted and could respond to the text message on a first come first serve basis. However, we noted that that the BMI care of the deteriorating patient policy stated that there should be an anaesthetist rota in place which meant that the policy did not align with the BMI practising privileges policy. The hospital subsequently informed us that this discrepancy had not been identified by the corporate provider's National Clinical Governance Board who were responsible for these policies. The hospital had also not identified or escalated this discrepancy to the corporate governance board but told us that they had escalated the issue of the anomaly following our inspection.
- Between April 2018 and March 2019 there were 14 unplanned returns to theatres and one unplanned transfer to another hospital.
- The hospital did not have any issues when transferring patients out to a local NHS trust but was also in the process of agreeing a formal service level agreement with the local NHS hospital.
- Staff could access mental health support 24 hours a day, seven days a week if they had concerns about a patient's mental health.

Nursing and support staffing

- **The service had enough staff with the right qualifications, skills, training and experience to keep patients safe from avoidable hard and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix, and gave bank, agency and locum staff a full induction.**
- The hospital used a BMI nursing staffing planner tool to determine staffing levels. The tool was populated with activity, acuity and staff rosters in advance so that staffing levels could be reviewed and planned in a timely manner. We attended handovers and daily bed meetings which discussed staffing levels for the day and any needs for cross cover across wards. Staff in theatres and wards reported generally good levels of staffing. Staff said that this enabled good supervision of more junior staff and also allowed for staff to be able to complete documentation, post-op phone calls and audits.
- However, staff in pre-operative assessment told us staffing levels were low. The pre-operative assessment team comprised one sister, one registered nurse, one healthcare assistant and one administrator. Staff told us that while an advertisement had gone out to recruit another nurse to the pre-operative assessment team, the post had not been filled for some time and this had put a strain on the team's workload. The senior management team were aware of staffing levels in pre-operative assessment and we saw that this was recorded on the risk register.
- The service was meeting the Association for Perioperative Practice standards and there was sufficient staffing to meet the needs of surgical patients admitted for procedures. There were 50 whole time equivalent staff members in theatres, the minor procedures unit and endoscopy. Four members of staff were allocated per surgical list and an additional surgical first assistant if required. The department had seven surgical first assistants and four in training. The department provide surgical first assistants in 90% of all cases that required them. At the time of our inspection there were four vacancies in theatres which were filled using bank staff. Theatres did not use agency staff. The service undertook elective surgeries and was able to plan staff accordingly. During our inspection we saw that there were enough staff allocated to theatres, recovery and the surgical wards.
- Staff sickness and turnover rates were low. From May 2018 to April 2019, the hospital reported a staff turnover rate of 1.8% for inpatient and theatre staff. From May 2018 to April 2019 turnover for theatre staff was 0% for nursing staff and 2% for operating department practitioners and healthcare assistants. The hospital reported a staff sickness rate of 4.7% in the same reporting period. Bank and agency staff were used on wards and staff told us that they tried to get the same agency staff in order to maintain continuity of care to patients.
- There was an information board on the wards which detailed staffing levels for the day, the name of the nurse in charge, fire warden and the physiotherapist on the ward.

Medical staffing

- **The service had medical staff, with the right mix of qualification and skills, to keep patients safe and provide the right care and treatment.**
- Consultants and anaesthetists worked under BMI practising privileges agreements. Under practising privileges, a medical practitioner is granted permission to work within an independent hospital. Practising privileges were granted to consultants by the medical advisory committee. Consultants with practising privileges had their appraisal, mandatory training and revalidation undertaken by their NHS trust however BMI The Clementine Churchill monitored annual compliance and followed up with staff when updates were required.
- Consultants reviewed patients daily and we saw evidence of this in patient notes we reviewed.
- The hospital used resident medical officers (RMO) provided by an external company who provided 24-hour, seven day a week service on a rotational basis. All RMOs working at the hospital were selected specifically to enable them to manage a varied patient caseload and particular requirements. There were two RMOs who worked split shifts to ensure that they had time off during the 24 hours. The shifts worked were 8am to 4pm, 4pm to midnight and midnight to 8am.

- At our last inspection we found that there were 462 consultants with practising privileges at the hospital and 57% of these consultants had not carried out any episodes of care between April 2014 and March 2015. The executive director had conducted a review of consultants with practising privileges and as at April 2019, there were 345 doctors with practising privileges for more than six months at the hospital. The hospital removed practising privileges from consultants if there was non-compliance with documentation or under-utilisation at the hospital. Between May 2018 and June 2019, 78 doctors had their practising privileges removed by the hospital as they had not practised at the hospital for six months or more. In the same period, there were 18 cases of suspended practising privileges of medical staff.
- The hospital also had an on-call team which included a radiographer and on-site duty nurse who covered 24 hours day seven days a week.
- Anaesthetists were responsible for their patients throughout their stay in hospital and while there was no formal rota for on call consultants or anaesthetists, the relevant staff were contacted directly by staff when required. Staff were aware of this arrangement and did not report any concerns with this process.
- Consultant surgeons were required to be contactable by telephone and be able to attend to their patient at all times or ensure there was suitable cover to attend to patients in the event of an emergency.
- The pre-operative assessment nurses liaised with anaesthetists and consultants with to ensure the right tests and investigations were arranged for patients. At the time of our inspection, there was a team of four anaesthetists allocated to pre-operative assessment whom nurses could approach. However, we were told that this would be reduced to one anaesthetist and staff expressed concern that this would impact upon the workload of the clinics and timely access to an anaesthetist. We spoke with senior leaders about this who told us that the lead anaesthetist's role would be dedicated to pre-operative assessment clinics and therefore they would be available on the phone at all times. It was also planned that the anaesthetist would run two to three sessions a week on site.

Records

- **Staff kept detailed records of patients' care and treatment. Records were clear, up to date, stored securely and easily available to all staff providing care.**
- The hospital used paper records to record patient needs, care plans and risk assessments. Consultants sent letters to a patient's general practitioner (GP) with information around the outcome of a consultation. Patients who were admitted to the hospital would also have a discharge summary sent from the hospital and consultant to the patient's GP.
- Patient notes were kept securely in locked cupboards. The service was in the process of replacing the cupboards with purpose built medical records storage which would allow for more space to securely keep records.
- Staff in pre-operative assessment commented that patients sometimes did not arrive with a completed record which meant that there were gaps in history or medication. This meant that staff had to contact GPs to seek the information and this would sometimes mean a patient's surgical appointment could be delayed or cancelled.
- Pre-operative assessments were completed by nursing staff either face to face or over the telephone depending on the type of surgery the patient was to have. Pre-operative assessment records included the patient's medical history, medication they took, allergies, fasting instructions and discharge instructions. We saw in patient records that risk assessments had been completed such as a malnutrition risk assessment, pressure ulcer risk assessment, moving and handling risk assessment and falls risk assessment.
- We reviewed 10 sets of patients records and found that they were comprehensive and detailed. Records noted patients' additional needs such as if a patient required additional support with regards to mobility. National early warning system (NEWS2) observations were completed, venous thromboembolism (VTE) risk assessments were completed and signed off by the consultant. Care plans were in place and there was evidence that these were reviewed daily. Allergies were also recorded on drugs charts. We saw evidence in patient records and our observations in theatres that staff completed the safety checks undertaken during

procedures using the World Health Organisation (WHO) five steps to safer surgery checklist. The latest WHO observational audits as at March 2019 showed 97% compliance.

- At our last inspection, we found gaps in patient records around admission details and patients' specific needs. At this inspection we found that patient records completion had improved, and admission details were comprehensive with detail around the patient's needs such as if the patient had mobility difficulties.
- At our last inspection we found anaesthetic records variable with gaps in documentation and illegible writing. At this inspection we found these records were comprehensive, noted patient's past medical history and medication given was written clearly and was legible. Operation notes were legible and postoperative plans were clearly documented.
- Records audits for March 2019 showed 80.1% compliance for Epping ward and 82.3% compliance for Downing ward however we did not see the action plans to improve compliance rates during our inspection.
- We observed staff logging off computers after use. Information governance formed part of mandatory training for nursing and medical staff.

Medicines

- **The service used systems and processes to safely prescribe, administer, record and store medicines.**
- Suitable arrangements were in place for the ordering, dispensing, prescribing, recording and handling of medicines.
- All staff undertook medicines management training as part of their mandatory training.
- Medicines were stored safely in locked cupboards and fridges within keypad locked treatment rooms. Checks for expired medicines were completed as well as the daily temperature checks of the room and the fridge used to store medicines. The fridge temperature logs that we checked were all within acceptable range.
- Nursing staff were aware of the policies on the administration of controlled drugs (CDs) (medicine that is controlled under the 'Misuse of Drugs Act' (2001). CDs were stored in line with required legislation and recorded in a controlled drugs register. The register containing details of the contents of the CD cupboard was stored within the cupboard and identified the expected stock of medicine. Two members of staff checked the CD stock levels. We checked a sample of CD stock levels and found them to be accurate and the medicine in date. The keys for the CD cupboard was held by the lead nurse on the ward.
- The pharmacy team undertook controlled drugs audits. Audit results for March 2019 showed an improvement since the last inspection with compliance rates of 96% for Downing ward, 100% for Epping ward and 100% for theatres.
- Patients records showed that the allergies were clearly documented when medicines were prescribed. Medicines to take out (TTO) were stored securely until the patient was discharged.
- At our last inspection we found bags of intravenous (IV) fluid which were stored in unsecured drawers in the minor procedures unit. At this inspection we found IV fluids in the minor procedures unit were now stored in locked cupboards.
- Microbiology protocols for the administration of antibiotics were available on the hospital intranet and via an app and staff knew how to access these.
- A pharmacist visited the ward every day and checked prescription charts and CD books. Staff told us they were always available to provide advice and guidance. The pharmacy service was available Monday to Friday from 8.30am to 8pm, Saturdays 9.30am to 2pm and there was an on-call service on Sundays. Outside of these hours, staff could contact an on-call pharmacist. Pharmacy staff completed medicines reconciliation in a timely manner.
- The pharmacy team produced a medicines management newsletter which informed staff of any medicines incidents, safety alerts and updates. The pharmacy team would also attend the daily "comm cell" meetings to share any medicine information with clinical services managers who would then disseminate the information to staff on wards and in theatres. "Comm cell" meetings were held every morning and attended by heads of department and the senior management team. Incidents, complaints, policy

updates, expected admissions, and risks were discussed at the meeting and information was cascaded down through ward or theatre team meetings as well as by email.

Incidents

- **The service managed patient safety incidents well. Staff recognised and reported incidents and near misses. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support. Managers ensured that actions from patient safety alerts were implemented and monitored.**
- At our last inspection incidents were reported using a paper-based system. At this inspection the hospital was now using an electronic incident reporting system. Staff were aware of their responsibilities for reporting incidents and near-misses and were able to explain how this was done. Staff told us they were encouraged to report incidents and generally received feedback on the incident they reported. Staff told us that as a result of an increase in reports of patient falls, a falls group was created to review any incidents and key learning arising from them.
- Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event. From September 2018 to August 2019 to June 2018, the hospital reported no incidents classified as never events for surgical services.
- In accordance with the Serious Incident Framework 2015, there were five serious incidents (SIs) in the reporting period.
- From April 2018 to March 2019 there were 1098 incidents reported within the hospital. Of these 763 were within surgical services. Of these, 806 were categorised as 'no harm', 278 as 'low harm' and 12 as 'moderate harm'. There were zero severe harm and two unexpected deaths. We reviewed the root cause analysis (RCA) reports for the SIs in surgical services and found that these were investigated appropriately in accordance with the Serious Incident Framework 2015. All RCA reports had corresponding action plans in place where action needed had been identified.
- 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. Staff we spoke with were able to explain the duty of candour fully.
- Managers investigated incidents thoroughly. Learning from incidents was shared at daily "comm cell" meetings and at ward meetings. Ward managers printed out the learning and put it in the staff room so staff who were unable to attend the meeting could still access the learning. We also viewed monthly theatre team minutes and saw that the meeting discussed incidents with lessons learned within surgical services. The monthly clinical governance meetings also discussed deaths and root cause analysis investigations from incidents.

Safety Thermometer

- **The service used monitoring results well to improve safety. Staff collected safety information and shared it with staff, patients and visitors.**
- The safety thermometer is used to record the prevalence of patient harm and to provide immediate information and analysis for frontline teams to monitor their performance in delivering harm free care. It measured the proportion of patients that experienced 'harm free' days from pressure ulcers, falls, urinary tract infections in patients with a catheter and venous thromboembolism (VTE). Staff were aware of their duty to report and reduce incidents of pressure ulcers, falls and VTE. Audits showed that all patients had been assessed for VTE.
- We saw that safety thermometer data was displayed in Downing and Epping wards. Quality and safety boards on the ward showed that in Downing ward it had been 248 days since the last hospital acquired pressure ulcer; 248 days since the last surgical site infection and 156 days since the last patient fall. In Epping ward, the

quality and safety board showed that it had be 248 days since the last hospital acquired pressure ulcer, 248 days since the last surgical site infection and 95 days since the last patient fall.

Are surgery services effective?

Good

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

Evidence-based care and treatment

- **The service provided care and treatment based on national guidance and evidence-based practice. Managers checked to make sure staff followed guidance. Staff protected the rights of patients subject to the Mental Health Act 1983.**
- The service delivered care in line with national clinical guidance. Staff had access to policies and procedures based on national guidance on the hospital intranet. The service was meeting standards set out by the Association for Perioperative Practice. Outcome data was reviewed at clinical governance meetings and "comm cell" meetings. The surgical service held academic half days once a month where everyone in the department was invited to view audit outcomes for the division.
- We reviewed a sample of hospital policies including policies for safeguarding adults, pre-operative assessment and local safety standards for invasive procedures which were all in date and appropriately referenced national guidance and best practice such as that recommended by the National Institute for Health and Care Excellence (NICE) and the association of surgeons of Great Britain and Ireland. Policies contained appropriate guidance for screening referrals and specific interventions.
- Policies were reviewed by the quality and risk manager and changes to policies were discussed at clinical governance meetings. The quality and risk manager alerted clinical services managers of any policy changes at "comm cell" meetings. Clinical services managers then shared the information at ward meeting. Staff also received emails alerting them to changes that had been made to policies.
- The service used evidence based 'care bundles'. A care bundle is a set of evidenced based interventions that, when used together, can improve patient outcomes. For example, we saw that staff used catheter care bundles. The service also used the sepsis six care bundle which consists of three treatments and three tests for the management of patients with presumed or actual sepsis. The surgical service used the 'One Together' assessment toolkit which assessed seven areas of care that were fundamental to best practice in minimising the risk of surgical site infection.
- Adherence to and understanding of NICE guidelines was embedded and evidenced through the use of audit programmes to benchmark practice. The service was able to demonstrate that it participated in several national clinical audits such as the national joint registry (NJR), patient reportable outcome measures (PROMS) and the national breast and implant register.
- We saw that there was a formal annual clinical audit plan in place to evidence performance monitoring, quality measures or patient outcomes relating to surgical services. The audit plan detailed the frequency at which the audits should be undertaken and included audits for infection prevention, WHO five steps to safer surgery, patient pathway, falls and the One Together toolkit. Managers monitored and discussed results at clinical governance meetings.

Nutrition and hydration

- **Staff followed national guidelines to make sure patients fasting before surgery were not without food for long periods.**
- There were appropriate processes in place to ensure patients' nutrition and hydration needs were met on the wards. The service had dedicated dietitians to support nutritional planning for patients.
- Food menus catered for different patient groups including those with specific dietary requirements such

as allergies and intolerances. We saw that water jugs in patients' rooms were regularly replenished and patients told us they could ask for snacks or hot drinks throughout the day.

- We saw that catering staff were made aware of patients' dietary requirements on a board in the kitchen.
- Fasting instructions were given to patients at the pre-operative assessment stage and patients told us that staff checked with them that they understood the instructions.
- The service used evidence-based tools to screen for malnutrition. We saw in patient records that the service used the malnutrition universal screening tool (MUST) tool for assessing patients' nutrition. We saw fully completed fluid charts which were used to monitor patients particularly after a surgical procedure.

Pain relief

- **Staff assessed and monitored patients regularly to see if they were in pain and gave pain relief in a timely way. They supported those unable to communicate using suitable assessment tools and gave additional pain relief to ease pain.**
- Staff used standardised pain assessment tools to measure patients' pain. Patients were asked to describe their pain with a score of zero (no pain) to three. For patients who had difficulties communicating, staff used a series of smiley face symbols which a patient could point to in order to describe their level of pain. Pain advice booklets were also given to patients upon discharge with information and telephone numbers to call if they had any concerns about pain when they were at home. Patients we spoke with told us their pain had been managed appropriately and that they received pain relief in a timely manner.
- Pain management was audited as part of the health documentation audit. The audit covered 18 areas around pain management including whether there was documented evidence of pain scores on pain management care plans, whether the patient's pain management was planned and evaluated throughout their stay, whether any non-pharmaceutical pain management methods were advised, evidence that patient pain levels were managed appropriately and whether information on pain management was given on discharge. Results for the March 2019 showed 98% compliance for Downing ward and 99% compliance for Epping ward.
- There was an up to date policy and guidelines for treating acute pain in in-patients which was accessible on the hospital intranet.

Patient outcomes

- **Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for patients.**
- The hospital audited patient outcomes and reported on these at clinical governance meetings. We viewed minutes of the last clinical governance meeting which showed discussion around key performance indicators such as unplanned readmissions, unplanned returns to theatre, unplanned transfers out of the service, healthcare associated infections and significant incidents.
- From April 2018 to March 2019 there were 2307 in-patient attendances. In the reporting period there was one unplanned transfer to another hospital, 11 unplanned readmissions within 28 days of discharge and 14 unplanned returns to theatre.
- The service participated in national audit programmes such as the national joint registry (NJR) which collects data to monitor the performance of joint replacement implants and the effectiveness of different types of surgery. The best practice tariff for hip and knee joint replacement surgery is conditional on hospitals achieving a minimum compliance rate of 75% with the NJR. BMI The Clementine Churchill Hospital achieved 91% in 2018 and 100% this year to date.
- The service also participated in patient reportable outcome measures (PROMs). Patient reported outcome measures (PROMs) assesses the quality of care delivered to NHS patients from the patient perspective. Patients undergoing elective inpatient surgery for hip and knee replacement, are asked to complete questionnaires before and after their operations to assess improvement in health as perceived by the patients themselves. Results showed that there was a consistent

improvement in health gain following hip and knee surgery achieved by patients. The hospital also participated in PROMS for private funded patients for hips, knees, hernias and cataracts.

- The hospital was also working towards EQ-5D which is a patient-reported outcome measure (PROM) that captures five dimensions of health-related quality of life: mobility, self-care, usual activities, pain/discomfort, and anxiety/depression.
- The hospital reported surgical site infections from hip and knee replacement surgery to Public Health England. From March 2019 to October 2019 there had been one surgical site infection which was investigated to be a community attributed superficial site wound infection.
- The hospital submitted data to the private healthcare information network (PHIN). PHIN is an independent patient information network that works to empower patients to make informed choices about their care provider.

Competent staff

- **The services made sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and development.**
- Staff were experienced, qualified and had the right skills and knowledge to meet the needs of patients.
- New staff received a comprehensive week-long hospital induction and were given competency booklets which were signed off by senior members of staff once a competency had been achieved. Staff told us that their training needs were met, and managers were always willing to support their development. On Downing Ward, staff participated in yearly cardiac arrest simulation training, delivered by the Resuscitation Council (UK). Staff also told us there were opportunities for them to undertake university accredited courses.
- The hospital's appraisal year ran from November to October. At the time of inspection, 67.6% of theatre staff and 53% of healthcare assistants and operating department practitioners had completed their appraisal. 15.2% of inpatient ward nursing staff had completed their appraisal with 84% on track to complete their appraisal before the end of October 2019. The senior management team told us they planned to ensure all appraisals had been completed and recorded electronically by the end of 2019.
- The service used regular agency staff to ensure continuity of care. There were specific induction packs for agency staff.
- Staff told us that they would sometimes have student nurses undertaking their final placements at the BMI The Clementine Churchill Hospital. There were no student nurses at the time of our inspection; however, staff showed us a folder where student nurses had left comments about their experiences on the ward during their placements. Comments were very complimentary and included comments around good learning opportunities, environment and support received.
- There was a practice educator in theatres who supported preceptorships. The hospital was in the process of recruiting to another clinical practice educator post which was vacant at the time of our inspection.
- Revalidation was introduced by the Nursing and Midwifery Council (NMC) in 2016 and is the process nurses and midwives must follow every three years to maintain their registration Nursing staff told us they were supported with their revalidation through clinical supervision.
- A number of staff had taken on roles as link nurses in various specialities. For example, the service had dementia champions, IPC nurses and nurses who had undertaken tissue viability courses. The service also had a specialist spinal nurse and access to a breast care specialist nurse.
- All consultants under practising privileges received an induction pack which included details on what was required of them to practise at BMI. Each application for practising privileges was assessed by the Medical Advisory Committee (MAC) and we saw evidence of this in the MAC minutes we reviewed. Consultants also had a biennial review with the executive director which discussed clinical indictors such as returns to theatre, readmissions, infection rates complaints and incidents, procedure volumes and scope of practice.

- Resident medical officers were recruited through an external organisation and were required to have advanced life support training. All nursing staff had immediate life support training and healthcare assistants were trained in basic life support.

Multidisciplinary working

- **Doctors, nurses and other healthcare professionals worked together as a team to benefit patients. They supported each other to provide good care.**
- We saw evidence of good multidisciplinary team (MDT) working within the surgical service. We saw evidence of good working relationships between nurses and medical staff. Nursing staff said that consultants were always available for advice and support. In theatres we saw that there was respect for each member of the team and the contribution they made.
- We observed multidisciplinary approaches to care planning for patients and families. Patient records demonstrated input from the full clinical team of doctors, nurses and allied health professionals such as physiotherapists from pre-operative assessment through to post-operative care.
- Staff throughout the surgical service reported good working relationships and timely input from physiotherapy staff and dietitians.
- There was evidence of effective multidisciplinary partnership working with external agencies and professionals. The hospital had strong links with social services and local NHS hospitals. Letters were sent to a patient's general practitioner (GP) to share outcomes and discharge information.
- At our last inspection we observed a handover take place at the nursing station where sensitive information could be overheard. At this inspection, we saw that staff took care not to undertake handovers or sensitive conversations in areas where they could be overheard.
- At our last inspection we noted that there was no evidence of multidisciplinary liaison between therapy and nursing staff for patients with complex moving and handling needs. At this inspection we saw physiotherapists liaising with nursing staff and saw that records had comprehensive input from physiotherapists and occupational therapists. Physiotherapists and occupational therapists were involved in both pre and post-operative assessment and care.
- Similar to what we reported at the last inspection, while there were no formal multidisciplinary team meetings held for surgical patients, meetings were held for complex patients. We observed a multidisciplinary meeting for a complex patient which involved the patient, their relative and the surgical team including an anaesthetist, haematologist and surgeon. The meeting was facilitated by the assistant director of clinical services. There was a holistic discussion about the patient's needs and communication was clear and inclusive.
- The daily "comm cell" meetings were attended by MDT staff. Pharmacists supported on the ward and provided information to patients on their medications. The also attended the daily "comm cell" meetings.
- The theatre team had afternoon briefings to discuss changes to lists, disseminate safety messages and discuss staffing levels. There were also daily safety huddles on the wards to discuss patient care which were attended by nurses, healthcare support workers and therapy staff.

Seven-day services

- **Key services were available seven days a week to support timely care.**
- Theatres, recovery and the minor procedures unit operated from Monday through to Saturday from 7.30am to 8pm. Consultants who had patients at the hospital were required to be within a 30-minute commute to the hospital in case of a patient emergency or make necessary arrangements for cover. Resident medical officers provided cover 24 hours a day, seven days a week for patients on the wards.
- The pharmacy operated from Monday to Friday 8.30am to 8pm and 9.30am to 2pm on Saturdays. There was an on-call service on Sundays. There was out of hours access to pharmacy by the resident medical officer and senior nurse in charge.
- There was access to 24-hour diagnostic imaging on site (with the exception of MRI and SPECT CT). The hospital also had access to an on-call radiographer.

Good

Surgery

- Patients received a daily review from their consultant and there was a full physiotherapy service for patient seven days a week from 8am to 8pm. A physiotherapist could also be contacted out of hours.
- There was an on-call team which included a radiographer, theatre team and senior staff who were supported through an on-site duty nurse who covered 24 hours day seven days a week. The on-call theatre team were available for emergency returns to surgery out of hours.
- An Arabic speaking interpreter was also available on site seven days a week.

Health promotion

- **Staff gave patients practical support and advice to lead healthier lives. However, there were few examples of health promotion materials in ward areas.**
- Staff advised patients on smoking cessation in pre-operative assessment. Staff could refer patients to see the physiotherapists and dietitians during their stay in hospital.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- **Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients' consent. They knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health.**
- We saw completed consent forms in all 10 patient records we reviewed. We observed consent being confirmed with patients in theatre prior to anaesthetisation.
- Staff understood how and when to assess whether a patient had the capacity to make decisions about their care.
- Staff received training on the Mental Capacity Act (2005) as part of their mandatory training within the consent module. Compliance rates for staff in theatres, wards and pre-operative assessment was 100%.
- Staff were able to give clear explanations of their roles and responsibilities under the Mental Capacity Act 2005 (MCA) regarding mental capacity assessments and deprivation of liberty safeguards (DoLS).
- Patients who had taken the decision to undergo cosmetic surgery had a 'cooling off' period of 14 days where they could change their mind about their decision. Depending on the procedure, consultants ensured that patients were reviewed by a psychiatrist prior to undergoing cosmetic surgery.

Are surgery services caring?

Good

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

Compassionate care

- **Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.**
- Feedback from patients confirmed that staff treated them well and with kindness. Staff promoted privacy and patients were treated with dignity and respect. In the recovery bay we saw nurses covering a patient with a blanket to keep them warm and in wards we saw nurses knocking on patient room doors before entering.
- We observed all staff in theatres, recovery and surgical wards to be caring and compassionate with both patients and their relatives without exception during the inspection. Comments from patients included: "Care has been fantastic, I cannot fault them and nothing is too much trouble" and "Staff are attentive and respectful."
- Patients and relatives spoke highly of the service and how supportive the staff were. Relatives told us that they were welcomed on the ward by staff and one relative told us staff helped them set up their laptop so they could work by their loved one's bedside. We observed a housekeeper being attentive to a patient's needs.
- BMI used a friends and family test satisfaction survey that measures patients' satisfaction with the healthcare they have received. The hospital's results were

consistently high. In July 2019, the hospital response rate based on 218 responses was 55.5%. This response rate was higher than the England average of 26.1%. 98% of those who responded said they would recommend the service to their friends and family.

- However, the hospital patient-led assessment of the care environment audit (PLACE) showed the hospital scored 65% for privacy, dignity and wellbeing. This was worse than the national average of 84.2%. We did not see the action plan during our inspection in response to this score however patients we spoke with said their privacy and dignity was respected, especially during physical or intimate care.

Emotional support

- **Staff provided emotional support to patients, families and carers to minimise their distress. They understood patients' personal, cultural and religious needs.**
- We spoke to a patient who told us that staff helped allay their fears of surgery by spending time with them and listening to their worries. We saw staff reassuring patients in the recovery
- Staff described that patients were given a direct line to the ward when they were discharged so they could call for advice and support at any time of the day.
- Staff were passionate about their work and focused on delivering patient centred care. We observed staff spending time chatting with a patient and leaving their patient room door open as requested so they did not feel so isolated in their private room.
- In most records we reviewed, a patient's religious needs were documented. Staff told us that they would make arrangements to help patients and relatives use prayer rooms which were located on site

Understanding and involvement of patients and those close to them

- **Staff supported and involved patients, families and carers to understand their condition and make decisions about their care and treatment.**
- Staff involved patients and those close to them in decisions about their care and treatment.Patients told us they felt comfortable asking doctors and nurses questions and felt involved in their treatment plans. Patients told us staff spent time explaining and repeating any details that they did not understand.
- We saw staff introducing themselves to patients and taking the time to answer any questions they had about their care. We heard from both patients and staff that NHS and non-NHS patients were not treated differently at the hospital.
- Patients told us that conversations about finances were done so with sensitivity at the beginning of the process and that they had all the information they needed before deciding to proceed. However, one patient commented that they felt the pre-assessment stage was rushed.
- We observed a multidisciplinary team meeting where a patient discussed their procedure and specific needs with the medical team. The team answered the patient's questions and repeated explanations to ensure they understood the procedure and its associated risks.
- Staff worked with patients to promote their understanding and empowered them to play an active role in their treatment and care. Patients commented that they regularly saw the physiotherapist who helped them rehabilitate and encouraged early mobilisation after surgery to encourage independence and helped build confidence.

Are surgery services responsive?

Good

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

Service delivery to meet the needs of local people

- **The service planned and provided care in a way that met the needs of local people and the communities serviced. It also worked with others in the wider system and local organisations to plan care.**
- Surgery was the main inpatient activity within the hospital. The service covered range of specialities including orthopaedics, ophthalmology, urology

gynaecology, general, ear, nose and throat, spinal and cosmetic surgery. Services provided to the NHS were mainly orthopaedics, ophthalmology, gynaecology, urology, ear, nose and throat and general surgery.

- In the reporting period March 2018 to February 2019 there were 2,307 inpatient cases and 7,777day case episodes of care recorded at the hospital; of these 39% were NHS-funded and 61% other funded.
- There were five theatres within the main operating department each with an adjacent anaesthetic room which operated from 7.30am to 8pm. The main theatres had access to a ten bedded recovery bay. There were two theatres in the minor procedures unit which also operated from 7.30am to 8pm and had a dedicated two bedded recovery bay.
- The hospital had three wards: Chartwell, Downing and Epping. During our inspection Chartwell ward was not in use due to low activity. Downing ward had 26 single rooms with en-suite facilities and accommodated medical and general surgery patients. Epping ward was the orthopaedic and spinal ward and accommodated 29 patients in single rooms with en-suite facilities.
- There was a pre-operative assessment clinic on the ground floor of the building which comprised three clinic rooms and a staff office. Telephone pre-operative assessments were offered to patients who were assessed as appropriate for a telephone assessment. This meant that patients did not always need to travel to the hospital.
- All surgical procedures were elective which meant that workflow could be planned. Surgeons were allocated theatre times in advance to allow prior planning of theatre activity. Daily bed meetings took place where theatre lists were discussed for the next day and week. Patients were therefore able to book surgery dates to suit their plans and commitments.
- At our last inspection we were told by staff that they had difficulty accessing diagnostic imaging services. At this inspection we were told by staff that they did not experience difficulty accessing these services and there were protected slots for inpatients.
- At our last inspection we found there were rooms suitable for bariatric patients which had extra wide doorways but did not see any other adaptations to accommodate bariatric patients. At this inspection, staff told us they had access to bariatric equipment such as wheelchairs and could order additional equipment if required. We also saw that there was a designated theatre which had facilities for bariatric patients.
- There was wheelchair access throughout the hospital and there were signs and maps which gave patients directions to the hospital restaurant, disabled toilets and baby changing facilities. However, staff in the minor procedures unit told us that patients would have difficulty finding the unit and would sometimes wait in the wrong area for their appointment.
- The senior management team at BMI The Clementine Churchill Hospital reported that they had a good working relationship with their local clinical commissioning group (CCG) in the planning and delivery of care. The hospital hosted quarterly meetings with the CCG where the quality and risk manager and director of clinical services attended and discussed patient outcomes, incidents and complaints. The executive director and director of operations also attended a quarterly contract performance meeting with the clinical commissioning group.
- In 2018, the hospital had a score of 55% assessing dementia care in the patient-led assessment of the care environment (PLACE) audit. This was below the national average of 78.9%. To address this, the hospital had trained staff as dementia champions.
- The hospital took part in the north west London commissioning for quality and innovation (CQUIN) framework which supports improvements in the quality of services and the creation of new, improved patterns of care. The north west London CCG proposed two CQUINS for BMI. The first CQUIN related to the electronic transmission of discharge summaries eliminating delays in general practitioners (GP) receiving information on their patients who have been admitted to BMI Hospitals. The second CQUIN was to ensure BMI Clementine Churchill Hospital was in line with national guidance around the electronic submission of discharge summaries, sent the summaries to GP practices through a direct messaging system. As at March 2019, BMI The Clementine Churchill Hospital had achieved 79.2% compliance. A weekly “comm cell” had been set up to ensure that this remained a focus in the hospital and administrative staff also received regular calls with the

national lead to remind them of the importance of the electronic transmission of discharge summaries. The calls also provided a forum to raise any issues as they arose.

Meeting people's individual needs

- **The service was inclusive and took account of patients' individual needs and preferences. Staff made reasonable adjustments to help patients access services. They coordinated care with other services and providers.**
- Staff could arrange interpreting services to support patients and their families whose first language was not English. Staff confirmed that it was easy to book interpreting services which could be arranged face to face, or by telephone. Staff commented that the interpreting service offered language support in over 200 languages and could be arranged at the pre-operative assessment stage so the patient would be supported throughout their time at the hospital. The service also had access to British sign language (BSL) services for patients and had an Arabic speaking interpreter on site 24 hours a day, seven days a week. Staff told us they would ensure they respected cultural preferences for example, they told us they always checked if a patient needed a female interpreter.
- The service had dementia champions on the wards who supported patients living with dementia. However, similar to what we found at our last inspection, there was no access to communication aids for patients with learning disabilities and staff told us they relied on patients' carers to help with communication. We spoke with the senior management team who told us they were in the process of a developing a learning disability paper and were working with colleagues at other BMI sites to explore and ensure that people with learning disabilities are able to access high quality healthcare with positive outcomes when attending the hospital. This paper aimed to provide guidance on how the service would be able to identify these needs and identify any staff training to support delivery.
- Food menus catered for specific cultures and preferences such as halal, vegetarian or gluten free options. There were also menus with pictures of meals. Patients told us that there was a good choice of food on the menu.
- Snacks and drinks could be prepared by the catering staff at any time of the day. We saw staff providing patients with cups of coffee and tea throughout the day.
- There was a prayer room on site and access to multi-faith chaplaincy services.
- The hospital had a small garden situated near the wards which could be used by patients and visitors. The garden had a seating area and a ramp for wheelchair users. Staff told us that they would take patients who were well enough into the garden area of the hospital.
- Nursing staff discussed patients' individual needs at pre-operative assessment clinics such as arrangements after discharge and whether the patient would require assistance or additional equipment once home.
- We saw nurses conducting hourly comfort rounds where they checked on patients to make sure their needs were met in terms of pain relief, adequate food and drink and any other needs they had. We saw comfort round forms in patient records and saw that they had been fully completed.
- Specialist nurses were available on the ward to support patients such as a specialist spinal nurse. The hospital also had dementia champions on wards and in theatres.
- Patients had access to allied health professionals such as physiotherapists and occupational therapists throughout their clinical pathway including at pre-operative assessment.
- Staff could access mental health support if they were concerned about a patient's mental health however patients with significant mental health issues were not admitted to the hospital.
- The service offered a 'Joint School' which was specifically for patients who were scheduled to undergo a hip or knee replacement. It focused on patient education to allow patients to learn about what to expect from preparing for admission through to recovery at home. Joint school allowed patients to meet the theatre team, orthopaedic nurse, physiotherapist and occupational therapist to learn about the surgical procedure they were to have and discuss any worries or concerns. This would also be an opportunity where staff could organise equipment and additional care needs a patient might have when they were discharged from hospital so that this would all be in place beforehand.

- Upon discharge, patients were given a discharge pack of useful numbers to call, a patient questionnaire and leaflets relevant to the procedure they had. However, we did not see that these leaflets were available in languages other than English. Following the inspection, we were told that leaflets in different languages were available on request.
- Discharge telephone calls were made 48 hours after a patient was discharged. Nurses kept a log of calls made and followed up on any concerns expressed by patients. They told us that any urgent issues were escalated to the clinical services manager who would call the patient back.

Access and flow

- **People could access the service when they needed it and received the right care promptly. Waiting times from referral to treatment and arrangements to admit, treat and discharge patients were in line with national standards**
- There was timely access for surgical services at BMI The Clementine Churchill Hospital. Waiting times from referral to treatment and arrangements to admit, treat and discharge patients were in line with good practice. The referral to treatment (RTT) standard for NHS-funded patients was within 18 weeks (admitted pathway) of referral. Between April 2019 and September 2019 there was consistently good compliance of an average of 99.6% for RTT at the hospital. Patients we spoke to told us they did not have to wait long for their procedure to be arranged.
- At our last inspection we were told by staff in pre-operative assessment that it was sometimes difficult to contact the anaesthetist to discuss high risk patients' suitability for anaesthesia which then caused delays in additional investigations. At this inspection, staff did not report this problem as there was a team of four anaesthetists dedicated to pre-operative assessment who could be contacted. However, we were told that this would be reduced to one anaesthetist and staff expressed concern that this would impact upon the workload of the clinics and timely access to an anaesthetist. We spoke with senior leaders about this who told us that the lead anaesthetist's role would be dedicated to pre-operative assessment clinics and therefore they would be available on the phone at all times. It was also planned that the anaesthetist would run two to three sessions a week on site.
- We followed the patient journey through theatres and found that patients were transferred from the recovery bay to the ward appropriately and without delay. Staff reported that they did not experience access issues moving patients from theatres to recovery as capacity was never at 100%. Patients had a designated room on one of the surgical wards which was reserved from admission so there were no delays moving patients back to the ward.
- There were enough beds on the wards for patients who required an unexpected stay overnight, for example patients undergoing day case surgery.
- The service did not treat complex patients, such as psychiatric patients, but did treat some patients with multiple co-morbidities, in line with the admission criteria. The service had strict admission criteria and did not accept bariatric patients with a body mass index (BMI) of 40 or greater and patients with complex comorbidities where patients were NHS funded in line with their standard contract. Specific needs following discharge such as additional equipment to aid mobility were also planned at the pre-operative assessment stage.
- An on-call theatre team was also available in event of an emergency and consultants were required to be contactable at all times while their patient was in the hospital.
- The service was in the process of agreeing a formal service level agreement with a local NHS trust to transfer patients who required more complex care and treatment.
- Staff told us the discharge process was effective and they had few cases of delayed discharges. Medicines to take away were prepared before discharge so a patient did not need to wait for this upon discharge.
- There was a total of 46 cancelled procedures for non-clinical reasons from March 2018 to February 2019. Of these, 41 patients (89%) were offered another appointment within 28 days of the cancelled appointment.

Good

Surgery

Learning from complaints and concerns

- **It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff. The service included patients in the investigation of their complaint.**
- We looked at the complaints log for the hospital. Between December 2018 and May 2019, the service received 35 complaints. We saw evidence that complaints were responded to in line within 20 days which was in line with the BMI complaints policy. Complaints were investigated, learning was identified, and the hospital apologised to patients when something went wrong.
- Staff logged complaints on to the electronic incident reporting system.
- Complaints were overseen by the executive director and the quality and risk manager supported by the customer services team. Feedback was shared at "comm cell" meetings. Managers would then share these with staff at ward meetings. Complaints were also discussed at senior management team meetings, the clinical governance meetings and medical advisory committee. We saw evidence of discussion of complaints in the minutes of these meetings. The senior management team also shared complaints with the clinical commissioning group.
- The hospital also produced a newsletter which included information on complaints trends and key learning from these.
- There were a number of ways patients and families could send feedback including filling in feedback forms. Patients we spoke with were aware of how to make a complaint and told us they felt comfortable about speaking directly with staff if they wanted to complain. Nurses said they tried to address concerns as they arose by speaking to patients and families directly and explaining how they would address their concerns. The senior management team told us that all patients who made a complaint were offered a face to face meeting.
- Patients were also provided with information on how to make a complaint to the Independent Healthcare Sector Complaints Adjudication Service (ISCAS) and the Parliamentary and Health Services Ombudsman (PHSO) if they were not satisfied with the hospital's complaints process. From May 2018 to April 2019, one complaint was referred to ISCAS.

Are surgery services well-led?

Good

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

Leadership

- **Leaders had the integrity, skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff. They supported staff to develop their skills and take on more senior roles.**
- The surgical service was led by a clinical services manager for theatres and the clinical services manager for wards.
- The senior management team consisted of the executive director, director of clinical services, director of operations and quality and risk manager.
- The executive director who was the CQC registered manager reported to London and South East Region executive director and was supported by the regional team and medical director where required. Regional executive directors met regularly.
- Day to day leadership was managed by the senior management team on site. The senior management team attended daily "comm cell" meetings where incidents, complaints, patient satisfaction scores and mandatory training rates were discussed with the heads of department.
- All staff spoke highly of the clinical services managers of theatres and wards and said that they were approachable and supportive. Both nursing and medical staff spoke of good teamwork. Staff told us they were supported by their managers to develop their leadership skills and access development opportunities.
- Staff on the wards and theatres commented on the visibility of the senior management team and that they

would see them on 'walk arounds.' Staff told us that the executive director and director of clinical services had an open-door policy and they felt able to approach them if they had any concerns.

- The IPC lead told us they were fully supported by the director of clinical services who supported them fully in their work within the hospital and their personal development.
- Leaders had a strong understanding of issues, challenges and priorities in their service and other services within the hospital.
- Consultants told us they felt listened to and encouraged by the leadership team.

Vision and strategy

- **The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with relevant stakeholders.**
- The hospital had a clear vision and a strategy to turn the vision into action. The hospital's vision was to be the hospital of choice in Harrow and to attract patients, staff and consultants through delivering the best care, experience and outcomes.
- The hospital's five-year business development plan had been developed by the senior management team. The BMI strategy for 2015-2020 identified eight objectives which included information, efficiency, growth, communication, patients, facilities, people and governance and these were underpinned by a clinical and non-clinical strategy. The clinical strategy focused on ensuring an integrated approach where risk management, clinical governance and quality improvement were part of the culture of everyday management practice. Objectives of the strategy included to promote an honest, open and blame-free culture where risks were identified and addressed at every level and escalated appropriately.
- The senior management team spoke of the five-year plan which focused on developing the day surgery service and to improve patient flow. Leaders had sought input and involvement from staff and clinical services managers in the development of these plans.
- Staff we spoke with were aware of the hospital's vision, including their role in achieving them.
- There were plans to refurbish parts of the hospital to improve patient experience. Staff we spoke with knew about plans to refurbish areas of the hospital and were proud of the changes that had already occurred to the fabric of the hospital to enhance patient experience and improve patient safety. For example, the removal of carpeted flooring and refurbishment plans for sluice rooms and installation of clinical handwash basins.
- The executive director held staff forums called 'Tea with the SMT' and 'Squeeze the Day with the SMT' which were open to all staff to attend where information was shared on the hospital's vision as well as performance and any key issues.

Culture

- **Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service promoted equality and diversity in daily work and provided opportunities for career development. The service had an open culture where patients, their families and staff could raise concerns without fear.**
- Staff were passionate about their work and spoke of good teamwork in a patient-centred environment. We found an inclusive and constructive working culture within surgical services.
- We found an open and honest culture and staff were knowledgeable about the duty of candour. Staff knew about the hospital's processes and procedures and could give examples of how they applied the duty of candour and the learning that was shared from an incident.
- Leaders promoted a positive culture that supported and valued staff, creating a sense of common purpose based on shared values. The senior management team were actively involved in the day to day management of services and attended daily "comm cell" meetings. Staff we spoke with told us they felt able to report concerns to their managers and spoke of an open-door policy. They told us the senior management team were visible throughout the hospital.
- Most staff we spoke with, including nurses, allied health professionals, catering staff and administrative staff told

us they felt supported by their managers and spoke of being supported to access development opportunities. However, some admin staff told us they rarely saw their managers.

- At the last inspection we found that feedback from consultants about the culture within the hospital was variable. At this inspection, consultants we spoke with told us there was now a supportive culture and they felt able to approach the senior management team.
- We attended safety briefings and handovers and found that there was respect for each member of the multidisciplinary team and the contribution they made.
- The hospital had appointed a freedom to speak up guardian. Freedom to speak up guardians promoted an open culture, allowing staff to speak up about concerns easily however not all staff we spoke with knew about the role of the freedom to speak up guardian.
- Staff gave us examples of times when they directly approached the executive director to express concerns that they had and how they had been supported and listened to by the executive director. The executive director also told us that staff came to her with concerns or wrote directly to her and that this was a positive change in the culture of the hospital where staff now felt able to raise concerns and report incidents.
- Staff we spoke with were proud of working at BMI The Clementine Churchill Hospital and spoke highly of the culture often referring to there being a 'family' feel within the hospital.
- BMI adhered to the annual regulatory reporting requirements of the Workforce Race Equality Standards (WRES) working in partnership with the NHS England WRES Implementation Team as an independent healthcare provider. There was clear ownership of the WRES report within the management and governance arrangements which included the WRES action plan.

Governance

- **Leaders operated effective governance processes, throughout the service. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.**
- Governance structures were in place for surgical services. The surgical service held academic audit and governance half days once a month where everyone in the department was invited to view audit outcomes for the division.
- Staff we spoke with had a good awareness of governance arrangements and knew how to escalate their concerns. There were a number of meetings where staff could voice their concerns. There was a nurse leadership team meeting once a month which was chaired by the director of clinical services and attended by clinical services managers and heads of departments and discussed risks and lessons learned from incidents.
- The clinical services managers on the wards also held monthly team meetings which were attended by nursing staff and healthcare assistants. The meeting looked at the performance dashboard which was displayed on the wall of the staff room. This included patient satisfaction data, risk register items by ward, mandatory training compliance, link nurse roles, complaints trends by ward, 48-hour post-discharge phone call compliance, and incidents and learning.
- Theatre team meetings were held monthly and attendance included the theatre clinical services manager, theatre practitioners, theatre healthcare assistants. We viewed the meeting minutes which showed that the meeting discussed feedback from the heads of department meetings and clinical governance meetings, mandatory training performance, incidents and lessons learned, complaints and feedback, risk register, safety alerts and actions arising from the meeting.
- "Comm cell" meetings were held every morning and attended by heads of department and the senior management team. Incidents, complaints, policy updates, expected admissions, and risks were discussed at the meeting and information was cascaded down through ward or theatre team meetings as well as by email. The pharmacy lead also attended "comm cell" meetings and shared information on changes to guidelines and policies. They also produced a monthly newsletter which was emailed to all staff with key information around updates, audit results, safety alerts and learning from medicines management incidents.

- The heads of department meeting was held monthly and was attended by the executive director and the senior management team, clinical services managers for all areas including pharmacy. The heads of department meeting fed into clinical governance meetings. We saw in minutes that the meeting discussed topics such as financial forecasts, governance updates, complaints and the risk register. Feedback from the heads of department meetings was cascaded to team meetings and discussed at monthly theatre team meetings for example.
- The clinical governance meeting was held monthly and was attended by the senior management team, the heads of departments, consultant anaesthetist, consultant orthopaedic surgeon and consultant general surgeon. The infection prevention and control lead and pharmacy clinical services manager also attended these meetings. We saw minutes of clinical governance meetings which included feedback from the national clinical governance committee, discussion of monthly clinical quality dashboards, a review of incidents and investigations, policy updates, risk register updates and audit feedback. There was also a governance report that was completed by the quality and risk manager monthly and was fed back corporately.
- The medical advisory committee (MAC) met bimonthly and reviewed clinical quality and governance matters. The MAC received minutes and actions from the clinical governance meeting and subcommittees such as the infection prevention and control subcommittee. The executive director assessed applications with the lead specialist in the particular specialism a consultant had applied for and applications would be discussed and agreed the medical advisory committee.
- The surgical department was represented at the medical advisory committee (MAC) by the director of clinical services, anaesthetic representative and surgical representative. At our last inspection there was no general surgical representative at the MAC however we viewed minutes of the MAC meetings which showed that there was now a general surgical representative at the meetings.

Managing risks, issues and performance

- **Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events.**
- There was a hospital risk register and separate risk registers for each department which were maintained by the clinical services managers. Risks on the risk registers were reviewed regularly and discussed at clinical governance meetings, heads of department meetings and team meetings in theatres and wards. Each risk was given a rating, review date, and set of control measures. Risks to the service had been considered in planning and delivery. For example, there were clear timescales for refurbishments to sluice rooms, theatre doors and completion of the theatre equipment database.
- At our last inspection we found that senior staff were unsure of how to access the risk register and unable to identify risks that had been recorded. At this inspection, senior staff all knew how to access the risk register and were knowledgeable on the content of the risks recorded for the hospital as well as for individual departments. The risk register now included the risk around monitoring of the number consultants with practising privileges and ensuring the consultant database was up to date.
- The issues and risks which managers identified were in line with what we found on inspection and there was alignment between these and the risks outlined on the risk register. Risks for theatres included facilities such as the gaps between theatre doors and the equipment database to ensure oversight of records pertaining to service and maintenance of medical devices within theatres. Theatre managers told us that some of the theatre doors had already been replaced and were due to be completed by December 2019 and the equipment database was nearly complete with 5% remaining to be inputted by October 2019. Action plans were in place to address staffing in pre-operative assessment and the director of clinical services was leading the plan to improve pre-operative assessment services.
- Risks on the surgical wards included vacancies on Epping ward and Downing ward which were mitigated by using regular agency staff. Leaders told us that they had a good relationship with the nursing agency and

were able to secure regular staff to cover vacancies. Managers also told us that the medical records storage was soon to be replaced with a purpose-built storage which would allow for more space for patient records. Managers told us of the sluice room refurbishment programme and plans to put clinical handwash basin into rooms on Downing ward which was starting later in September 2019.

- There was a formal audit plan in place for theatres and surgical wards which outlined the frequency of the audits and dates of the audits. Audit results were fed back at the clinical governance meetings, heads of department meetings as well as discussed at ward meetings, theatre academic audit and governance half days and nursing leadership team meetings.
- The pharmacy team also had an annual audit calendar which we saw was adhered to. The pharmacy team also produced a bimonthly newsletter to inform staff of updates on guidelines as well as audit results and learnings from incidents. The pharmacy team told us that they were currently about to do a joint audit with the infection, prevention control team and after collecting the results would roll out training sessions for areas that needed improvement.
- We saw that the BMI care of the deteriorating patient policy stated that "All BMI hospitals with theatres should have an anaesthetic rota." However, the hospital did not have an anaesthetic rota and was following a BMI practising privileges policy which stated that anaesthetists retained responsibility for anaesthetic requirements during a patient's entire clinical pathway and were required to come in to the hospital to attend to their patient when required or organise cover if they are were not able to attend. Staff we spoke with were fully aware of the protocol and could give examples where consultants and anaesthetists were called to attend to their patient out of hours. Medical staff we spoke with had a full understanding of the practising privileges policy and their responsibilities however we were concerned that the two BMI policies did not align and could cause confusion to new staff for example. Both the practising privileges policy and the care of the deteriorating patient policy had been reviewed in January 2019, but the discrepancy had not been picked up. The hospital subsequently informed us that this discrepancy had not been identified by the corporate provider's National Clinical Governance Board who were responsible for these policies. The hospital had also not identified or escalated this discrepancy to the corporate governance board but told us that they had escalated the issue of the anomaly following our inspection.

Managing information

- **They service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were integrated and secure. Data or notifications were consistently submitted to external organisations as required.**
- Staff mostly had access to patient's health records and the results of investigations and tests in a timely manner. Senior leaders told us there was full access to records for NHS patients but that the records for private patients were sometimes not complete. They were therefore working on ensuring full access to patients' notes were achieved by ensuring all consultant letters and clinic notes were included in the patient's record and signed off. This was on the risk register and the director of operations was working on a project to improve medical records compliance and ensuring adequate storage for them.
- Paper records were well organised and stored securely in lockable cupboards at the nurse's station. The service was in the process of replacing records storage to a purpose-built records storage. There were clearly labelled drawers at the nurse's station where staff could access forms, assessment tools and leaflets for discharge packs.
- There were effective arrangements to ensure the confidentiality of patient identifiable data. Paper based patient records were stored securely and electronic information was only accessible by authorised staff members. There were computer stations throughout surgical services and staff told us there were sufficient numbers of computers to access when they needed. We observed staff logging off after using computers.
- Staff commented that the IT system was user friendly and showed us they could easily find policies on the hospital intranet.

- The hospital now had an electronic incident reporting system which made it easier for the hospital to effectively monitor and assess risks and trends. Staff also commented on how this was an improvement to the previous system and that the electronic system was easy to use.
- Service leads and the senior management team monitored quality and risk information at governance meetings where audit results, risks and incidents were discussed.
- We saw that access to staff offices which contained confidential information and records were by keypad lock to prevent unauthorised access.
- The hospital had Wi-Fi for public use. Patients and visitors we spoke with said they were able to access the Wi-Fi service.

Engagement

- **Leaders and staff actively and openly engaged with patients, staff, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients.**
- Patients and relatives were encouraged to share their views on the quality of the service through feedback questionnaire cards which were given to patients on discharge.
- The hospital also monitored feedback from their BMI friends and family test results. Comments from the survey were discussed at "comm cell" meetings and team meetings.
- In-patients were contacted by nurses 48 hours after discharge to check if the patient had any concerns and to ask questions on their experience around the care and treatment they received while in hospital. We saw the log where all the comments from calls were documented and where issues had been escalated to the clinical services manager or consultant.
- The hospital held long service awards to recognise staff who had worked at the hospital for five, 10, 15, 20 or 25 years. Staff were presented with a badge at an awards tea party held on site by the executive director. In theatres, there was a staff member of the month scheme where staff members were encouraged to fill in a form to nominate a staff member who had gone the extra mile in their work.
- The executive director produced a monthly newsletter which was emailed out to all staff. The newsletter covered areas such as governance, operational updates, key learning from incidents, policy updates as well as listing new starters and leavers.
- Staff were engaged in the planning and delivery of the service. Staff told us that they felt able to suggest new ideas to their managers and that they were listened to. For example, the hospital had consulted staff at all levels around the hospital's plans to improve patient flow and create a purpose-built day surgery ward.
- The executive director also held staff forums called 'Tea with the SMT' which were open to all staff to attend where information was shared on performance and any key issues as well as giving staff an open forum to feedback on any concerns or comments they had about the planning and delivery of services at the hospital. However, some staff said they did not always have the time to attend the forums. The executive director produced a monthly staff newsletter where the hospital's vision as well as information on governance and operational updates were shared.
- The hospital took part in a BMI engagement staff survey in 2018. The overall engagement score for BMI The Clementine Churchill Hospital was 61/100 which was significantly higher than the score of 51/100 achieved in 2017 but lower than overall BMI Healthcare score of 63/100. The survey looked at questions such as employee views on BMI Healthcare, the executive leadership team, the employee's job, management, communication and wellbeing. The 2018 survey showed that 45% of employees gave positive responses to the survey questions. This was a significant improvement from 28% of employees in 2017 who answered positively to the engagement questions. The 2018 survey showed that 13% of employees answer negatively to the engagement questions which was also an improvement from 16% of employees in 2017.

Learning, continuous improvement and innovation

Good

Surgery

- **All staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them.**
- Staff were committed to continuous learning. Staff told us they were supported by their managers to develop their leadership skills and access development opportunities. The hospital offered university accredited courses such as a masters level anaesthetics course, learning courses for healthcare assistants and university accredited management and leadership development course.
- The hospital had a clinical skills lab where staff attended courses such as moving and handling, infection prevention and control and immediate life support. The room was equipped to enable simulation exercises and training. Staff from other BMI hospitals also attended courses held in this room. Staff told us that every year they attended cardiac arrest simulation training which was held in the clinical skills lab.
- The hospital sought new ways to improve services for patients. The hospital had continued to work on provision for patients living with dementia. They had implemented a falls group where trends and learnings could be identified. There were now dementia champions on all wards and in theatres. The hospital was also working with a local care home to further develop dementia awareness training for staff.
- Theatres had produced a prosthesis booklet for patients to take home with them. The booklet had the patient's information, date of their operation, the type of operation performed and what prosthesis they had. The patient could then keep the booklet for their records so that if they needed the information, for example, while on holiday, they had the information to hand.

Good

Critical care

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

Information about the service

BMI The Clementine Churchill Hospital has a six-bed intensive care unit providing level two and level three care. Level three care is where patients require advanced respiratory support alone or basic respiratory support with support of two other organ systems. Level two care is where patients require more detailed observation and higher levels of care such as those receiving basic respiratory support or with single organ failure.

The critical care provision at BMI The Clementine Churchill Hospital is made up of a six bedded intensive care unit. The unit has two individual side rooms and four cubicles . The cubicles are semi-permanent structures used to divide the unit area into separate individual spaces resembling rooms. Patients could be admitted directly to the unit, post-operatively from theatres, or from medical wards. The intensive care unit saw patients across a range of medical and surgical specialities. The service admits patients mostly from the United Kingdom, however, also admits patients from international places of origin.

Staffing on the intensive care unit consists of critical care consultants, resident medical officers and nursing staff, and is managed by a clinical services manager. There is also multidisciplinary team support that included pharmacy, physiotherapy, dietitian, onsite pathology, imaging, and phlebotomy.

The unit started submitting data to the Intensive Care National Audit and Research Centre (ICNARC) in January 2016. The ICNARC data input is carried out by a healthcare assistant.

There were 2190 level two and level three critical care bed days available in the hospital from October 2018 and September 2019. Of these 692 level two critical care bed days were used, while 303 level three bed days were used.

Between October 2018 and September 2019, there were 277 patients. Of these, 244 were planned admissions and 33 were unplanned admissions. There were 265 level two patients and 11 level three patients.

Our unannounced inspection of the critical care at BMI The Clementine Churchill took place over two days. During our inspection we spoke with 12 members of staff including managers, hospital staff, medical staff, and nursing staff. We spoke with two patients and no relatives and reviewed five medical records. We completed checks of clinical and non-clinical equipment, and reviewed information provided by the hospital.

Are critical care services safe?

Requires improvement

Our rating of safe stayed the same We rated safe as **requires improvement.**

Mandatory training

- **The service provided mandatory training in key skills to all staff and made sure everyone completed it.**
- Nursing staff received and kept up-to-date with their mandatory training. All new employees and bank staff were required to complete all their mandatory training within three months of their start date.

- The mandatory training was comprehensive and met the needs of patients and staff
- Managers monitored mandatory training and alerted staff when they needed to update their training.
- Compliance with mandatory training was good. All mandatory training modules were meeting the hospital target of 90% compliance.

Safeguarding

- **Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.**
- Nursing staff received training specific for their role on how to recognise and report abuse. Safeguarding vulnerable adults and children level 2 was included in mandatory training.
- Safeguarding training was included in mandatory training; as such 100% of staff had completed safeguarding training. The training also included modules on female genital mutilation and protecting people at risk of radicalisation (PREVENT).
- Staff knew how to identify adults and children at risk of, or suffering, significant harm. Staff were aware of, and could describe, the types of safeguarding incidents that should be reported. Staff were aware of how they could access further help and advice.
- Staff knew how to make a safeguarding referral and who to inform if they had concerns.

Cleanliness, infection control and hygiene

- **The service controlled infection risk well. Staff used equipment and control measures to protect patients, themselves and others from infection. They kept equipment and the premises visibly clean.**
- The service had established systems in place for infection prevention and control, which were accessible to staff. These were based on the department of health code of practice on the prevention and control of infections, and included guidance on hand hygiene, use of personal protective equipment such as gloves and aprons, and management of spillage of body fluids.
- All the infection prevention and control standard operating procedures we reviewed were up to date and accessible by staff on the hospital intranet.
- There were housekeeping staff dedicated to the whole hospital and were responsible for cleaning the intensive care unit (ICU). Housekeepers worked 24 hours a day.
- We reviewed patient areas on the intensive care unit as well as sluice rooms and treatment rooms. All areas were visibly clean and free from dust. This had improved since the last inspection.
- Green 'I am clean' stickers were used to identify which equipment had been cleaned by staff and was ready to be reused, such as commodes. We saw stickers were marked with the date the item was cleaned and observed staff replacing stickers once they returned the clean equipment.
- We inspected various pieces of equipment such as commodes and found a good level of cleanliness including under the seats and on the commode legs.
- Infection prevention and control (IPC) was part of mandatory training and had been completed by 100% of staff. This was above the hospitals target of 90%.
- There was easy access to personal protective equipment (PPE) such as aprons and gloves in all areas we inspected and saw all staff used PPE as required.
- Staff were 'bare below the elbow' and adhered to infection control precautions throughout our inspection, such as hand washing and using hand sanitisers when entering and exiting the unit and bed spaces and wearing PPE when caring for patients.
- Hand sanitisers were readily available at entrances to the intensive care unit and next to each bedside. We observed staff and visitors decontaminating their hands when entering and leaving the unit. Since the last inspection the unit had built in sinks at each bed space.
- We observed bed space curtains were labelled and dated when they were last changed.
- We looked at the hand hygiene audit for critical care from March 2019. The audit checked 76 items including before patient contact, after contact with bodily fluids,

and after patient contact. The audit looked at registered nurses and medical staff. The service scored 75 out of 76 and was 99% compliant. Hand hygiene results for September 2019 was 100%.

- In 2019 so far, the intensive care unit had no cases of hospital acquired meticillin-resistant staphylococcus aureus (MRSA) and no cases of hospital acquired Clostridium Difficile (C.Diff). MRSA and C.Diff are both healthcare-associated infections that can develop either as a direct result of healthcare interventions such as medical or surgical treatment, or from being in contact with a healthcare setting.
- There were four bays on the main intensive care unit, and each bay had a 'Safety and Cleaning Checklist' displayed on the door. Staff were required to complete this daily and seal the door with an 'I am clean' sticker.
- There was a cleaning schedule displayed for staff which listed what needed cleaning within the unit, how often it should be cleaned, who it should be cleaned by and finally how it should be cleaned. For example, it described how beds and mattresses should be cleaned. This had been introduced since the last inspection.
- Intensive Care National Audit and Research Centre (ICNARC) data showed the rate of unit acquired blood infections for the intensive care unit were better (0.0) than comparator units (1.2).
- The unit had an infection, prevention and control link nurse who staff could access for support.

Environment and equipment

- **The design, maintenance and use of facilities, premises and equipment kept people safe. Staff were trained to use them. However, the ICU did not meet all of the building regulations for critical care services and this was on the risk register.**
- There were four cubicles in the main unit area of the intensive care unit and two side rooms which were located outside the main unit. Previously there were two cubicles and since the last inspection the unit had increased this to four cubicles. Senior leaders informed us the unit currently did not meet all of the building regulations for critical care services guidelines (HBN 04-02). However, this was only a requirement for newly built intensive care units and this was on the services risk register.
- The cubicles had an integral air handling system to provide negative airflow where required (in the event of patients with potentially infectious diseases).
- There were two side rooms which would be used as isolation rooms. The rooms did not have separate lobbies and there was no option of negative airflow. The side rooms were also outside of the main intensive care unit and had no direct access to bathrooms.
- Entrance doors to the main intensive care unit were secured by an electronic system, with visitors required to ring a bell to be admitted. This ensured that patients' safety was maintained. One of the doors was swipe access and one was via keypad. The side rooms also had a swipe card access pad for staff to gain access.
- The intensive care unit was bright and spacious unit and there was appropriate levels of storage. Most of the areas had natural light.
- There were no toilets or shower rooms available for patients on the unit. Senior leaders told us patients would need to be escorted to their bedrooms on the surgical wards if they wanted to use the bathroom.
- We looked at the invasive devices management audit for the intensive care unit from March 2019. The audit checked six items including catheter nags being positioned so they drain freely and were not as risk of contamination from the environment. The service scored five out of six and was 83% compliant.
- We looked at the patient equipment audit for critical care from March 2019. The audit checked 16 items including commodes, single use patient equipment and 'I am clean' labels. The services scored 15 out of 16 and was 94% compliant.
- Emergency trolleys were located at appropriate intervals throughout the unit. We saw the contents of the trolleys were checked daily by nursing staff and were tagged and sealed. This had improved since the last inspection.
- The unit had access to a 'difficult airway' intubation trolley, which contained equipment to help staff

intubate patients with challenging anatomy. The content of the trolleys met recommendations from the Difficult Airway Society (DAS) 2013. DAS guidelines were also attached to the trolley providing information on what to do if there was an unanticipated difficult tracheal intubation.

- There was an intubation and procedural trolley which staff were required to complete daily checks. For October 2019 these were all completed and signed. There was a bronchoscopy trolley and tracheostomy and chest drain trolley which required weekly checks. Both of these were fully completed for October 2019.
- Needle sharps bins were available at each bed space and within the medicines preparation area. All bins we inspected were correctly labelled and none were filled above the maximum fill line.
- Sluice rooms contained facilities for disposing of clinical waste and cleaning equipment.
- Staff told us they were able to access equipment required to care for patients. There were computer terminals to access pathology results and other policies and guidelines on the staff shared drive.
- The main critical care unit did not have an electronic patient call bell system. Manual bells were provided to each patient, and were kept within reach, for patients to alert staff if they required assistance. We tested one bell during the inspection and found it did not work. This was replaced. One patient told us they were happy with the manual bells provided.
- We found no issues of concern in our review of a random sample of portable electrical equipment throughout the unit. All equipment we reviewed had been tested and displayed the planned date for the next test.
- Staff disposed of clinical waste safely. Waste was collected in foot operated bins through the unit. Clinical waste was appropriately segregated, bagged and stored awaiting disposal.
- We reviewed a random selection of consumable stock held within the store room and on trolleys throughout the unit. All stock we viewed was within the manufacturer's recommended expiry dates.

Assessing and responding to patient risk

- **Staff completed and updated risk assessments for each patient and removed or minimised risks. However, there was not sufficient medical cover and escalation procedures in place to ensure patients were not at risk when medical staff were called off the unit to attend to other duties within the hospital.**
- As most admissions to the unit were planned as part of elective surgery, assessment of each patient's risks, likely dependency, and acuity needs commenced at the pre-admission assessment stage. Staff worked with the admitting consultant, and pre-assessment nursing team, to understand individual patient needs.
- The service ensured appropriately skilled staff were available to support each patient. Shift changes and handovers included all necessary key information to keep patients safe. A formal handover sheet was used to ensure staff were aware of patients' allergies, the procedure/reason for admission to the unit, details of patients' in-situ lines, pain control, medicines and oxygen.
- Staff completed risk assessments for each patient on admission / arrival and updated them when necessary and used recognised tools. All four patient records we reviewed included risk assessment for the development of venous thromboembolism (blood clot), the development of pressure ulcers, and the risk of falls. We saw evidence that patients were reassessed as their conditions changed, and that blood clot prophylaxis medicines were prescribed and administered appropriately.
- The unit used the 'Richmond Agitation-Sedation Scale' to score the level of sedation for each patient receiving sedative medicines.
- Patients were evaluated using the Confusion Assessment Method for the intensive care flowchart to determine whether delirium was evident, in line with best practice guidance from the Faculty of Intensive Care Medicine Core Standards for Intensive Care Units. We saw evidence this assessment was completed in patient records.
- Safety huddles were held at the start of each shift. A handover document ensured that key information about each patient was discussed during these

meetings. Staff were informed of any key messages received from the daily hospital communication cell safety briefing, and information from relevant incidents or alerts was also shared.

- All clinical staff on the unit were required to have immediate life support (ILS) training, which was reviewed annually. Compliance was at 93% for immediate life support for intensive care staff. All sisters and senior nursing staff had received advanced life support and paediatric life support training; compliance was 100%.
- Staff used a nationally recognised tool to identify deteriorating patients and escalated them appropriately. Patients' physiological parameters such as blood pressure, heart rate, temperature, respiratory rate, neurological status and oxygen saturation were continually monitored and recorded to determine if escalation of care was needed. This enabled staff to calculate and, where necessary, escalate the patient's care accordingly, using the National Early Warning Score system (NEWS2).
- The critical care service had pathways in place for patients at risk of deterioration. Staff we spoke with were aware of the actions taken when there were signs that a patient was deteriorating, and the pathways were posted on notice boards in the intensive care unit. This included pathways for sepsis, resuscitation, and anaphylaxis.
- Patients at a higher risk of deterioration were cared for in a bay closest to the nursing station. This allowed for additional monitoring from staff in communal areas.
- The resident medical officer on the intensive care unit and senior intensive care nurse provided a service similar to that which would normally be undertaken by an outreach team. They monitored and reviewed patients discharged from the unit following discharge.
- However, the resident medical officer and intensive care nurse were responsible for the unit, outreach and were the hospital emergency resuscitation team. We had concerns should a resuscitation call go out, the intensive care unit would be left without a doctor. If an intensive care unit patient deteriorated whilst the resident medical officer was on a resuscitation call this could leave the patient at risk. We raised this concern with senior leaders who informed us they would access the on-call medical consultant at the time. However, this risk was not on the department's risk register and there were no formal documented mitigations in place. There was also no documented escalation procedure in place to show how the unit was medically covered if the resident medical officer was called out.
- Audit data between December 2019 and March 2019 on outreach patient notes identified some issues with documentation. For example, staff were not always documenting the time patients were assessed.
- Management of sepsis was in accordance to the hospital's policy on sepsis recognition and management. Staff told us that they followed the United Kingdom sepsis guidance on the initial management of septic patients. The 'Sepsis Six' approach was used. Sepsis Six is the name given to a bundle of medical therapies designed to reduce mortality in patients with sepsis.
- All beds on the unit had been connected by telemetry to the nurses' station, which meant that vital signs could be monitored remotely.
- The service leaders told us they had access to consultant psychiatrists with practising privileges for mental health support if required.

Nurse staffing

- **The service had enough nursing and support staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix, and gave bank and agency staff a full induction.**
- Senior leaders told us staffing levels were based on the Faculty of Intensive Care Medical Core Standards for Intensive Care Units. This states that all ventilated patients (level three) are required to have a registered nurses to patient ratio of a minimum of 1:1 to deliver direct care, and for level two patients a ratio of 1:2. Patient allocation records demonstrated critical care complied with the required staffing levels. Patients with additional care needs would be nursed by two nurses.
- Nursing provision in critical care was reviewed throughout the day. The clinical services manager and

nursing staff identified if there was any need for additional staff, and this could be arranged with agency staff as necessary. Staffing was also discussed in the site safety huddles.

- The clinical services manager could adjust staffing levels daily according to the needs of patients. The clinical services manager reviewed the planned rota on a daily basis to ensure there were sufficient staff to safely meet the needs of all patients on the unit, including any unplanned admissions. The clinical services manager was supernumerary and, as such, was able to undertake clinical duties to meet any unexpected demands on the service.
- There was one clinical services manager leading the intensive care unit. There were three whole time equivalent band seven nurses in post. There were four whole time equivalent band six nursing posts with one vacancy and four whole time equivalent band five nursing posts also with one vacancy.
- The clinical educator was one of the unit's sisters and was allocated 7.5 hours per week to undertake clinical education.
- At the last inspection the intensive care unit relied heavily on agency staff. Best practice guidance suggests no more than 20% agency usage per shift. Nursing staff rotas we reviewed and our observation of nursing staff in duty during our inspection demonstrated compliance with this standard. Data provided by the hospital between October 2018 and September 2019 showed agency usage was above 20% in five months. Between May 2019 and September 2019 this varied between 29% and 36%. Senior leaders said the use of agency nurses was one of the main challenges and this was on the department's risk register.
- The hospital's induction policy included the induction of agency staff. Agency staff underwent an induction to the unit, and senior nurses told us that where possible they used agency staff familiar with the intensive care unit, as this helped to maintain consistency of care. All new starters in critical care received a workbook for completion, which included familiarisation with unit practice, signing off competencies, and orientation.

Medical staffing

- **The service did not have enough medical staff at all times to ensure patients were safe from avoidable harm and to provide the right care and treatment.**
- The service had enough medical staff with the right qualifications, skills, training and experience to keep people safe from avoidable harm and to provide the right care and treatment.
- The service was clinically led by three lead consultant intensivists. Consultant cover was scheduled for 24 hours a day, seven days a week. This meant, at full, capacity there was one consultant for six patients (four in the main unit and two side rooms). This maintained, and exceeded, the consultant to patient ratio recommendations of the core standards of one consultant for every eight to fifteen patients.
- However, consultants were not present during our inspection except for the ward rounds of patients. We were told consultants were available 24 hours a day on-call and within 30 minutes. The Faculty of Intensive care medicine, Guidelines for the Provision of Intensive Care Services says that a consultant in intensive care medicine must be immediately available 24 hours a day seven days a week. The consultant responsible for out of hours must be able to attend within 30 minutes. Consultants were following the out of hours 30 minute standards for the whole day and therefore consultant support was not immediately available during the daytime. However, we were told that during the day consultants were available via telephone.
- Medical cover on the wards during the daytime was by the Resident Medical Officer (RMO). Therefore, this meant that the intensive care unit had periods of no medical cover when the RMO was called to do outreach and resuscitation. This put patients at risk as there was no documented plan on how medical staffing would be covered in this event.
- We reviewed the consultant rota for October 2019 and found all shifts were allocated consultant cover. However, we noted that for one eleven-day period one consultant was down to cover nine 24-hour periods out of the eleven days. The national guidelines say the consultant rota should seek to avoid excessive periods of more than 24 hours. However, we found that the unit's rota was exceeding periods of 24 hours.

- Resident medical officers (RMO) for the intensive care unit were provided by bank staff. The RMOs ensured that they took six hours rest within a 24-hour period of working. The resident medical officers used designated forms to record the time they went off for their designated six-hour rest and the time they woke up. These forms were monitored by the clinical services manager. Where there was a busy shift and the six-hour rest was not fulfilled then the on-call consultant was available to support or cover the shift.
- Resident medical officers were trained to at least an ST4 or above and were supported by the nurse in charge out of hours and the clinical services manager in hours.
- The service had enough medical staff to keep patients safe. We reviewed the consultant and resident medical officer rota which confirmed there were enough medical staff scheduled for the usual demands of the service. However, the unit could be left unsupported if the resident medical officer was called away to attend the wards as part of the outreach team or resuscitation team.

Records

- **Staff kept detailed records of patients' care and treatment. Records were clear, up-to-date, stored securely and easily available to all staff providing care.**
- Patient records we reviewed were in paper form. We reviewed five patient records and found them to be legible and comprehensively completed. All records had detailed notes of the patient care from different disciplines, treatment plans, completed risk assessments, and results of any diagnostic tests the patient had received.
- For two of the five notes we checked we could not identify if a daily ward round had happened. Therefore, we were not assured ward rounds were happening for all patients.
- All patient records had a venous thromboembolism (VTE) risk assessment, however one record we reviewed did not have a consultant signature as required.
- Patients' observation charts were kept by the patient's bedside or just outside their rooms, and staff would input data at regular intervals. Once completed for the day it would be filed in the patient's records.
- Information governance was part of mandatory training for all staff. The hospital had a management of health records policy detailing the process for managing and completing patient records. We observed staff adhering to best practice in relation to information governance and storing records securely.
- The hospital had a dedicated medical records department with responsibility for filing, storing and maintaining medical record for patients. Staff within this department arranged for medical records to be readily accessible for patient care. We did not identify any concerns in accessibility of records while on inspection.
- The department displayed results their June documentation audit which found 92% compliance. Issues identified such as missing signature and grade of staff had been found. The service had action plans in place to address this which included staff education and regular checks.

Medicines

- The service used systems and processes to safely prescribe, administer, record and store medicines.
- The hospital pharmacy was open from 8:30am to 8pm Monday to Friday. There was a 24-hour on-call pharmaceutical advisory service via switchboard. The service had access to three pharmacist for the intensive care unit. However, they were not an intensive care trained pharmacist as recommended per national guidance. Recommendations from the Faculty of Intensive Care Medicine Core Standards for Intensive Care Units identify there should be 0.6 WTE band 8A specialist pharmacist for the number of critical care beds provided. However, the three pharmacists had undertaken a critical care mentorship course.
- Staff we spoke to said they had access to the on-call pharmacist when required out of hours and did not experience delays in receiving discharge medicines.
- The unit was not meeting the Faculty of Intensive Care Medicine Core Standards for Intensive Care Units recommendations around pharmacy technical support. There was no dedicated technical support for the intensive care unit. However, we were told the hospital had technicians who could be accessed if required.

- Staff followed systems and processes when safely prescribing, administering, recording and storing medicines.
- Medicines were administered and stored securely in accordance with the medicines management policy of the hospital. The service had access to a provider wide Group Chief Pharmacist who supported compliance with legislation and best practice.
- Staff reviewed patients' medicines regularly and provided specific advice to patients and carers about their medicines.
- Controlled drugs were stored and managed appropriately. Drugs were kept in lockable wall units and staff performed daily checks of the controlled drugs to ensure they were accounted for.
- We looked at a controlled drugs (CDs) audit for critical care from March 2019. The audit checked 24 items including expired stock, storage of patient's own CDs and the CD register. The service had 100% compliance with all 24 items. In June 2019, compliance was 97%.
- Medicines requiring cool storage were appropriately stored in refrigerators. Fridge temperatures, as well as the temperature in the medicines room, were recorded daily.
- We saw the unit used medicines reconciliation process which meant that when patients were admitted to hospital the medicines they were prescribed on admission correspond to those they were taking before admission.
- We reviewed five prescription charts and saw they were fully completed. Allergies were clearly documented, and allergy stickers were applied to patients' records.
- Staff followed current national practice to check patients had the correct medicines.
- The service had systems to ensure staff knew about safety alerts and incidents, so patients received their medicines safely.

Incidents

- **The service managed patient safety incidents well. Staff recognised and reported incidents and near misses. The clinical services manager investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support. The clinical services manager ensured that actions from patient safety alerts were implemented and monitored.**
- Staff knew what incidents to report and how to report them. Staff reported all incidents that they should report, including near misses which had improved since the last inspection.
- Between August 2018 and August 2019, the critical care service reported 97 incidents. Of these, 30 (31%) were classed as no harm incidents, 61 (63%) were low harm incidents, two (2%) moderate harm and the remaining four (4%) were not classified.
- The critical care service had not had any never events during the same period of time. Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.
- 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.
- At the last inspection the service was unable to provide evidence of the duty of candour being applied following incidents. During this inspection we found staff had a good knowledge of the duty of candour. They were open and transparent and gave patients and families a full explanation if and when things went wrong. This included incidents that were low harm.
- Learning from incidents had improved since the last inspection. Managers shared learning about incidents with their staff and across the hospital. These were shared daily during staff handover meetings and in the monthly multidisciplinary meetings.
- Staff received feedback from investigation of incidents, both internal and external to the critical care service. Feedback was shared individually to involved staff

members, and more generally in the unit team meetings. Urgent information relating to incidents was shared at the daily safety huddles. There was also evidence that learning from incidents was shared via staff bulletins, newsletters and on notice boards.

Safety Thermometer (or equivalent)

- The service continually monitored safety performance. Staff collected safety information and shared it with staff, patients and visitors.
- In 2019 so far, there had been one patient fall and this information was displayed on a notice board. Falls risks assessments were carried out for patients on admission and were reassessed throughout the patients stay on the unit. Patients at higher risks of falls or delirium were cared for in a bay opposite the nurses' station.
- In 2019 so far, there were no cases of unit acquired pressure ulcers reported within the intensive care unit.
- We did not see any information displayed about catheter associated urinary tract infections. However, the department audited compliance with central venous catheters and indwelling catheters. In June 2019, compliance was 100% for both. We were not provided with more recent data.
- Venous thromboembolism risk assessments were recorded on patients' records and completed on a daily basis. Hospital audit data showed compliance in the September 2019 audit was 99%. There had been two thrombosis related incidents in 2019, however these had been reviewed by the Group Thrombosis Board and assessed as unavoidable.

Are critical care services effective?

Good

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

Evidence-based care and treatment

- **The service provided care and treatment based on national guidance and evidence-based practice. Managers checked to make sure staff followed guidance. Staff protected the rights of patients subject to the Mental Health Act 1983.**
- Policies and procedures were available on the hospital intranet. Intensive care specific policies and procedures were up to date and referenced to current best practice from a combination of national and international guidance. This included National Institute for Health and Care Excellence (NICE), Guidelines for the Provision of Intensive Care Services, Royal College guidelines and Intensive Care Society recommendations.
- Copies of several policies were printed and kept in the office. There were printed sheets for staff to sign to confirm that they had read and understood the policy.
- Staff assessed patients' needs and planned and delivered patient care in line with evidence-based, guidance, standards and best practice.
- Staff told us the leaders updated them regarding any changes to national guidance and evidence-based practice. Any updates were discussed in heads of department meetings and shared with staff. For example, we saw any medicines updates were shared via a newsletter.
- Care was delivered in line with best practice for treating critical care patients. Patients were assessed on admission using the Glasgow Coma Scale and were monitored using the National Early Warning Score (NEWS2). The service followed the sepsis guidance on the initial management of septic patients and used the 'Sepsis Six' approach as recommended to provide consistent care.
- Since the last inspection the intensive care unit was now contributing to the Intensive Care National Audit and Research Centre (ICNARC) database for England, Wales and Northern Ireland. This meant care delivered and patient outcomes were benchmarked against similar units nationally.
- There was a local audit programme in place to ensure certain audits were completed monthly such as infection control, pressure ulcer prevention and safety thermometer.
- The unit audited compliance with ventilator care bundles every three months. Data displayed on the audit board showed that in the three-month period before our inspection all elements were met. This was

with the exception of three occasions where the subglottic suction was not documented. The actions taken to address this were also displayed on the board which included staff education.

- We observed patients were risk assessed for venous thromboembolism (VTE) at appropriate intervals (on admission and after 24 hours) and that suitable VTE prophylaxis was in place. This was in line with NICE quality standard 3. Senior leaders had identified a need to improve ensure patients had their VTE re-assessed on admission to the intensive care unit. The unit had organised education for staff and the nurse in charge was spot checking patient records to ensure this was being completed.
- The unit was part of the North West London Critical Care Network, which provides a whole system approach to the delivery of safe and effective services across the patch.
- Staff carried out assessment of delirium (acute confusion) in patients at risk of delirium using the Confusion Assessment Method for intensive care (CAM-ICU) guidelines. This was supported by the use of a confusion assessment flowchart which was clearly displayed on the unit.
- The leaders took into account national safety standard for invasive procedures. This included safety checklists for chest drains, nasogastric tube insertion, tracheostomy and bronchoscopy procedures.
- The critical care service did not have a standard operating procedure for organ donation and staff were not trained on this. However, senior leaders told us they would link up with the organ donation service at the local NHS trust if required.

Nutrition and hydration

- **Staff gave patients enough food and drink to meet their needs and improve their health. They used special feeding and hydration techniques when necessary. The service made adjustments for patients' religious, cultural and other needs.**
- The intensive care unit did not have a dedicated dietitian; however, dietetic review and support was available to all patients that required it. Similarly, speech and language therapy support was available if required. This provision was not compliant with the British Dietetic Association recommended numbers for whole time equivalent dietitians for the number of critical care beds that were available which should be 0.6 whole time equivalent.
- We reviewed patient records on inspection and found that the nutritional needs of patients were monitored using the Malnutrition Screening Tool (MUST). Records reflected the use of fluid balance charts for each patient, as well as evidence of intravenous feeding when patients were not eating or drinking.
- Staff used a nationally recognised screening tool to monitor patients at risk of malnutrition. Staff fully and accurately completed patients' fluid and nutrition charts where needed. Our record review indicated that none of the patients we reviewed required specialist dietetic input or speech and language therapy assessment; however, all four records showed that nursing staff had appropriately and accurately recorded patients' fluid and nutritional balances.
- The service had an enteral feeding protocol to assess the nutritional needs of patients, based on height, weight and body mass index. The nurses implemented the feeding protocol when patients were admitted to the unit. Enteral feeding refers to the delivery of a nutritionally complete feed, containing protein, carbohydrate, fat, water, minerals and vitamins, directly into the stomach.
- Parenteral nutrition(PN) is the feeding of a person intravenously, bypassing the usual process of eating and digestion. The person receives nutritional formulae that contain nutrients such as glucose, salts, amino acids, lipids and added vitamins and dietary minerals. Parenteral nutrition (PN) was started upon agreement of the intensive care unit medical team. PN could be started out of hours or at weekends by intensive care unit staff. Dietitians were not available over the weekend, so if a patient was admitted on a Friday, they would be unable to have a dietitian assessment until the Monday.

Pain relief

- **Staff assessed and monitored patients regularly to see if they were in pain and gave pain relief in a timely way. They supported those unable to communicate using suitable assessment tools and gave additional pain relief to ease pain.**
- Staff assessed patients' pain using a recognised tool and gave pain relief in line with individual needs and best practice. There were processes in place to assess patient's pain. Individual care plans included pain assessments for all patients.
- We reviewed five patient records and found pain scores were recorded for all five patients. However, we noted the use of different scales for pain scores. The department's policy stated pain scores should be recorded on a scale of one to three. However, we found an example where this scale was not used.
- We could not ascertain from patient records whether patients had their pain assessed by an anaesthesiologist on a daily basis.
- Patients received pain relief soon after it was identified they needed it, or they requested it. Our records review showed that patients were provided with pain relief promptly when required.
- Staff prescribed, administered and recorded pain relief accurately. Pain relief was routinely prescribed as part of individual patient management, and additional pain relief was available at patient request.
- There was no pain team within the hospital. However, staff told us they would seek advice from medical staff if required.

Patient outcomes

- **Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for patients. The service had been accredited under relevant clinical accreditation schemes.**
- Since the last inspection the service now submitted data to the Intensive Care National Audit & Research Centre (ICNARC) for all patients treated within the intensive care setting. This meant care delivered and patient outcomes were benchmarked against similar units nationally. The hospital provided the most recent ICNARC report from April 2019 to June 2019.
- ICNARC data showed there were no observed deaths in the reporting period. Therefore, mortality was not compared to other units.
- The mean length of stay on the intensive care unit reported by ICNARC was 1.5 days which was less than the average for comparable units (3.4 days).
- Patients discharged 'out of hours' between 10pm and 7am were associated with worse outcomes and ICNARC data demonstrated the HDU unit was performing better (0%) than other similar units (0.6%).
- ICNARC data showed there were no unplanned readmissions to the intensive care unit within 48 hours of discharge, which represented 0% of patients admitted to the unit in this period. This was better when compared to other similar units (0.8%).
- The service conducted a regular programme of audits to evaluate the quality of care being received by patients. The results were reviewed in regular and action plans were put in place to address any concerns.
- The unit was part of the critical care network. The unit had been reviewed in August 2019 and a gap analysis of the intensive care society standards (ICS) had been conducted.

Competent staff

- **The service made sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and development.**
- At the time of the last inspection we identified that there was no formal educator on the intensive care unit. The service now had a nurse in post with responsibility for monitoring mandatory training, ensuring staff competencies, and supporting staff development. Staff told us they were positive about the support and involvement of the practice educator.
- All staff received a hospital induction. Staff completed an induction and competency checklist when they first started which covered use of equipment, using the service's systems, departmental understanding, and clinical competency skills relevant to their job role and experience. Competencies were then signed off by the clinical and nursing leads.

- Staff were regularly assessed on competencies based on national competency frameworks for critical care, such as the core standards of The Faculty of Intensive Care Medicine. Any areas of positive performance and areas for development were recorded and action plans were put in place.
- Staff were required to provide evidence of their registration with the regulated body of their profession. We saw evidence of staff registration with the Health and Care Professions Council (HCPC) and General Medical Council (GMC). Staff were required as part of their employment to ensure they retained their registration and revalidated when it came close to expiry. Resident medical officers were trained to at least an ST4.
- The service supported staff to develop through regular, constructive clinical supervision of their work. Staff told us that they received an annual appraisal and found it useful to discussing their development goals. Data submitted by the service showed that, as of March 2019, 100% of inpatient nursing staff and healthcare assistants, including critical care staff, had received an appraisal. Three members of bank nursing staff were due to have their appraisals before the end of October 2019.
- The unit met the Intensive Care Society standards for registered nurse work force. This included ensuring a dedicated clinical nurse educator for critical care nursing staff, all newly appointed nursing staff receiving a period of supernumerary practice, and a minimum of 50% of nursing staff possessing a post registration award in critical care nursing. New starters on the unit received six to twelve weeks of supernumerary practice, and 82% of staff had completed a critical care course.
- Staff could apply for funding for courses for professional development including support towards a master's qualifications.
- Medical staff supporting the unit were appraised by their substantive NHS employers. However, a process was in place for sharing the appraisal documentation with the service's leaders.
- The critical care unit used a resident medical officer to provide a day to day medical presence on the unit. Consultants were positive about the quality of the resident medical officers that they worked with and stated there was a regular group who consistently worked at BMI. The resident medical officers competencies were checked before their application to work on the unit was confirmed.

Multidisciplinary working

- **Doctors, nurses and other healthcare professionals worked together as a team to benefit patients. They supported each other to provide good care.**
- The critical care provision included the input of consultants, resident medical officers, nursing staff, physiotherapy and dietitian (as needed). Staff stated they had good working relationship as a critical care team and across disciplines. Staff stated they worked well together collaboratively, and this was supported by an effective and approachable manager.
- Nursing and healthcare assistant staff attended safety huddles at the start of each shift. Information about each patient, their needs, and any notable events in their care during the previous shift were discussed. The huddle also shared information about safety alerts, incidents, or learning, and key messages from the hospital's daily communication cell briefings.
- Critical care patients had access to multidisciplinary input to provide rehabilitative care as necessary. The critical care team worked with physiotherapists to meet rehabilitation needs in line with The National Institute for Health and Care Excellence (NICE) clinical guidance 83. On inspection we observed physiotherapists working with patients and discussing their care.
- A dietitian was available upon request but was not based at the hospital site.
- Ward rounds were undertaken twice a day. However, due to the nature of the service, it was not always possible to co-ordinate a full range of multidisciplinary representation at each ward round. This meant there was a risk that communication between multidisciplinary team members could be disjointed.
- The intensive care unit was not funded for dedicated whole time equivalent (WTE) physiotherapists, which did not meet the Intensive Care Society (ICS) recommendations. The ICS recommends a minimum

ratio of one physiotherapist to four patients, meaning the unit should have 1.5 WTE physiotherapists. Physiotherapy was shared with the whole hospital and requested as needed.

- The unit did not have any dedicated WTE funded occupational therapy (OT) which was below the ICS recommendation of 0.22 WTE OTs per level three bed.
- The Faculty of Intensive Care Medicine states that patients should have access to SALT staff with critical care experience. We were told SALT was provided on a need's basis.
- Medicines, including antibiotics, prescription and usage was reviewed daily by the hospital's pharmacist. Although there were no specific antimicrobial ward rounds, telephone advice could be obtained from a microbiologist if required.

Seven-day services

- **Key services were available seven days a week to support timely patient care.**
- The critical care service was available seven days a week. Most of admissions to the unit were planned admissions following surgery.
- Staffing rotas showed that nurse staffing levels and consultant cover were sufficient to meet the core standards. The critical care service maintained on-call consultant and specialty and resident medical officer medical cover seven days a week, 24 hours a day.
- The critical care service was supported by 24-hour pathology services and radiology services which were available within 30 minutes of request.
- Consultants attended daily ward rounds on the unit, including weekends. Patients were reviewed by their admitting consultant in line with their care pathway. Staff told us ward rounds happened twice daily. However, in two of the five patient notes we reviewed we did not see evidence that these ward rounds had taken place.
- The hospital pharmacy was open from 8.30am to 8pm Monday to Friday. There was a 24 hour on-call pharmaceutical advisory service via switchboard. However, the service did not have also had a dedicated trained intensive care trained pharmacist.
- The outreach team were the critical care staff on duty that day. These staff were available 24 hours a day seven days a week.

Health promotion

- **Staff gave patients practical support and advice to lead healthier lives.**
- There were limited opportunities for staff to undertake health promotion, due to the nature of the care provided by the unit. However, the service supported staff to promote healthy lifestyles to patients including smoking cessation at relevant opportunities.
- On inspection we did not see any leaflets that included advice on health promotion for all patients. For example, smoking cessation or diet and health management.
- Hospital staff provided advice to patients on managing their care after discharge. Staff told us they advised patients on how to maintain their recovery after they had left the hospital. Staff also encouraged patients to contact the unit if they had any questions.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- **Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients' consent. They knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health. They used agreed personalised measures that limit patients' liberty appropriately.**
- Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005, including the Deprivation of Liberty Safeguards. All staff had completed training relating to the two Acts as part of their mandatory safeguarding training.
- Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Health Act and Mental Capacity Act 2005 and the Children Acts 1989 and 2004 and they knew who to contact for advice. Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. They understood that consent was decision-specific.

Good

Critical care

- Staff gained consent from patients for their care and treatment in line with legislation and guidance. When patients could not give consent, staff made decisions in their best interest, taking into account patients' wishes, culture and traditions. They followed the service's policy and procedures when a patient could not give consent.
- Staff made sure patients consented to treatment based on all the information available. Staff clearly recorded consent in the patients' records. Written consent was obtained during the pre-admission assessment stage.
- Staff were aware of the potential impact of delirium on patient's capacity to consent. Staff assessed this daily using the confusion assessment method for intensive care units (CAM-ICU)
- Staffs knowledge of Deprivation of Liberty Safeguards (DoLS) was good. Staff could explain the principles behind DoLS and were clear how this was applicable in a critical care setting. For example, staff knew to use hand mitts, a DoLS assessment needed to be completed.
- When patients could not give consent, staff made decisions in their best interest, taking into account patients' wishes, culture and traditions.
- Nursing staff completed training on the Mental Capacity Act and Deprivation of Liberty Safeguards.
- Clinical staff completed training on the Mental Capacity Act and Deprivation of Liberty Safeguards achieving the hospital's target.

Are critical care services caring?

Good

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

Compassionate care

- **Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.**
- During the inspection, we observed staff providing care and treatment and speaking with patients in a calm, compassionate and kind manner.
- Staff were discreet and responsive when caring for patients. Staff were conscious of maintaining privacy as best possible within the treatment bays. Staff took time to interact with patients in a respectful and considerate way. Staff were motivated to provide person-centred care.
- We spoke with two patients in the intensive care unit during the inspection. Patients spoke positively about the care they received and how they were treated on the unit. Patients told us staff were respectful and provided them with space to ask questions about their care. Patients also stated that staff were professional and well informed about their treatment.
- We observed medical staff during ward rounds and found the interacted appropriately with patients. Staff took extra time to explain care and treatment options and answered any questions the patients had.
- We observed many thank you cards and letters expressing gratitude and compliments from previous patients about the care they received. Comments included; 'wonderful experience', 'awesome patient care, kindness and compassion', and 'very good service'.
- Staff understood and respected the personal, cultural, social and religious needs of patients and how they may relate to care needs. The unit frequently admitted international patients, and this was taken into consideration when planning and delivering care.
- The intensive care unit did not have a separate patient satisfaction friends and family test. We were told patient satisfaction was looked at hospital wide and not as an individual service. This was reported in a hospital wide report and performance was monitored in clinical governance meetings.

Emotional support

- **Staff provided emotional support to patients, families and carers to minimise their distress. They understood patients' personal, cultural and religious needs.**
- Staff understood the impact that patients' care, treatment and condition had on wellbeing. Staff stressed the importance of treating patients as individuals and this was reflected in the interactions we observed.

Good

Critical care

- Staff provided reassurance and support for patients throughout their care. Staff demonstrated a calm and reassuring attitude to put patients at ease. We observed staff taking time to explain their treatment to patients and asking them if they had any questions about their care.
- Staff told us that they regularly assessed the patient's physical and emotional welfare and made referrals to the appropriate professionals when needed.
- The service did not provide bereavement or counselling services. We were told there was access to psychiatrists with practising privileges if required for additional support.
- Staff we spoke with stated they could arrange chaplaincy services for patients.

Understanding and involvement of patients and those close to them

- **Staff supported patients, families and carers to understand their condition and make decisions about their care and treatment.**
- Patients and their families could give feedback on the service and their treatment and staff supported them to do this.
- Staff supported patients to make advanced and informed decisions about their care. There was evidence of discussions of patient care with those close to them in the patient records.

Are critical care services responsive?

Good

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

Service delivery to meet the needs of local people

- **The service planned and provided care in a way that met the needs of local people and the communities served. It also worked with others in the wider system and local organisations to plan care.**
- The intensive care unit served a combination of specialities from wards within the hospital. Patients could be admitted after elective or emergency operations or after becoming medically unwell on both surgical and medical wards within the hospital.
- The critical care service admitted international patients, particularly from Kuwait. The hospital had an international team based on site which liaised with the Kuwaiti embassy to arrange admissions and manage discharges for these patients.
- Senior leaders told us there had been some elective surgery cancelled because of a lack of intensive care beds. Between June 2019 and September 2019, there were 78 cancellations of surgery across the hospital. Of these only two were due to there being no bed available on the unit.
- The unit could flex patient distribution to respond to patient need. Therefore, the unit's beds could be used as both level two and level three beds. However, staff told us they would generally use the two side rooms for level three patients as they offered more privacy.
- ICNARC data from April 2019 and June 2019 showed the intensive care unit primarily admitted theatre planed admission following elective/scheduled surgery (80%) followed by unplanned admission following elective/scheduled surgery (12.3%).
- Unplanned admissions were referred to the consultant on duty who was responsible for deciding whether patients should be admitted for care.
- Senior leaders told us the intensive care unit did not offer a follow up clinic for patients who stayed longer on the unit. However, we were told patients would receive a follow up call from a qualified nurse to identify if patients required any additional support following discharge. During the inspection we identified that some of the follow up calls had been completed by the unit's healthcare assistant. Follow up calls were meant to be completed by a qualified member of staff to ensure any risks were appropriately identified.

Meeting people's individual needs

- **The service was inclusive and took account of patients' individual needs and preferences. Staff made reasonable adjustments to help patients access services. They coordinated care with other services and providers.**
- The service had standard visiting hours between 11am and 9pm; however, by agreement with the lead nurse, open visiting could be supported on the unit.
- A relative's room was available across the corridor from the unit. Overnight visitor accommodation could be supported within the units if a room was available.
- A translation service was available for patients and their visitors. Staff told us they could book both telephone and face-to-face consultations and told us services were available in a range of different languages. There was also an on-site Arabic speaking interpreter who was available 24 hours a day, seven days a week.
- The critical care service provided food that catered to dietary requirements and cultural preferences. Patients told us they were happy with the quality of the food that they received.
- The unit was designed to meet the needs of patients living with dementia. Staff supported patients living with dementia and learning disabilities and had access to a dementia lead for support. There were dementia friendly clocks available if required.
- At the time of the inspection there were no patient on the unit with learning disabilities. Staff told us if there was a patient with a learning disability, they would link with the safeguarding team or medical staff for support.
- Patients were given a choice of food and drink to meet their requirements, cultural and religious preferences.
- Due to there being no bathrooms within the unit there was potential for mixed sex breaches. A mixed-sex accommodation breach occurs in a critical care unit when there are male and female patients in the same unit and one or more of them no longer needs that level of critical care and becomes ready to be transferred to a level one unit, but there is no available bed for transfer.
- There was a 24-hour chaplaincy service available on-call as required.
- We did not see evidence that the service had information leaflets available in languages spoken by the patients and local community, other than English. However, the information signs on the doors to the side rooms were also in Arabic. Staff told us this was because international patients were put into the side rooms. Following the inspection, we were told that leaflets in different languages were available on request.

Access and flow

- **People could access the service when they needed it and received the right care promptly. The service admitted, treated and discharged patients in line with national standards.**
- People could access the service when they needed it and received the right care promptly. The service admitted, treated and discharged patients in line with national standards.
- The majority of admissions to the unit were planned following elective surgery. This meant that bed occupancy was usually planned. However, the clinical services manager reviewed staffing levels on a daily basis to ensure there was sufficient permanent, or bank, staff available to meet the needs of any unexpected and unplanned admissions.
- On admission to the intensive care unit, irrespective of the time of day, all non-elective surgical patients had a treatment plan discussed with a consultant. Consultants were made aware of all planned elective admissions and all level two or level three patients were reviewed in person by a consultant in intensive care medicine within 12 hours of admission to intensive are.
- Between April 2019 and June 2019, data submitted to the Intensive Care National Audit and Resource Centre (ICNARC) showed the critical care unit provided care for 64 patients, of which 14 stayed on the unit for longer than 48 hours. Eight of the admissions were unplanned admissions following elective surgery, and one was an admission following emergency surgery. The unit admitted three deteriorating patients from the ward areas.
- The occupancy rate for the unit varied between 26% and 66% between October 2018 and September 2019. These rates did not go above the 70% occupancy rate recommended by The Royal College of Anaesthetists.

Good

Critical care

- The service monitored patients' length of stay on the unit. Between April 2019 and December 2019, on average, patients stayed 1.5 days on the critical care unit. This was less than the average length of stay at similar units (3.4 days).
- Between April 2019 and June 2019, 25 patients were discharged within four hours of being fully ready for discharge (lines out), 39 patients were discharged between four and 24 hours of being fully ready, and no patients were discharged after 24 hours of being fully ready.
- Between April 2019 and June 2019, there were 546 available bed days in the critical care unit. The average percentage of bed days occupied by patients with discharge delayed more than eight hours was zero per cent. The unit performed the same as similar critical care units (0.0%) and better than the national aggregate of 4.3%.
- Staff did not move patients between the unit and wards at night unless they needed to, and with agreement of the onsite escalation managers.
- Between April 2019 and June 2019, no patients were discharged to the wards between 10pm and 7am. This equated to 0.0% of admissions that resulted in a non-delayed, out-of-hours discharge to the ward. This was within expected range and better than the national aggregate of all units (1.9) and slightly better than similar units (0.6).
- The service moved patients only when there was a clear medical reason or in their best interest. Between April 2019 and June 2019, the critical care unit did not transfer any patients out to other NHS healthcare organisations. This was reflected in the unit's data submission to ICNARC, which also showed there were no transfers out from the unit for non-clinical reasons. On this measure, the unit performed within the expected range and the same as similar critical care units (0.0%) and slighter better than the national aggregate of all units (0.3%).
- Managers and staff worked to make sure that they started discharge planning as early as possible. We reviewed patient records on the unit and found that discussions on discharge were proactive and included input from different disciplines.
- At the time of the last inspection the intensive care unit did not have a follow up clinic where patients could reflect upon their critical care experience and be assessed for progress. The service still did not have a follow up clinic for patients following discharge from the hospital. This was not in line with Guidelines for the Provision of Intensive Care Services which state that patients discharged from intensive care must have access to a follow up clinic.

Learning from complaints and concerns

- **It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff. The service included patients in the investigation of their complaint.**
- The unit had received two written complaints in the 12 months preceding our inspection.
- The hospital clearly displayed information about how to raise a concern in patient areas. Information on how to provide feedback or complain was displayed in the hospital reception. Information on how to complain was included on the hospital's website.
- Staff understood the policy on complaints and knew how to handle them.
- Managers investigated complaints and identified themes. Complaints and associated documentation were managed through the hospitals incident reporting systems. Although the unit had not received any complaints, they would be investigated in line with the hospitals complaints policy.
- Managers shared feedback from complaints with staff and learning was used to improve the service. The clinical services manager shared any learning from complaints, including those highlighted in the wider hospital, at team meetings and at safety briefings as appropriate.

Are critical care services well-led?

Good

Our rating of well led improved. We rated well led as **good.**

Good

Critical care

Leadership

- **Leaders had the integrity, skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff. They supported staff to develop their skills and take on more senior roles**
- Critical care had a clear management structure where the clinical services manager had responsibility for the day to day running of clinical areas. Staff knew the management arrangements and their specific roles and responsibilities.
- A supernumerary senior nurse was allocated as a shift coordinator for each shift. The shift coordinator provided clinical support to staff, as well as leadership for the delivery of care.
- We observed critical care staff interacting well with the unit leadership during the inspection. Managers and senior staff of the unit appeared to be approachable.
- All staff we asked told us they felt supported by the clinical services manager and the senior management team Staff felt their leaders were visible on the unit, were supportive and approachable. During our inspection we observed the senior leaders visiting the unit daily.
- The nursing and medical clinical leadership teams worked closely together to plan and deliver care. Staff from both disciplines were positive about the working relationship on the unit.
- Resident medical officers said they were well supported by their consultants on the critical care unit. Consultants we spoke with were also positive about the support of their colleagues in critical care. The Medical Advisory Committee (MAC) approved new practising privileges for consultants. The lead critical care consultant attended the MAC.
- The clinical services manager understood, and could describe the ambitions, priorities and the issues and challenges for delivering the critical care service. Environmental infrastructure was the main challenges for the unit and were dependent on the need for hospital and/or corporate funding.

Vision and strategy

- **The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. Leaders and staff understood and knew how to apply them and monitor progress.**
- The hospital had its own vision which was 'To be the hospital of choice in Harrow, attracting patients' staff and consultants through delivering he best care, experience and outcomes.' This was supported by a five-year developmental strategy to upgrade rooms and departments. The strategy was coming to an end in 2020.
- Senior leaders told us the vision for the intensive care unit was to continue to play a supportive role to the wards in the hospital. We were told they would like to increase provision for complex rehabilitation patients. One key aim was to support the business as it moved forward with complex spinal and bariatric patients. However, we did not see a formal documented strategy for the unit to meet this goal.
- Since our last inspection the department's strategy had been to improve the service based on issues identified in the last report. This included improving infection prevention and control practice, nurse education and improving the way the department monitored patient outcomes.
- Staff told us that they were generally aware of the vision and strategy for the service, and that they would be kept informed on developments and consulted about any changes.

Culture

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

- Staff we spoke with told us that there was a no blame culture, and that they felt valued and respected. We found that a positive working culture was embedded in the unit, and this was encouraged by supportive and available leadership.
- There was evidence of staff and teams working collaboratively to deliver good quality of care. We observed a safety huddle during the inspection and found this to encourage contributions from all staff attending.
- Staff were proud of the work they carried out. They enjoyed working at the service and were enthusiastic about the care and services they provided for patients.
- We saw evidence of the service complying with the regulatory duty of candour in line with the joint Nursing and Midwifery Council and General Medical Council guidance, Openness and honesty when things go wrong: the professional duty of candour. The duty of candour requires a health service body, as soon as reasonably practicable after becoming aware that a notifiable safety incident has occurred, to notify the relevant person that the incident has occurred, provide reasonable support to the relevant person in relation to the incident and offer an apology.
- Equality and diversity were promoted within and beyond the organisation. We looked at the BMI corporate equality and diversity protocol which was last updated in May 2018 and scheduled for renew in May 2021. There were clear references to protected characteristics under the Equality Act.
- BMI adhered to the annual regulatory reporting requirements of the Workforce Race Equality Standards (WRES) working in partnership with the NHS England WRES Implementation Team as an independent healthcare provider.

Governance

- **Leaders operated effective governance processes, throughout the service and with partner organisations. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.**
- The service had a local governance structure in place which was led by the quality and risk manager. The unit's clinical services manager led a team of charge nurses and senior nurses. The clinical services manager for the intensive care unit reported into the director of clinical services.
- There was a corporate governance framework in place which oversaw service delivery and quality of care. This included a monthly critical care meeting, led by the intensive care unit clinical services manager and attended by unit staff
- We saw records of the last three governance committee minutes and saw they discussed complaints, incidents, key performance indicators, training, and any other clinical issues and audits. Actions to address concerns or outstanding issues were identified and monitored through the team meetings. The meetings were shared with other staff who were not able to attend.
- The service had effective systems to monitor the quality and safety of the intensive care unit. The use of audits, risk assessments, quality indicators and recording of information related to the service performance was to a high standard. The service completed regular clinical audits and monitored key performance indicators, and adapted service delivery in response to the results.
- The Medical Advisory Committee (MAC) met every two months and reviewed matters relating to the delivery of clinical care across the hospital and new practising privilege applications from consultants. We reviewed minutes from MAC meetings and found the meetings were well attended by consultants from each clinical area.
- All staff were clear about their roles and understood what they were accountable for and to whom.
- Staff regularly received corporate clinical governance and quality and risk bulletins with lessons learned. These bulletins contained information on safety alerts, never events, incidents, cancellations, medicine management, patient safety alerts, medical device alerts and latest NICE guidance.
- Governance arrangements were proactively reviewed and reflected best practice. A systematic approach was taken to working with other organisations to improve care outcomes.

- Staff attended monthly staff meetings and held daily huddles throughout the day. There were minutes kept of all team meetings.
- All staff were able to access policies and procedures and all staff had access to the BMI intranet.
- Processes and systems were in place to undertake mortality and morbidity reviews of any deaths on the critical care unit as part of governance meetings. However, as there had been no deaths by the time of the inspection, the effectiveness of such meetings had not yet been tested.

Managing risks, issues and performance

- **Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events. Staff contributed to decision-making to help avoid financial pressures compromising the quality of care.**
- The hospital had a local risk register which included risks relating to critical care. We reviewed this register and found consistent evidence of action plans put in place to control or eliminate the risks.
- Three risks were down to insufficient investment in facilities and critical care equipment and one was the lack of power utility supply continuity.
- However, we did find risks within the department which was not on the services risk register. This was around the resident medical officer for the intensive care unit holding responsibility for the intensive care unit, outreach and emergency resuscitation at the same time. If the resident medical officer was called out for either outreach or emergency resuscitation this could leave the intensive care unit with no medical cover. In addition, we were not assured there was consultant presence on the intensive care unit to mitigate this risk.
- Risks that we identified at the last inspection around infection, prevention and control had been action planned and addressed.
- The hospital had systems to monitor performance, including incidents reporting, clinical governance meetings, patient feedback, audits and staff appraisals.
- The unit's key risks and actions were circulated monthly via the monthly intensive care unit meeting.

Managing information

- **The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were integrated and secure. Data or notifications were consistently submitted to external organisations as required.**
- The service collected, analysed, managed and used information well to support all its activities, using secure electronic systems with security safeguards.
- The service subscribed to the Intensive Care National Audit and Research Centre (ICNARC). This meant the service was able to benchmark its performance against other similar units and with all units in England.
- Staff had access to up-to-date, accurate and comprehensive information on patients' care and treatment. Patient records were predominantly paper based.
- Standard operating policies, works instructions and procedures were available on the hospital's intranet. We reviewed a range of policy and procedure documents held and these were the latest versions; all had a clear review date in place.
- All staff demonstrated they could locate and access relevant information and patient records easily, which enabled them to carry out their roles. Senior staff informed us they were General Data Protection Regulation (GDPR) compliant and that patient information was managed in line with data protection guidelines and legislation. On inspection we observed staff compliance with information governance guidance.
- Urgent updates, including patient safety and equipment alerts, were shared with staff during the handover safety huddles, staff bulletins and information boards.

Engagement

- **Leaders and staff actively and openly engaged with patients, staff, equality groups, the public and local organisations to plan and manage services.**

Good

Critical care

- Staff encouraged patients to complete a feedback form in the waiting area. If individual staff members were complimented and mentioned by name and the feedback was circulated to all staff. The named staff member was offered a free lunch in the restaurant as a token of appreciation by BMI.
- Clinical governance information was communicated to staff via a monthly newsletter and during the daily safety huddle.
- There was a hospital wide patient survey which the unit was involved with. However, the service did not collect specific department patient feedback via surveys.

Learning, continuous improvement and innovation

- **Staff had a good understanding of quality improvement methods and the skills to use them.**
- All staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them.
- The intensive care unit was part of the North London Critical Care Network. The network promoted safe working and improvements in all the network's participating units. The clinical services manager had also visited a local NHS trust to share learning and ideas.
- We did not find any examples of innovation within the service.

Good

Services for children & young people

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

Information about the service

BMI The Clementine Churchill Hospital provides a paediatric non-interventional outpatients service. Services for children and young people were a small proportion of hospital activity and accounts for 2% of outpatient activity.

The outpatients department specialities include orthopaedics, ear, nose and throat, urology, rheumatology, gastroenterology. Children are seen in imaging for the following modalities: general x-ray, MRI, ultrasound and CT.

Where arrangements were the same, we have reported findings in the outpatients and diagnostic imaging sections of the report.

- Children of all ages were seen in outpatients in the reporting period as follows:
  - 910 children aged 0 to 2 years old.
  - 3,248 children aged 3 to 15 years old.
  - 802 young adults aged 16 and 17 years old

Where our findings for outpatients and diagnostic imaging also apply to services for children and young people, we do not repeat the information but cross-refer to the outpatients and diagnostic imaging sections of the report.

Are services for children & young people safe?

Good

We rated safe as **good.**

Where our findings for outpatients and diagnostic imaging also apply to services for children and young people, we do not repeat the information but cross-refer to the outpatients and diagnostic imaging sections of the report.

Mandatory training

- **The service provided mandatory training in key skills to all staff and made sure everyone completed it.**
- The children and young people's sister and clinical services manager for critical care were trained in advanced paediatric life support (APLS). 26 members of staff had qualifications in paediatric basic life support and immediate paediatric life support. The general ward resident medical officer was available 24 hours a day and held the APLS. They were also a member of the resuscitation team.
- At the time of our inspection two healthcare assistants in the imaging department were also being booked to attend paediatric life support training.
- A list of all children visiting the outpatients department was looked at each day before clinic to ensure that the child's consultant had up to date paediatric advanced life support training.
- Clinical staff completed training on recognising and responding to children and young people with mental health needs, learning disabilities and autism.
- For further information, please see the outpatients and diagnostic imaging sections of the report.

Safeguarding

- **Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.**
- Staff knew how to identify children at risk of significant harm, or suffering, and worked with other agencies to protect them. Staff we spoke with had good awareness and knowledge about female genital mutilation (FGM) and child sexual exploitation (CSE) which was part of mandatory training within safeguarding and knew how to escalate concerns to the imaging manager and safeguarding lead. Staff described to us an occasion where they had made a safeguarding referral when they had concerns where a child was repeatedly not brought to their appointment.
- Staff followed safe procedures for children visiting the department. A list of all children visiting the outpatients department was looked at each day before clinic to ensure that the child's consultant had the right level of safeguarding training to see their patient.
- Chaperones were required when consultants needed to examine a child, there was a chaperone register available in each clinic room. Details of consultants who had used a chaperone, and the chaperone that attended were kept in a chaperone folder. Chaperone training was done via e-learning and all staff were up to date with chaperone training.
- The children and young people sister in outpatients was trained to level 4 in paediatric safeguarding. Two of the paediatricians that saw children were trained to a level 5 in paediatric safeguarding. There were also two bank paediatric nurses that were trained to a level 3, this ensured that shifts and annual leave was covered easily.
- All registered practitioners including consultants in the department who were involved in assessing, planning and treating children were trained to level 3 children safeguarding.
- The director of clinical services who was also the safeguarding lead in the hospital was trained to level four children safeguarding. They were also supported by the children and young people's sister and were both on the local safeguarding children's board.
- We reviewed the safeguarding policy for children and young people and found it to be comprehensive and reflected the intercollegiate document. The policies covered topics dealing with staff roles and responsibilities, types of abuse, allegations of abuse, confidential counselling service, The Mental Capacity Act 2005, deprivation of liberty and training. The policy highlighted modern slavery, and female genital mutilation as types of abuse. The safeguarding children and young people policy were in date and was next scheduled for a review in March 2022.

Cleanliness, infection control and hygiene

- **The service controlled infection risk well. Staff used equipment and control measures to protect patients, themselves and others from infection. They kept equipment and the premises visibly clean.**
- A separate cleaning rota was available for the daily cleaning of toys. The toys were cleaned by nursing staff. There were however, several folders where this information was recorded, which could lead to confusion.
- For further information, please see the outpatients and diagnostic imaging sections of the report.

Environment and equipment

- **The design, maintenance and use of facilities, premises and equipment kept people safe. Staff were trained to use them. Staff managed clinical waste well.**
- Outpatients had a separate paediatric emergency trolley. We saw that the equipment on the top of the trolley was checked every day and record check sheets were completed daily. The equipment in the drawers was checked on a weekly basis and expiry dates were documented on the record check sheets.
- For further information, please see the outpatients and diagnostic imaging sections of the report.

Assessing and responding to patient risk

- **Staff completed and updated risk assessments for each patient and removed or minimised risks. Staff identified and quickly acted upon patients at risk of deterioration.**
- We saw that a children's environmental risk assessment had been completed daily in the imaging department main patient waiting area and imaging rooms. The assessment looked at areas such as the cleanliness of toys and safety aspects such as sharps bins and were fully completed.

Good

Services for children & young people

- If a child deteriorated, nursing staff would escalate for support from the resident medical officer (RMO) who was trained in paediatric advanced life support. The RMO would contact the patient's consultant, bleep the hospital's critical care outreach team or arrange for transfer to a local NHS hospital depending on the severity of the patient.
- The Glasgow coma scale was available to monitor a deteriorating child, and the hospital used the paediatric early warning scores to indicate a deteriorating child. These tools had not been required but were readily available if they were.
- Leaflets and posters on spotting early signs of sepsis in a child were available in the outpatients department.
- For further information, please see the outpatients and diagnostic imaging sections of the report.

Nursing and medical staffing

- **The service had enough staff with the right qualifications, skills training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix and gave bank, agency and locum staff a full induction.**
- The children and young people's sister was a registered children's nurse and oversaw the service and monitored staffing levels. Children were cared for by registered children's nurses.
- A consultant paediatrician also supported the children and young people's service. When they were not available, they arranged for another consultant paediatrician to cover.
- For further information, please see the outpatients and diagnostic imaging sections of the report.

Records

- **Staff kept detailed records of patients' care and treatment. Records were clear, up to date, stored securely and easily available to all staff providing care.**
- BMI The Clementine Churchill Hospital had recently implemented contemporaneous medical records for the children and young people service with plans to incorporate this into the other services for the hospital to improve access to medical records.
- The retention of records policy clearly outlined how long notes should be retained for. For example, children's notes were stored in medical records for six months and then archived until the child was 25 years old.
- For further information, please see the outpatients and diagnostic imaging sections of the report.

Medicines

- **The service used systems and processes to safely prescribe, administer, record and store medicines.**
- For further information, please see the outpatients and diagnostic imaging sections of the report.

Incidents

- **The service managed patient safety incidents well. Staff recognised and reported incidents and near misses. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave children, young people and their families honest information and suitable support. Managers ensured that actions from patient safety alerts were implemented and monitored.**
- For further information, please see the outpatients and diagnostic imaging sections of the report.

Are services for children & young people effective?

Not sufficient evidence to rate

We did not rate effective.

Where our findings for outpatients and diagnostic imaging also apply to services for children and young people, we do not repeat the information but cross-refer to the outpatients and diagnostic imaging sections of the report.

Evidence-based care and treatment .

- **The service provided care and treatment based on national guidance and evidence-based practice. There was a BMI corporate children and young people's policy in place for the care of children which reflected national best practice guidelines.**
- Staff told us they knew how to access policies and procedures on the hospital's intranet system. We viewed

the parent/guardian failure to bring children/young person to appointment policy which was in date and contained instructions on the escalation protocol for when a child was not brought to an appointment.
- For further information, please see the outpatients and diagnostic imaging sections of the report.

Nutrition and hydration

- **Staff gave children, young people and their families enough food and drink to meet their needs.**
- Specialist support from staff such as dietitians was available for children and young people who needed it.
- For further information, please see the outpatients and diagnostic imaging sections of the report.

Pain relief

- **Pain relief was not required in outpatients or diagnostic imaging services. However, staff had access to pain tools and could support those unable to communicate using a suitable assessment tool.**
- For further information, please see the outpatients and diagnostic imaging sections of the report.

Patient outcomes

- **No outcomes were gathered for children and young people's services visiting the outpatients department.**
- For further information, please see the outpatients and diagnostic imaging sections of the report.

Competent staff

- **The service made sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and development.**
- Only staff with appropriate competencies saw paediatric patients in outpatients, physiotherapy and imaging.
- All radiographers undertook paediatric basic life support training.
- For further information, please see the outpatients and diagnostic imaging sections of the report.

Multidisciplinary working

- **Doctors, nurses, radiographers and other healthcare professionals worked together as a team to benefit children and young people. They supported each other to provide good care.**
- Staff worked across health care disciplines and with other agencies when required to care for children, young people and their families.
- For further information, please see the outpatients and diagnostic imaging sections of the report.

Seven-day services

- **Key services were available seven days a week to support timely care for children, young people and their families.**
- For further information, please see the outpatients and diagnostic imaging sections of the report.

Health promotion

- **There was limited evidence of staff giving children, young people and their families practical support and advice to lead healthier lives.**
- We did not see any child-friendly or easy read leaflets within the outpatients department.

Consent and Mental Capacity Act

- **Staff supported patients to make informed decisions about their care and treatment. They knew how to support children and young people who lacked capacity to make their own decisions or were experiencing mental ill health.**
- Staff understood Gillick Competence and Fraser Guidelines and supported children who wished to make decisions about their treatment. Fraser and Gillick competencies help assess whether a child under the age of 16 years has the maturity to make their own decisions without consent of a parent or guardian. Staff were aware of situations where these principles would be applied.

Are services for children & young people caring?

Not sufficient evidence to rate

We did not rate caring because we did not see any children's clinics taking place during our inspection and therefore did not have the opportunity to speak with children, young people and their families.

Good

Services for children & young people

Where our findings for outpatients and diagnostic imaging also apply to services for children and young people, we do not repeat the information but cross-refer to the outpatients and diagnostic imaging sections of the report.

Compassionate care

- **Staff treated children, young people and their families with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.**
- Staff followed policy to keep care and treatment confidential.
- Staff understood and respected the personal, cultural, social and religious needs of children, young people and their families and how they may relate to care needs.

Emotional support

- **Staff provided emotional support to children, young people and their families to minimise their distress.**
- Where a young person aged 16 or older had been assessed as suitable for admission under the adult pathway the children's nursing team provided additional emotional support throughout the pre-assessment, admission, discharge and follow up.
- Staff undertook training on breaking bad news and demonstrated empathy when having difficult conversations.
- Staff understood the emotional and social impact that a child or young person's care, treatment or condition had on their, and their family's, wellbeing.

Understanding and involvement of patients and those close to them

- **Staff supported and involved children, young people and their families to understand their condition and make decisions about their care and treatment. They ensured a family centred approach.**
- However, we did not see ways in which children, young people and their families could give feedback on the service and their treatment such as child-friendly comment boxes. However, after the inspection we were told that child-friendly feedback forms were available in the consulting rooms and were given to children and young people to complete. However we were not provided with examples of these forms.

Are services for children & young people responsive?

Good

We rated responsive as **good.**

Where our findings for outpatients and diagnostic imaging also apply to services for children and young people, we do not repeat the information but cross-refer to the outpatients and diagnostic imaging sections of the report.

Service delivery to meet the needs of local people

- **The service planned and provided care in a way that met the needs of local people and the communities served. It also worked with others in the wider system and local organisations to plan care.**
- Facilities and premises were appropriate for the services being delivered. There was a play corner for children in the waiting areas of outpatients and imaging with children's books and wipeable toys.
- The service booked in all children's appointments before 6pm. The imaging department booked children in on a specific day so that a dedicated block of time was kept for paediatric patients.
- For further information, please see the outpatients and diagnostic imaging sections of the report.

Meeting people's individual needs

- **The service was inclusive and took account of children, young people and their families' individual needs and preferences. Staff made reasonable adjustments to help patients access services. They coordinated care with other services and providers.**
- There were two separate children's clinic rooms which were decorated to be child-friendly and colourful. Within these rooms there was a child table and chair set with a colouring set and pictures. Teenagers who visited the department had access to an electronic tablet with access to the internet. The internet access was restricted to age appropriate material.

Good

Services for children & young people

- Children living with autism were offered a quiet consultation room whilst waiting for their appointment and toys were brought into the room that were age appropriate for the child.
- Patients and staff had access to a paediatric psychiatrist at all times.
- Children, young people and their families could get help from interpreters or signers when needed. However, the service did not have information leaflets available in languages spoken by the children, young people, their families and local community. Following the inspection, we were told that leaflets in different languages were available on request.
- For further information, please see the outpatients and diagnostic imaging sections of the report.

Access and flow

- **People could access the service when they needed it and received the right care promptly.**
- Waiting times were not formally monitored but staff told us waiting times did not exceed 10 minutes. There were also dedicated days for paediatric clinics in both outpatients and diagnostic imaging.
- When children and young people had their appointments cancelled, administration staff made sure they were rebooked for as soon as possible. If a child was not brought to an appointment, this was logged as an incident on the electronic incident reporting system and the children and young people's sister and safeguarding lead would be notified. A safeguarding referral would then be made. Staff also contacted parents and GPs of children and young people if they did not attend their appointments.
- For further information, please see the outpatients and diagnostic imaging sections of the report.

Learning from complaints and concerns

- **It was easy for children, young people and their families to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff. The service included patients in the investigation of their complaint.**
- Complaints were overseen by the executive director and the quality and risk manager supported by the customer services team. Managers shared feedback from complaints with staff and learning was used to improve the service. In the last six months, services for children and young people had not received any complaints.
- Children, young people and their families knew how to complain or raise concerns. The service clearly displayed information about how to raise a concern in patient areas.
- Staff knew how to acknowledge complaints and children, young people and their families received feedback after the investigation into their complaint. Managers also shared feedback from complaints with staff and any learning was used to improve the service.
- For further information, please see the outpatients and diagnostic imaging sections of the report.

Are services for children & young people well-led?

Good

We rated well-led as **good.**

Where our findings for outpatients and diagnostic imaging also apply to services for children and young people, we do not repeat the information but cross-refer to the outpatients and diagnostic imaging sections of the report.

Leadership

- **Leaders had the integrity, skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service. They supported staff to develop their skills and take on more senior roles.**
- The children and young people's service was led by the children and young people's sister and a consultant paediatrician.
- The consultant paediatrician was also the deputy chair of the medical advisory committee.
- For further information, please see the outpatients and diagnostic imaging sections of the report.

Vision and strategy

- **The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The**

vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. Leaders and staff understood and knew how to apply them and monitor progress.

- Children and young people services had their own BMI vision, and a five-year plan. The vision was to deliver high quality care to children and young people in a child and family focused service. The five-year plan aimed to look at eight separate tasks which were; information, efficiency, growth, communication, patients, facilities, people and governance.
- For further information, please see the outpatients and diagnostic imaging sections of the report.

Culture

- **Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service promoted equality and diversity in daily work, and provided opportunities for career development. The service had an open culture where patients, their families and staff could raise concerns without fear.**
- There was a culture of collective responsibility between teams and services. There were positive relationships between staff in the children and young people's service, outpatients and diagnostic imaging.
- For further information, please see the outpatients and diagnostic imaging sections of the report.

Governance

- **Leaders operated effective governance processes, throughout the service and with partner organisations. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.**
- The children and young people's sister was a member of the clinical governance committee and reported on a monthly basis to the committee. All incidents and patient feedback from the children and young people's service were fed back to the committee with associated action plans.
- The hospital had recently implemented a children and young people's service group which was to report to the medical advisory committee but this had not yet been implemented at the time our inspection.
- For further information, please see the outpatients and diagnostic imaging sections of the report.

Managing risks, issues and performance

- **The management of risks, issues and performance was integrated with the outpatients department. Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events. Staff contributed to decision-making to help avoid financial pressures compromising the quality of care.**
- We looked at the risk register for the hospital which was split by department. Each risk had a unique identification number, a risk name, a current risk score, an acceptable risk score, control assessment, a description, and a next review date. Risks on the risk register were reviewed regularly and discussed at clinical governance meetings. Each risk was given a rating, review date, and set of control measures. We saw in the minutes of the clinical governance meetings and medical advisory committee meetings that the risks for children and young people's service was regularly reviewed and discussed.

Managing information

- **The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were integrated and secure. Data or notifications were consistently submitted to external organisations as required.**
- For further information, please see the outpatients and diagnostic imaging sections of the report.

Engagement

- **Leaders and staff did not actively engage with children, young people and their families, staff, quality groups, the public and local organisations to plan and manage children and young people's services.**

Good

Services for children & young people

- We did not see evidence of engagement with staff or children, young people and their families to plan and manage the service. We did not see evidence of continuous learning and improvement within the children and young people's service.

Learning, continuous improvement and innovation

- **We did not see evidence of continuous learning and improvement within the children and young people's service.**

Good

Outpatients

Safe	Good
Effective	
Caring	Good
Responsive	Good
Well-led	Good

Information about the service

The outpatients department was one of the main services of the hospital's activity. The outpatients department at BMI The Clementine Churchill Hospital has 23 consulting rooms and 2 treatment rooms. The department is open from 8am to 9pm Monday to Friday and 8am to 1pm on Saturdays.

Activity (May 2018 to April 2019):

- 24,511 non-NHS funded patients were seen in the reporting period as first attendances and 30,157 non-NHS funded patients seen in follow up attendances.
- 7,061 NHS funded patients were seen in the reporting period as first attendances and 12,945 NHS funded patients seen in follow up attendances.
- 61,897 adults aged 18 to 74 were seen in the reporting period. 7,817 adults aged 75 and over were seen in the reporting period.
- Children of all ages were seen in outpatients in the reporting period as follows:
- 910 children aged 0 to 2 years old.
- 3,248 children aged 3 to 15 years old.
- 802 young adults aged 16 and 17 years old.
- The outpatients department employed registered nurses, care assistants and receptionist, as well as having its own bank staff. The accountable officer for controlled drugs (CDs) was the registered manager.

During the inspection, we visited the outpatients department, including the outpatient physiotherapy department, cardiology, phlebotomy and pharmacy departments. We spoke with 20 staff including registered nurses, health care assistants, reception staff, medical staff, pharmacists, phlebotomists, physiotherapists, cardiac nurse specialists and senior managers. We spoke with 10 patients in total. During our inspection, we reviewed 12 sets of patient records.

Are outpatients services safe?

Good

We rated safe as **good.**

Mandatory training

- **The service provided mandatory training in key skills to all staff and made sure everyone completed it.**
- Nursing staff received and kept up-to-date with their mandatory training.
- Audiology staff had 100% mandatory training compliance. Cardiology staff had 96.6% mandatory training compliance. Pathology staff had 95.85 mandatory training compliance. Pharmacy staff had 95.4% mandatory training compliance. Physiotherapy staff had 84.5% mandatory training compliance. Clinical staff in consulting rooms had 94.9% mandatory training compliance. This included staff that was on maternity leave and on long term sick leave.
- There was a strong emphasis on mandatory training and the percentage of completed training was announced daily at each huddle.
- The mandatory training was detailed and met the needs of patients and staff. Training modules included information governance, moving and handling, equality,

diversity and human rights, fire safety, safeguarding, dementia awareness, conflict resolution, consent and chaperone training. Staff also had protecting people at risk of radicalisation (PREVENT) training.

- Mandatory training certificates were printed off and individual staff members kept copies of their own certificates in a personal folder. This meant that staff were easily able to look at their training completion records and bring this with them to their appraisals.
- Examples of training certificates we saw were for equality, diversity and human rights, and cleaning and sterilising scopes. All certificates we saw were in date.
- BMI had electronic systems whereby staff could log in and access their training modules. The BMI system indicated training required for each staff member.
- Managers had access to this system and monthly training records were produced by the training officers and sent to managers. This meant that managers were able to monitor mandatory training compliance and were able to alert staff when required to update their training.
- We looked at a spreadsheet for consultant training records, which highlighted which consultants had up to date training and which mandatory training modules were due to expire.
- The executive director's executive assistant kept track of all the consultants training records. consultants were emailed by the executive assistant when training was due.
- Where consultants did not have up to date training mitigation measures were put in place. For example, if a consultant did not have up to date basic life support training a nurse trained in basic life support attended the consultant's clinics until training was completed. This was recorded as a risk until the training was completed. Consultants we spoke with informed us that the executive director would suspend practising privileges until training was up to date.
- Clinical staff completed training on recognising and responding to patients with mental health needs, learning disabilities, autism and dementia.

Safeguarding

- **Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.**
- Nursing staff received training specific for their role on how to recognise and report abuse.
- Staff knew how to identify adults and children at risk of significant harm, or suffering, and worked with other agencies to protect them.
- Staff knew how to make a safeguarding referral and who to inform if they had concerns. Staff gave an example about a homeless patient who was using the services and escalated their concerns to the patient's GP through the correct BMI procedures.
- All staff had training in awareness and action necessary in cases of female genital mutilation.
- Staff could give examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act.
- Safeguarding flowcharts were visible and available to all staff and were located in the main reception of the hospital, in the outpatients waiting area and various other locations within the outpatient department.
- Staff we spoke with knew who the designated safeguarding lead was in the hospital and how to contact the lead if they needed to.
- Chaperone training was done via e-learning and all staff were up to date with chaperone training.
- Staff we spoke to had built a strong rapport with nurses from nearby trusts and were able to contact them for advice if they needed to.
- We reviewed the safeguarding policy for adults and found them to be comprehensive. The policies covered topics dealing with staff roles and responsibilities, types of abuse, allegations of abuse, confidential counselling service, the Mental Capacity Act 2005, deprivation of liberty and training. The policy highlighted modern slavery, and female genital mutilation as types of abuse. The policy also identified the government's 2011 PREVENT strategy as a means to prevent people from being radicalised.
- There were policies and procedures in place for patients requiring extra observation, supervision, restraint and if needed rapid tranquillisation. Senior staff we spoke with told us that this situation had never occurred before but that the department had the relevant procedures in place such as the deprivation of liberty form that would be completed if required and sent to relevant council. The police would be contacted for patients from overseas. Staff we spoke with said that they would reflect on their conflict resolution training to help them in this situation.

Good

Outpatients

Cleanliness, infection control and hygiene

- **The service controlled infection risk well. Staff used equipment and control measures to protect patients, themselves and others from infection. They kept equipment and the premises visibly clean.**
- Clinical areas were clean and had suitable furnishings which were clean and well-maintained. Patients we spoke with commented positively about the cleanliness of the environment.
- Cleaning records were up-to-date and demonstrated that all areas were cleaned regularly. For example, we saw the height at weight machine in the department was last cleaned on 3 September 2019.
- Cleaning schedules were in place in each clinic room, and domestic staff signed the schedule when the room was last cleaned. Deep cleaning of clinic rooms was completed once a week.
- Cleaning schedules were noted on the door of every toilet and the times they were last checked and cleaned was documented.
- Staff followed infection control principles including the use of personal protective equipment (PPE). Each consulting room had a supply of gloves, aprons and face masks. Spare PPE stock was stored in the department's store room. We saw staff cleaning equipment after patient contact.
- Policies were in place when seeing people with suspected communicable diseases, for example, tuberculosis. We looked at the policy for the infection control management of patients with tuberculosis. This was in date, was last reviewed in 2014 and due for renewal in 2020. Filtering face masks were available for staff when seeing patients with suspected communicable diseases. Patients referred to the hospital with known communicable diseases were screened before they came in for their appointment. Staff were kept informed of these patients, and the necessary PPE was used for the patient. These patients were kept in isolation from other patients and, if possible, consultant lists were rearranged beforehand. Clinic rooms and isolation areas were decontaminated after use.
- We looked at the hand hygiene audit for outpatients from March 2019. The audit checked 76 items including before patient contact, after contact with bodily fluids, and after patient contact. The audit looked at registered nurses and medical staff. The service scored 72 out of 76 and was therefore 95% compliant. There was no evidence of an action plan to increase the score to 100%. Staff we spoke with said that action plans were to be completed by the end of September. We asked for the compliance target for this audit and was provided with the BMI How to Audit procedure. Targets were normally set to 100% to ensure that all patients receive the best care.
- The hospital followed the guidance outlined in the Health Technical Memorandum in the management and decontamination of flexible scopes.
- We looked at the hand hygiene audit for physiotherapy from March 2019. The audit checked 76 items including before patient contact, after contact with bodily fluids, and after patient contact. The audit looked at physiotherapy staff. The service scored 76 out of 76 and was therefore 100% compliant.
- Sharps bins in phlebotomy were attached to a fixed security bar on the wall, which stopped the bins from falling. All sharps bins we looked at were closed and were not overfilled. Staff in phlebotomy had access to PPE and handwashing facilities.

Environment and equipment

- **The design, maintenance and use of facilities, premises and equipment kept people safe. Staff were trained to use them. Staff managed clinical waste well.**
- The service had suitable facilities to meet the needs of patients' families.
- The service had enough suitable equipment to help them to safely care for patients. We saw that staff carried out daily safety checks of specialist equipment.
- We examined the emergency trolley and saw that the equipment on the top of the trolley was checked every day and record check sheets were completed daily. The equipment in the drawers was checked on a weekly basis and expiry dates were documented on the record check sheets.
- We looked at the patient equipment audit for outpatients from March 2019. The audit checked 16 items including PPE, cleaning schedules and single use detergent and disinfectant wipes. The services scored 16 out of 16 and was therefore 100% compliant.

- We looked at the patient equipment audit for physiotherapy from March 2019. The audit checked 16 items including I am clean stickers, commodes, and single use items. The services scored 16 out of 16 and was therefore 100% compliant.
- All equipment in the department had a unique asset number tag. These asset numbers were stored on a database where senior staff could check and see if a piece of equipment needed electrical safety testing or servicing. We looked at several items of equipment including a glucose machine; an examination light and a suction machine and saw that the electrical safety testing was in date in each case.
- The phlebotomy environment had been newly renovated and now provided ample space for safe working. This was an improvement from the last inspection.
- We saw that staff disposed of clinical waste safely.

Assessing and responding to patient risk

- **Staff completed and updated risk assessments for each patient and removed or minimised risks. Staff identified and quickly acted upon patients at risk of deterioration.**
- Staff responded promptly to any sudden deterioration in a patient's health.
- Risk assessments for patients were paper based and included patient infection risk assessments and a venous thromboembolism (VTE) tool for pre-surgical patients.
- Staff knew about and dealt with any specific risk issues. We saw appropriate risk assessments in place for outpatients. Staff were required to sign the risk assessments once they had read and understood the risks. Risk assessments were completed for first aid on site and the use of the hoist. The main risk identified was moving and handling.
- Staff shared key information to keep patients safe when handing over their care to others, during shift changes.
- There were daily resuscitation meetings in the outpatient department to discuss who was undertaking specific roles in the event of a patient cardiac arrest. These meetings were held three times a day.
- Alarm bells were fitted in all of the clinic rooms and situated by the consultant's desk. In the event of a cardiac arrest, staff could push the alarm bell which would bleep the outreach and resuscitation team.
- Acute mental health referrals were made by consultants at the service. Staff had access to a 24/7 mental health liaison (if staff were concerned about a patient's mental health). Staff knew the named doctor to contact and their contact information however they told us they had not needed to do this in the 9 years they had been working in the service.
- Managers had ensured that plans were in place to develop Local Safety Standards for Invasive Procedures using the National Safety Standards for Invasive Procedures. We saw corporate standard operating procedures turned into local work instructions that were approved by the clinical governance committee. These were for blood gases, full blood count, urinalysis and biochemistry.

Nurse staffing

- **The service had enough staff with the right qualifications, skills training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix and gave bank, agency and locum staff a full induction.**
- The service had enough nursing staff of relevant grades to keep patients safe. There were six registered nurses in outpatients and 10 health care assistants.
- Managers calculated and reviewed the number and grade of nurses, nursing assistants and healthcare assistants needed for each shift in accordance with national guidance. The manager could also adjust staffing levels daily according to the needs of patients.
- An information board opposite the patient toilets listed the nurse in charge, the registered nurse, the health care assistants and the fire warden on duty. This information was updated throughout the day. We saw that during our inspection the number of nurses and healthcare assistants on all shifts matched the planned numbers.
- Staff we spoke with in physiotherapy told us that there were two vacancies for physiotherapy including one specialist respiratory physiotherapist which was being recruited for. This was documented on the risk register. The department also used two physiotherapy assistants, one of which was a bank staff member.
- Managers limited their use of bank and agency staff and requested staff familiar with the service. Managers made sure all bank and agency staff had a full induction and understood the service.

- In April 2018, 30.5% of nursing shifts were covered by bank staff, and 41% of shifts were covered by agency staff. Data provided by the hospital showed that between May 2018 and April 2019 there was an average of 19.4% use of bank and agency staff as a share of total staff for outpatient nurses which showed a reduction in bank and agency usage and an improvement from April 2018.
- Data provided by the hospital showed that between May 2018 and April 2019 there were no bank or agency staff used as a share of total staff for healthcare assistant staff in outpatients or to cover shifts.
- Data provided by the hospital showed that between May 2018 and April 2019 there was an average of 9.6% sickness rate in outpatient nurses.
- Data provided by the hospital showed that between May 2018 and April 2019 there an average of 3.2% sickness rate for health care assistants in outpatients.
- Staff turnover for nursing staff was down to 1.1% in the reporting period of May 2019 to April 2019, which was an improvement in comparison to 4.7% between May 2017 and April 2018.
- Staff turnover for HCA staff was 1.0% in the reporting period of May 2019 to April 2019, which was comparable to the 0.9% figure recorded between May 2017 and April 2018.

Medical staffing

- **The service had enough medical staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix and gave locum staff a full induction.**
- The service had enough medical staff to keep patients safe. We saw on inspection that the number of medical staff matched the planned number on all shifts in the outpatients department.
- The service had a good skill mix of medical staff on each shift and reviewed this regularly. Each consultant was responsible for their own clinic.
- Employee compliance co-ordinators kept information on Disclosure and Barring Service (DBS). Original certificates were not kept by human resources which was in line with best practice and were returned to individuals, but relevant information was inputted onto a database. If DBS checks were due for renewal, reminders were sent to management who would then follow this up with the relevant medical staff.

Records

- **Staff kept detailed records of patients' care and treatment. Records were clear, up to date, stored securely and easily available to all staff providing care. However, patient notes were not filed in a particular order and were difficult to follow.**
- Records were stored securely. The hospital had a dedicated medical records department with responsibility for filing, sorting and maintaining an adequate medical record for patients treated and all staff could access them easily.
- Medical records were prepared in advance of outpatient clinics.There were checking processes in place to ensure that patients' notes were confirmed as available and complete on the afternoon before a patient attended.
- When patients transferred to a new team, there were no delays in staff accessing their records.
- All private patients had their notes dictated by consultants and written up by their secretaries. Delays in typing sometimes meant that private patients were seen without their notes. Staff told us that this was documented as a risk in the risk register.
- The service did not record what percentage of patients that were seen in outpatients without all relevant medical records being available.
- We reviewed 12 patient records in total, three from the physiotherapy department and nine from the outpatients clinic.
- Patient notes were comprehensive and well completed in physiotherapy. The physiotherapy department spot checked their patient records every two months and audited their notes every six months as per the record keeping guidance from the Chartered Society of Physiotherapy. Patients were never seen without their notes in physiotherapy.
- In outpatients, records were clearly documented and included clinical data such as full medical histories and previous medical interventions. However, notes were not attached to folders and were kept loose in a cardboard file. Information such as NHS patient trackers and NHS outpatient outcomes form were stapled to the front of the cardboard files. This looked untidy and there was a risk that these forms could be torn off and lost.

- Even though the information available in patient's notes was comprehensive the information was not filed in any order. There was no systematic filling within the notes or dividers used to help navigate through the notes. For example, in one set of notes we found an allergy status documented on an in-patient coding form, along with the patient's co-morbidities midway through the set of notes. This was documented on an orange coloured piece of paper, which did stand out but as the notes were kept loose in the cardboard file there was a risk that this could fall out and get lost.
- All of the nine notes we looked at in outpatients had incomplete record sheets such as the co-morbidity sheet, clinical coding sheet. In half the records we looked at the patient's labels were not clearly printed.
- Outpatient records were not audited or part of an audit schedule.
- All patient records we looked at showed good communication to the referring doctor and the patients GP. We were able to look at clinical letters sent to the patients GP in all of the records.
- The retention of records policy clearly outlined how long notes should be retained for.

Medicines

- **The service used systems and processes to safely prescribe, administer, record and store medicines.**
- Staff followed systems and processes when safely prescribing, administering, recording and storing medicines.
- The medicine cabinet was kept in the locked storage room and the keys to the room were kept with the nurse in charge. All nurses of all grades had access to this room. However, once in the room the key to the medicine cabinet was kept in a key safe and only registered nurses had access to the key safe.
- We checked several medicines kept in the medicine cabinet and all were in date, stock rotations had been done for most medicines such as eye drops and lotions. This is when old (in date) stock was put forward to be used first and new stock was stored behind the old stock.
- We looked in the medicine storage room and saw that room temperatures were done daily and staff we spoke to knew to report temperatures that were out of the optimum range.
- Nurses made up medicines bags for orthopaedic patients that contained required items needed for orthopaedic appointments. These were stored in the medicine storage room, in a locked cupboard. This saved time for both the consultant and patient. The bags contained a list of what had been used and when and were re-filled accordingly.
- Staff reviewed patients' medicines regularly and provided specific advice to patients and carers about their medicines.
- Staff stored and managed medicines and prescribing documents in line with the provider's policy. We saw that prescription pads were kept in a locked room in the pharmacy department and required to be signed out by a pharmacist and collected by a registered nurse. Only management and senior nurses could order prescription pads. There was a log kept for each in prescription pad signed out of the pharmacy department. Each prescription had a unique number and tracker. There were mitigations in place to avoid prescriptions being photocopied, via a fraud protection strip on each prescription.
- Staff followed current national practice to check patients had the correct medicines. Decision making processes were in place to ensure people's behaviour was not controlled by excessive and inappropriate use of medicines.
- The pharmacy department had a direct link to the Medicines and Healthcare products Regulatory Agency (MHRA), which is an executive agency of the Department of Health and Social Care in the United Kingdom responsible for ensuring that medicines and medical devices work and are acceptably safe. Through MHRA, the department was able to keep up to date with changes, for example which medicines were covered by controlled drugs legislation. Senior staff gave an example of a medicine which changed to a controlled drug in April 2019.
- The electronic dispenser in pharmacy tracked patient prescriptions, how often medicines had been prescribed, and gave access to the patient's medicine history. Staff we spoke with said that they were able to speak with the patient's consultant if they felt a patient was abusing controlled drugs. Staff said they would have the support of the accountable officer to do this.
- The last medicine management audit was in February 2019. We looked at the audit which was completed by the pharmacy manager and we saw an action plan to address the areas that had not been met which had been signed off by the outpatients manager.

Good

Outpatients

Incidents

- **The service managed patient safety incidents well. Staff recognised and reported incidents and near misses. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support. Managers ensured that actions from patient safety alerts were implemented and monitored.**
- Staff knew what incidents to report and how to report them. Staff reported all incidents that they should report. Incidents were reported on an electronic form, which all staff had access to and were familiar with. The form was easily accessible and was clearly displayed on the intranet homepage.
- The form was split into different headings which made inputting information easy. The information included the date, description of the incident, type of incident occurred, and a suggestion to prevent recurrence of incident. The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support to that person, under Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Staff we spoke with understood the duty of candour, and told us that they were open and transparent, and gave patients and families a full explanation if and when things went wrong. Also, if a patient was involved in an incident staff would call that patient after 24 hours for a follow up and to provide support.
- The policy for reporting an incident was in date and made reference to the duty of candour.
- Staff received feedback from the investigation of incidents, both internal and external to the service. Staff met regularly to discuss the feedback and look at improvements to patient care.
- All staff we spoke with were familiar with the latest incident in the outpatients department and gave examples of where mitigating actions were in place to prevent the same incident from occurring again.
- Managers investigated incidents thoroughly. Patients and their families were involved in these investigations where necessary.
- In the reporting period, the service had not experienced any never events. Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.
- Staff had access to a corporate BMI counselling line which was provided 365 days a year and 24 hours per day. Counselling was provided for any incident that arose at work.

Are outpatients services effective?

We do not rate effective for this service.

Evidence-based care and treatment

- **The service provided care and treatment based on national guidance and evidence-based practice. Managers checked to make sure staff followed guidance. Staff protected the rights of patients subject to the Mental Health Act 1983.**
- Staff followed up-to-date policies to plan and deliver high quality care according to best practice and national guidance.
- The service ensured that it identified and implemented relevant best practice and guidance, such as The National Institute for Health and Care Excellence (NICE) guidelines. Updates were shared via the "comm cell" meetings, which were passed on by the quality and risk manager directly from BMI.
- Policies were discussed at clinical governance meetings and standard operating procedures were agreed at these meetings.
- Individual BMI staff accounts would list documents that had changes made in accordance to best practice and guidance relevant to their role. Staff were required to read the changed documents and were given limited access to their accounts until all the changes had been read.
- Staff would receive alerts by email signposting changes that had been made to local policies. There were also red alerts via the BMI online learning platform for any national policies that had not been reviewed by staff within a 30 day window.

Nutrition and hydration

- **Patients were provided with hot and cold drinks whilst waiting for their appointment.**
- Patients had access to hot and cold drinks which were free of charge and provided by the hospital in the patient waiting area.
- Staff encouraged patients to visit the hospital's restaurant if clinics were running late. Patients we spoke to spoke highly of the food in the restaurant and said that there was a good choice of hot and cold food options.

Pain relief

- **Staff assessed and monitored patients to see if they were in pain, medical staff gave pain relief in a timely way. Staff supported those unable to communicate using suitable assessment tool and additional pain relief to ease pain.**
- Staff assessed patients' pain using a recognised tool and consultants were able to prescribe pain relief in line with individual needs and best practice. Staff had access to a pain tool that could be used for non-verbal patients.
- There was no pain lead nurse for the outpatients department but staff were able to contact a consultant from the pain clinic if required.

Patient outcomes

- **Patient outcomes were not formally collected by staff in the outpatients department.**
- All patients received follow up appointment four to six weeks after treatment.
- The hospital did not participate in the Improving Quality in Physiological Services (IQIPS) accreditation scheme.
- Managers used information from the local audits to improve care and treatment.

Competent staff

- **The service made sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and development.**
- Managers gave all new staff a full induction tailored to their role before they started work. This included bank staff, who had the same access to BMI training portal as full-time staff workers.
- Managers made sure staff received any specialist training for their role. Staff were given a day off each week to study. Nursing staff told us they received regular, constructive clinical supervision and appraisals of their work.
- Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. Staff told us they discussed their training needs with their line manager and were supported to develop their skills and knowledge.
- Staff at all levels reported lots of opportunities were available for training. The hospital also had a super user booking trainer to assist with the bookings of training on the BMI intranet. Super users were trained to provide assistance to staff for electronical systems. HCAs were being trained to work in the ophthalmic clinic and gained competencies in giving patients drops and taking measurements. Other healthcare assistants we spoke with were in the progress of completing an apprenticeship to become a nursing associate.
- All staff we spoke with said the outpatients department and the clinical services manager provided support for progression and personal development. Senior staff we spoke with were given the opportunity to complete the institute of leadership and management course with support from the heads of departments.
- The appraisal year ran from November 2018 to October 2019. A total of 68% of nursing staff in outpatients had an appraisal within the last completed appraisal year. This equated to 13 staff members, the remaining six staff members had an active appraisal status. All staff in physiotherapy were due to have a closing appraisal by 21 October 2019. Staff had initial meetings to set objectives which was reviewed mid-way through the year and then a closing appraisal.
- Managers identified poor staff performance promptly and supported staff to improve. Staff had access to online BMI corporate support to manage poor or variable staff performance. Staff were also able to call a support line and obtain advice over the phone for performance management.
- Managers made sure staff attended team meetings or had access to full notes when they could not attend.
- Staff carried a mini BMI prompt booklet which was the size of a keyring, and specific to BMI The Clementine Churchill Hospital. The booklet had various information

such as key contacts in the hospital, the hospital's vision, the five principles of the Mental Capacity Act 2005, top 10 risks of the hospital and information governance.
- The hospital had a dementia champion, with knowledge and skills in the care of people with dementia. They were an advocate for people with dementia and a source of information and support for co-workers.
- All pharmacists were competent to counsel patients regarding medicines. The clinical services manager for pharmacy was a member of the London North West Medications Safety Officer Group and attended meetings with the Medical Safety Officers from all local London NHS trusts and implemented changes that arose from these meetings.

Multidisciplinary working

- **Doctors, nurses, and other healthcare professionals worked together as a team to benefit patients. They supported each other to provide good care.**
- Staff in physiotherapy reported good support and rapport with administrative staff in the hospital.
- We saw positive relationships between staff in the pharmacy department and the outpatients department.
- Multidisciplinary medicines management committee meetings were chaired and run by the clinical services manager for pharmacy, the health and safety lead, infection prevention control lead and the quality and risk manager.

Seven-day services

- **Outpatients and physiotherapy were open six days per week. Key support services were available seven days a week to support timely patient care.**
- Staff could call for support from doctors and other disciplines, including mental health services and diagnostic tests.
- The outpatients department was open from 8am to 9pm Monday to Friday and on Saturdays it was open from 8am to 1pm.
- The physiotherapy department was open from 7.30am to 8pm Monday to Friday, and on Saturday it was open from 8.30am to 2pm. The hydrotherapy pool was in operation from Tuesday to Friday 9.30am to 6.30pm. The ward physiotherapy services ran from 8am to 8pm Monday to Friday, and on Saturdays it ran from 9am to 5pm. There was an on-call service provided to the hospital wards out of hours.
- The pharmacy department was open seven days a week from Monday to Friday services ran from 8.30am to 8pm. On Saturday services ran from 9.30am to 2pm and there was an on-call service on Sundays and bank holidays services. On-call services were provided out of hours and via an on-call service provided by the pharmacist department.

Health promotion

- **The outpatients department displayed information to encourage patients to live healthier lives.**
- The service had relevant information promoting healthy lifestyles and support in patient areas. For example we saw leaflets on smoking cessation. We also saw information leaflets on cancer displayed on a wall in the outpatients waiting area.
- Staff assessed each patient's health at every appointment and provided support for any individual needs to live a healthier lifestyle.
- There was a large free-standing poster supporting the next local half marathon, with joining instructions.
- Information leaflets displayed in an information stand contained information on weight loss, getting back into fitness and running injuries.

Consent and Mental Capacity Act

- **Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients' consent. They knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health.**
- Staff understood how and when to assess whether a patient had the capacity to make decisions about their care.
- Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Health Act, Mental Capacity Act 2005 and the Children Acts 1989 and 2004 and they knew who to contact for advice.

Good

Outpatients

- We saw that staff gained consent from patients for their care and treatment in line with legislation and guidance. Staff made sure patients consented to treatment based on all the information available. We saw that consent was clearly recorded in patient records.
- Staff could describe and knew how to access policies on Mental Capacity Act and Deprivation of Liberty Safeguards. Nursing staff completed training on the Mental Capacity Act and Deprivation of Liberty Safeguards. Staff training for Mental Capacity Act was incorporated into their safeguarding training. Clinical staff completed training on the Mental Capacity Act and Deprivation of Liberty Safeguards.
- Managers monitored how well the service followed the Mental Capacity Act and made changes to practice when necessary.

Are outpatients services caring?

Good

We rated caring as **good.**

Compassionate care

- **Staff treated patients with compassion and kindness, respected their privacy and dignity and took account of their individual needs.**
- There was a strong visible person-centred culture. Staff were highly motivated and inspired to offer care that was kind and promoted patient's dignity. Staff understood and respected the personal, cultural, social and religious needs of patients and how they may relate to care needs and followed policy to keep patient care and treatment confidential.
- Relationships between people who use the service, those close to them and staff were strong. We saw staff took time to interact with patients and those close to them in a respectful and considerate way. We observed staff being polite and taking the time to explain procedures to patients and relatives.
- We saw staff greeting patients with compassion and saw that staff had built a good rapport with those patients that they saw regularly. Patients said staff treated them well and with kindness.
- Patients we spoke with felt supported and said that they felt staff cared about them. We saw that staff were discreet and responsive when caring for patients. Staff told us that patients' emotional and social needs were as important as their physical needs.
- Patients we spoke with told us that staff were friendly, efficient and approachable. They told us they would recommend the hospital to friends and family.
- Patient satisfaction scores were displayed throughout the hospital for 2018. 94.4% of patients was likely or extremely likely to recommend the service to friends and family. 93.2% described the quality of care as very good or excellent. 91.3% of patients had their expectations met or exceeded.
- We requested up to date data on the BMI outpatients friends and family test results and we received data from August 2019 to September 2018. In August 2019 we saw that 95.8% of patients would recommend the physiotherapist service to friends and family if they needed similar care or treatment. In July and August 2019 100% of patients would recommend the nursing care in outpatients to friends and family.

Emotional support

- **Staff provided emotional support to patients, families and carers to minimise their distress. They understood patients' personal cultural and religious needs.**
- Staff gave patients and those close to them help, emotional support and advice when they needed it. We saw staff supported patients who became distressed in an open environment and helped them maintain their privacy and dignity.
- Staff undertook training on breaking bad news and demonstrated empathy when having difficult conversations. They understood the emotional and social impact that a person's care, treatment or condition had on their wellbeing and on those close to them.
- We noted a number of thank you cards from patients throughout the outpatients department to staff for their support and care.

Understanding and involvement of patients and those close to them

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

Good

Outpatients

- Staff made sure patients and those close to them understood their care and treatment. We saw staff talking with patients, families and carers in a way they could understand, using communication aids where necessary.
- Patients and their families could give feedback on the service and their treatment and staff supported them to do this.
- Staff supported patients to make advanced and informed decisions about their care.
- Patients we spoke with told us that they had received the appropriate information prior to attending their appointment and during their appointment.

Are outpatients services responsive?

Good

We rated responsive as **good.**

Service delivery to meet the needs of local people

- **The service planned and provided care in a way that met the needs of local people and the communities served. It also worked with others in the wider system and local organisations to plan care.**
- The outpatients waiting area had enough seats for patients and relatives, and refreshments, such as hot drinks and water were provided. Patients we spoke with enjoyed sitting in the atrium and said that it made the place feel less clinical. They said that it was nice to be in natural light.
- The environment for patients waiting to be seen in outpatients (the atrium) was on the risk register. The layout did not provide enough privacy for patients when booking in. However, this had been considered by the senior management team in the site development plan.
- The car park was free for patients and many patients knew about this. Patients we spoke with reported that there was lots of space in the patient car park. We did have some concerns expressed by patients that it was difficult to exit the carpark at peak times.
- The department was clearly signposted and there were also maps of the floor level patients were on which highlighted facilities such as the disabled toilets, baby changing toilets and vending machines. There were signposts and signs in the main outpatients reception and we observed patients following the instructions on the sign for the booking in process.
- The service was able to use ambulances (private, and emergency) or taxis on account to transport patients to and from the hospital.
- Patients received outpatient appointment letters with the times of their appointment, telephone numbers and any preparation required for the appointment such as fasting when required. Patients could request to receive their appointments via text or email. All patients were able to choose when they wanted to be seen and the service offered flexible appointment times to all patients. All appointment letters were sent out to patients in English.
- Pre-assessment appointments for surgery and endoscopic procedures were the only appointments initially conducted over the telephone.
- Clinics were consultant led at dietitian clinics.
- Patients were able to choose a physiotherapist of their choice throughout the duration of their treatment. Some patients we spoke with said they were happy to wait an extra week for their physiotherapy to see the physiotherapist of their choice.
- The outpatients department kept track of late clinics when patients were waiting to be seen by consultants and informed patients of how late the clinics were running. If there was a significant delay, patients were given the choice of waiting in the atrium or going to the restaurant for further refreshments.
- Interpretation services were made available to the staff through a service level agreement with an external company. Interpretation requirements were identified at the point of booking. There was a large volume of staff working at the hospital that could speak another language, and these members of staff were called upon if required. If staff were unable to get an interpreter over the phone or a member of staff for interpretation patient's appointments were re-scheduled. Friends and family were not used for interpretation.
- Chaplains were available and could be called if required.

Meeting people's individual needs

Good

Outpatients

- **The service was inclusive and took account of patients' individual needs and preferences. Staff made reasonable adjustments to help patients access services. They coordinated care with other services and providers.**
- Patients were given a choice of appointment times and day of the week that suited their needs. We spoke to a patient who was able to amend their appointment with ease in the same week due to another conflicting personal appointment.
- Waiting times for the initial first appointment was one week.
- Appointment slots were variable by consultant and also by category, for example new patients or follow up appointments. This meant that the service ensured that appointments for new service users allowed time to ask questions.
- Patients were given a choice in regard to disclosing test results, but the hospital preferred face to face appointments to discuss treatment options.
- Nurses or administrative staff would call patients by their name for their appointment. This was sometimes ineffective as the waiting area was a large atrium and seating was positioned on the outskirts of the room. Some patients we spoke with said that a better system was required for calling patients to their appointments. Staff we spoke with said that the department was in the process of ordering name plates to improve patient flow.
- There were no signs or boards to inform patients of waiting times once they arrived for their appointment. However, nurses would regularly verbally communicate this information in the waiting area, and patients were informed of any delays on arrival.
- In the site development plan from April 2019 we saw that there were plans to improve the outpatients waiting area reconfiguration from an aesthetic view but also to provide a more functional and efficient outpatients area. Changes included an electronic patient calling system and an electronic registration system.
- Staff we spoke with told us that did not attend (DNA) rates were very low. On Monday 2 September 2019 there was a total of six DNA out of 400 patients. DNA's were recorded on the booking system. We saw signs around the outpatients department notifying patients that a charge could be incurred for not turning up to appointments.
- Appointment letters sent out to patients indicated fees for the consultation and stated cancellation fees.
- There were porters available at the reception to collect patients from cars if required and take them to their appointment.
- Dementia champions were available on site for those patients living with dementia. Staff were able to communicate with nurses on the wards for additional support for patients living with dementia. Nurses were able to refer patients back to their consultant if they had concerns regarding mental capacity.
- Patients living with autism and patients that were unable to communicate were given visual aids in forms of photographs. For example, there were photographs of toilets to help a patient express their wish to use a toilet.
- Special arrangements could be made for patients that were anxious, for example longer appointment times.
- There were bariatric wheelchairs available in the reception waiting area and toilets were suitable for bariatric patients.
- The department had a hearing loop available for patients who had a hearing impairment. There was a sign at the reception desk notifying patients of the portable induction loop system available.
- We saw information printed in large print for those patients with a visual impairment, such as the Patient Information for Consent, Cataract Surgery. Staff we spoke with said the all leaflets could be printed in larger font as recommended by the Royal National Institute of Blind People guidelines.
- There were no separate private facilities for mothers to breastfeed their child; however, mothers were offered private consulting rooms to use.
- Occupational therapy and social services worked together with pre-assessment to discharge patients as quickly and safely as possible. Communication via email was sent to wards and theatres to prepare for discharge.
- Cancer services were reduced at this hospital, and the outpatients clinic usually saw patients pre-operatively and peri-operatively after cancer surgery. This was mainly for patients living with breast cancer. Patients referred for an urgent cancer appointment received their appointments quickly.
- The hospital was in the process of recruiting a breast cancer specialist nurse, but there was a breast cancer

specialist nurse available at a different BMI hospital close by. Patients had the option of where to be seen and the breast specialist nurse could move between sites to see patients.
- Managers made sure staff, and patients, loved ones and carers could get help from interpreters or signers when needed.
- Patients were able to request the same sex staff to treat them in physiotherapy.
- Staff we spoke with had received training in supporting patients when they had received bad news. This was not part of the mandatory training schedule, but staff had specifically asked for this training and completed the training off site.
- Trained staff were available to support patients when they had received bad news.
- All medicines came with a patient information leaflet. This information was only available in English. Patients that came to the pharmacy department with an interpreter had their instruction re-written in their preferred language by their interpreter. There were systems in place to call a translation service over speaker phone if required in the pharmacy department but staff we spoke with said they had not needed to do this.

Access and flow

- **People could access the service when they needed it and received the right care promptly.**
- The BMI national enquiry centre (NEC) booked private patients' appointments as well as medical secretaries. Patients were offered to be seen at BMI The Clementine Churchill Hospital but were also offered an appointment at different BMI hospitals when appointments could be booked in sooner.
- Administrative staff booked in all NHS patients. These patients were referred to the hospital by their GP. The patients GP would send a letter of referral to the hospital, this was then looked at by the clinical team and triaged. Before appointments were made senior nurses looked at the patient's referral letter to either reject or accept the patient's appointment. Some patients were rejected on the basis of their co-morbidities. The hospital had a strict admission criteria in place. Staff triaged and accepted or rejected patients based on this criteria and on the services available at the hospital to cater to the patients' care needs. A BMI of 40 threshold applied to NHS Patients which was in line with the NHS standard contract. Mentally acute patients were declined at this hospital.
- If a patient came for an appointment and a co-morbidity that was not suitable for this hospital was identified a referral was required and made elsewhere.
- Patients we spoke with in the waiting area had not been waiting for their appointment for longer than 10 minutes and said that they were usually seen on time.
- The hospital did not monitor waiting times for patients once the patient was at the hospital.
- All late running clinics was recorded by administration staff or nursing staff. Notes were made regarding the number of patients affected, negative patient feedback as a result of the delay and if there was a discussion with the consultant including the outcome. This was reviewed by the clinical services manager and escalated to senior management where necessary. The clinic team lead looked at late start times for clinics once a month and adjusted the length of appointment slots and clinic start times, per consultant.
- When clinics were cancelled for unforeseen circumstance the hospital looked at accommodating patients with another consultant on the same day to avoid disruption to the patient. Where this was not possible patients were rebooked in for their appointments as soon as possible. The hospital asked consultants to ensure that suitable notice for cancellation of clinics was provided and where these were done on the day for non-urgent reasons, they were escalated to the senior management team.
- Patients were able to travel to their appointment via public transport or via their own car. Patients we spoke with said that transport links were good, that the parking was free, and spaces were adequate.

Learning from complaints and concerns

- **It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff. The service included patients in the investigation of their complaint.**
- Patients, relatives and carers knew how to complain or raise concerns. New patients we spoke with said they felt comfortable in asking staff members on how to make a complaint.

Good

Outpatients

- The service clearly displayed information about how to raise a concern in patient areas.
- Staff understood the policy on complaints and knew how to handle them.
- Managers investigated complaints and identified themes. Staff we spoke with said that the main complaint received in the outpatient department was the temperature in the atrium waiting area. This had been improved by an installation of an air-conditioner, and the use of a black film over the glass ceiling. Other complaints included a queue at the reception desk, but this was also mitigated by the introduction of more administrative staff. The main complaint received by the hospital was around communication throughout the hospital.
- We looked at the complaints log for the whole hospital from December 2018 and May 2019, complaints were split by department. The outpatients consulting rooms received 14 complaints, physiotherapy, pathology and administration received two complaints each and pharmacy and audiology received one complaint each. The log showed how the complaint was received (in writing or verbally), when the complaint was received, the date of acknowledgment, the date of full response, classification on complaint, contract type, summary, outcome details and complaint resolved. All complaints received by the outpatient department had been resolved and closed.
- Complaints were overseen by the executive director and the quality and risk manager supported by the customer services team. Feedback was shared at "comm cell" meetings. Managers shared feedback from complaints with staff and learning was used to improve the service.
- Patients were provided with information on how to make a complaint to the Independent Healthcare Sector Complaints Adjudication Service (ISCAS) and the Parliamentary and Health Services Ombudsman (PHSO) if they were not satisfied with the hospital's complaints process.

Are outpatients services well-led?

Good

We rated well-led as **good.**

Leadership

- **Leaders had the integrity, skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff. They supported staff to develop their skills and take on more senior roles.**
- Leaders of the service were visible and approachable and spoke highly of their junior staff and senior staff. Senior staff we spoke with told us that they saw senior management every day. Junior staff we spoke with said they felt they could call or speak to the executive director if and when required.
- Leaders of the outpatients service held the right skills for the job and had a professional leadership qualification. They told us they were also given the opportunity to complete a leadership programme at BMI which was accredited.
- Leaders led by example and maintained their clinical competency and skills by working as part of the scanning team. We saw that leaders had their appraisals booked in and had one to one catch up sessions with their seniors every other week.
- Leaders had a deep understanding of issues, challenges and priorities in their service and other services within the hospital.
- There was compassionate, inclusive and effective leadership at all levels. Senior leaders we spoke with demonstrated high levels of experience, capacity and capability needed to deliver excellent and sustainable care.
- Staff described the leadership as good and flexible to individual staff needs.
- Consultants we spoke with said the hospital was very receptive to new ideas and the executive director's presence was very positive in the hospital.
- We saw open door offices with all the clinical services managers in the outpatient department.

Vision and strategy

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

- The hospital had its own vision, the vision was 'To be the hospital of choice in Harrow, attracting patients, staff and consultants through delivering the best care, experience and outcomes'.
- The hospital's vision was above the desk at the main entrance of the hospital and also dotted around the outpatient department.

Culture

- **Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service promoted equality and diversity in daily work and provided opportunities for career development. The service had an open culture where patients, their families and staff could raise concerns without fear.**
- Leaders had a shared purpose and strived to deliver and motivate staff to succeed. There was a culture of collective responsibility between team and services. There were positive relationships between staff and teams, issues were resolved quickly and constructively and responsibilities were shared.
- Leaders promoted a positive culture that supported and valued staff, creating a sense of common purpose based on shared values. There were processes for providing all staff at every level with the development they need including high-quality appraisal and career development conversations.
- Staff were proud of the organisation as a place to work and spoke highly of the culture. Staff we spoke with said the working atmosphere was nice, the patients were friendly and that there was an open culture.
- Equality and diversity were promoted within and beyond the organisation. We looked at the BMI corporate equality and diversity protocol which was last updated in May 2018 and scheduled for renew in May 2021. There were clear references to protected characteristics under the Equality Act.
- BMI adhered to the annual regulatory reporting requirements of the Workforce Race Equality Standards (WRES) working in partnership with the NHS England WRES Implementation Team as an independent healthcare provider.

Governance

- **Leaders operated effective governance processes, throughout the service and with partner organisations. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.**
- The service had a local governance structure in place which was led by the quality and risk manager. Information was cascaded from the outpatient department to the board through safety huddles, team meetings and head of department meetings.
- All staff were clear about their roles and understood what they were accountable for and to whom.
- Staff regularly received corporate clinical governance and quality and risk bulletins with lessons learned. These bulletins contained information on safety alerts, never events, incidents, cancellations, medicine management, patient safety alerts, medical device alerts and latest NICE guidance.
- Heads of departments met every month. A standard agenda was used which included risk register updates and feedback from complaints. There were also opportunities to discuss items outside the agenda.
- Governance arrangements were proactively reviewed and reflected best practice. A systematic approach was taken to working with other organisations to improve care outcomes.
- Staff attended monthly staff meetings and held daily huddles throughout the day. There were minutes kept of all team meetings.
- All staff were able to access policies and procedures and all staff had access to the BMI intranet.

Managing risks, issues and performance

- **Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events. Staff contributed to decision-making to help avoid financial pressures compromising the quality of care.**
- We looked at the monthly clinical governance report from May 2019. The report looked at patient activity, incidents by level of harm, total number of open incidents, classifications of incidents, incidents reported to the Care Quality Commission, patient deaths and action plans, lessons learnt and themes from May's incidents and the last three months of incidents.

- We looked at the risk register for the hospital which was split by department. Each risk had a unique identification number, a risk name, a current risk score, an acceptable risk score, control assessment, a description, and a next review date. We did not see whether or not risks had been closed or were still opened. There was one risk for administration, and three risks each for consulting rooms, pathology and consulting rooms. There were four risk each for physiotherapy and pharmacy.
- Staff we spoke with knew about the risks recorded on the risk register in their own department.
- There were processes to manage present and future performance. Huddles known as "comm cell" meetings were held in the outpatient's department, three times a day. This was a meeting for all staff in the department including non-clinical staff members. Different members of the outpatient's team took in turn to lead the meeting regardless of their seniority. We looked at meeting minutes from the last six months. The service department meetings followed a set agenda including mandatory training performance, incidents, complaints, the departmental risk register and clinical governance. We saw that the clinical services manager was present for all the meeting minutes we reviewed.
- The outpatients department had a "comm cell" board in the outpatients offices. The board displayed information and statistics regarding departmental activity, incidents and staffing. All staff in outpatients were able to see this board at all times. Information on this board was updated daily.

Managing information

- **The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were integrated and secure. Data or notifications were consistently submitted to external organisations as required.**
- The department had access to the BMI computer systems where they could access policies and resource material.
- Staff ensured that information was kept confidential by the use of privacy computer screens.
- All computers we saw were password protected and were locked.
- Offices that contained confidential information were kept locked either by key or via a keypad on the door.
- Completed feedback forms were kept in a locked cupboard for one month. Thereafter they were moved to medical records for data management.

Engagement

- **Leaders and staff actively and openly engaged with patients, staff, quality groups, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients.**
- Staff encouraged patients to complete a feedback form in the waiting area. If individual staff members were complimented and mentioned by name, the feedback was circulated to all staff. The named staff member was offered a free lunch in the restaurant as a token of appreciation by BMI.
- Services were developed with the full participation of those who used them, including staff. Leaders we spoke with gave examples of implementing change with their team support and ideas, rather than just implementing change without staff involvement. Staff felt proud to be involved in the new booking system and given the opportunity to help develop it.
- Staff had access to a list of key roles in the outpatient "comm cell board". This included the Caldicott guardian, the safeguarding lead, the infection prevention lead, the dementia lead, the resuscitation lead, VTE champions, the quality and risk manager and the health and safety lead.

Learning, continuous improvement and innovation

- **All staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them. Leaders encouraged innovation and participation in research.**
- All staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them. Leaders encouraged innovation and participation in research.
- Senior staff we spoke with spoke about having the support of the marketing team and senior leaders in regard to the development of new services. This included injection therapy and shock wave treatment.

Good

Outpatients

- Plans were in place to improve the infrastructure of the department and considered the views expressed by patients to make these improvements.

Good

Diagnostic imaging

Safe	Good
Effective	
Caring	Good
Responsive	Good
Well-led	Good

Information about the service

The diagnostic imaging department at BMI The Clementine Churchill Hospital provides the following services:

- General X-ray imaging
- OPG dental imaging
- Interventional and diagnostic ultrasound
- Digital full field mammography
- Mobile X-ray
- Computerised Tomography (CT)
- Magnetic Resonance Imaging (MRI)
- Radiographic imaging in theatre
- SPECT CT (single-photon emission computed tomography) / Nuclear medicine
- Fluoroscopy
- Dexa Scanning
- Neurophysiology

The service operates from Monday to Friday 8am to 9pm and treats both adults and children. Children are seen in imaging for the following modalities: general x-ray, MRI, ultrasound and CT. On Saturdays, general x-ray and ultrasound is open from 8am to 2pm and MRI operates from 8am to 8pm on Saturday and Sunday. SPECT CT is open from Monday to Friday 9am to 5pm. SPECT CT and MRI are not available out of hours.

For inpatients, there is access to 24-hour diagnostic imaging on site with the exception of MRI and SPECT CT which are not available out of hours. The hospital also has access to an on-call radiographer.

During our inspection we spoke with 13 members of staff including radiographers, healthcare assistants and administrative staff. We spoke with four patients.

Are diagnostic imaging services safe?

Good

We rated safe as **good.**

Mandatory training

- **The service provided mandatory training in key skills to all staff and made sure everyone completed it.** The hospital provided a structured induction and mandatory training programme for staff.
- Staff received their mandatory training through face-to-face sessions and online courses. All new staff received a week-long induction to complete the courses. Temporary (agency) staff received a local induction which included orientation of the department.
- The hospital set a target of 90% for completion of mandatory training courses. Mandatory training rates for imaging department staff as at September 2019 was 92%.
- The mandatory training programme included information governance, equality, diversity and human rights, basic life support, moving and handling, dementia awareness, care and communication of the deteriorating patient, consent, infection prevention and control fire safety, protecting people at risk of radicalisation (PREVENT) and medicines management. In addition to this, staff in the imaging department received appropriate training in the regulations, radiation risks, and use of radiation. We saw that staff had read and signed the local rules and policies which comes under the ionising radiation regulations.

Good

Diagnostic imaging

- We viewed staff folders which contained copies of external course certificates and competencies for all equipment and computer systems which were reviewed annually.
- Managers had access to monthly training records and monitored staff training compliance. Staff confirmed that it was easy to access the online learning platform and they received automatic emails reminding them to complete refresher training when they were due.
- Consultants with practising privileges were not required to complete training through the hospital's system. However, they were required to provide evidence to the hospital that they had completed their training at their main place of work. Their mandatory training compliance was monitored through a database which alerted the hospital when any training was due. We looked at a spreadsheet for consultant training records which highlighted which consultants had up to date training and which mandatory training modules were due to expire. Consultants would be notified to submit up to date training records.
- Resident Medical Officers' (RMO) training compliance was managed through an agency but they told us they also had access to the hospital's online training system. The agency sent copies of all RMOs' training records to BMI The Clementine Churchill Hospital so the provider could have sight and monitor training compliance. All RMOs at the hospital received a local hospital induction.

Safeguarding

- **Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.**
- We reviewed the hospital's safeguarding adults policy which was in date and available on the hospital's intranet. The policies detailed individual responsibilities and processes for reporting and escalation of concerns. The policies covered topics such as types of abuse, confidential counselling services and the Mental Capacity Act 2005.
- We also saw a safeguarding flowchart on the staff information board of relevant telephone numbers and contact details of the safeguarding lead.
- Staff we spoke with had good awareness and knowledge about female genital mutilation (FGM) which was part of mandatory training within safeguarding and knew how to escalate concerns to the imaging manager and safeguarding lead.
- The hospital set a target of 90% for safeguarding training. All staff in diagnostic imaging were trained to level three in both adult and child safeguarding. Compliance rates for staff in diagnostic imaging were consistently above 90%.
- All staff we spoke with demonstrated a good understanding of safeguarding vulnerable adults and children. Staff were able to identify the potential signs of abuse, the process for raising concerns and what would prompt them to make a referral. Staff knew how to escalate concerns to their manager and safeguarding lead.
- Staff undertook chaperone training through e-learning and all staff were up to date with chaperone training. Details of consultants who had used a chaperone, and the chaperone that attended were kept in a chaperone folder and also recorded on the imaging request form.

Cleanliness, infection control and hygiene

- **The service controlled infection risk well. Staff used equipment and control measures to protect patients themselves and others from infection. They kept equipment and the premises visibly clean.**
- We observed all areas of the service to be visibly clean. However, we noted that the waiting area for the MRI and CT scanner was carpeted which was not compliant with infection control guidance. We were told by senior leaders that there were plans to remove the carpeting when the new CT scanner was installed in the new year.
- We viewed the hospital's infection, prevention and control (IPC) policy which was in date and accessible on the hospital's intranet.
- Infection control was included in mandatory training for staff and training compliance rate was 100%.
- Staff followed manufacturers' instructions and the BMI IPC policy for routine disinfection. This included the cleaning of medical devices between each patient and at the end of each day. Staff demonstrated how they would clean medical devices using specific single use

wipes and recording this in the patient record. We saw staff cleaning equipment and machines following each use. We saw that equipment was labelled with green 'I am clean' stickers to show when it was last cleaned.

- Hand sanitisers were available in all areas including at the point of entry to consultation rooms and reception areas and in consultation rooms. Throughout our inspection, all staff were observed to be 'bare below the elbow' and adhered to infection control procedures, such as hand washing and using hand sanitisers.
- The IPC department link practitioners completed monthly audits which were overseen by the IPC Lead. The IPC Lead completed a quarterly infection prevention and control quarterly superior patient care audit. The results were shared with department leads and discussed at team meetings. Hand hygiene audits for the imaging department showed 100% compliance.
- There was easy access to personal protective equipment (PPE), such as aprons, face masks and gloves. We witnessed staff using PPE effectively.
- Patients we spoke with were satisfied about the level of cleanliness of the imaging department.
- During our inspection there were no infectious patients who were being scanned. However, staff told us that if there was an infectious patient, they would place them at the end of the list and the room would then be deep cleaned afterward. Staff showed us that they had access to the appropriate PPE such as gloves, aprons and face masks.
- Housekeeping staff cleaned the imaging department daily and followed a daily check sheet. We viewed cleaning records which were up-to-date and demonstrated that all areas were cleaned regularly. Cleaning schedules were in place in each clinic room, and housekeeping staff signed the schedule when the room was last cleaned. Deep cleaning of clinic rooms was completed once a week and when infectious patients were treated.

Environment and equipment

- **The design, maintenance and use of facilities, premises and equipment kept people safe. However, there was no clear signage warning people of the MR controlled access area and no additional locked door separating the waiting area from the controlled access area. This meant there was a risk that unauthorised persons could access the MR controlled access area. This was on the department's risk register.**
- The hospital's imaging department was on the ground floor and was divided into three distinct areas for MRI and CT, X-ray and SPECT CT/nuclear medicine. There were also two ultrasound rooms and a mammography room.
- The MRI waiting area was adjacent to the MR controlled access area. We noted that there was no clear signage warning people of the MR controlled access area and no additional locked door separating the MRI waiting area from the controlled access area. This meant there was a risk that unauthorised persons could access the controlled access area from the MRI waiting area which could pose a risk to their health. Staff told us that patients were supervised when they were taken to the MRI waiting area. The Medicines and Healthcare products Regulatory Agency (MHRA) Safety Guidelines for Magnetic Resonance Imaging Equipment state that access to the MR controlled access area should be controlled by suitable control methods such as self-locking doors. Due to the layout of the unit, it was also not possible for the staff member in the control room to see if someone had entered the controlled access area. This was on the risk register but the mitigation of putting a lock on the door to the MRI room still did not prevent the potential of unauthorised persons entering the MR controlled access area from the adjacent waiting area.
- The main patient waiting area was located next to x-ray. We noted that the waiting area was positioned close to the viewing area and there was a chance that patients could overhear staff conversations. Staff told us that this was on the risk register and to mitigate this, they ensured they had conversations behind a screened area so that they could not be overheard.
- We also noted that when inpatients required scans, they were wheeled on their beds through the main patient waiting area. While staff made sure patients were suitably covered with blankets, the proximity of the waiting area to the thoroughfare where patients came through, did not maintain the privacy and dignity of the patient.

Good

Diagnostic imaging

- Access to nuclear medicine for SPECT CT was through a keypad locked door. The unit was bright and spacious with seating for patients. There was also a 'hot' seating area and 'hot' toilet for patients to use after they had been scanned.
- Staff had enough space to move around the scanner and for scans to be carried out safely. During scanning all patients had access to an emergency call alarm and ear plugs. Patients could also speak to the radiographer through a microphone. We saw that staff wore radiation monitors where appropriate.
- During our inspection we checked the service dates for equipment, including scanners. All the equipment we checked was within the service date. All non-medical electrical equipment was electrical safety tested. Backup generators were available and were tested on a planned schedule early in the morning to ensure patient scanning was not affected. Staff told us that some equipment such as the CT scanner would be able to function for 20 minutes without the backup generators.
- The service leads were able to list high cost equipment that required replacing in the next 12-18 months. The hospital provided us with an equipment replacement programme document but the document did not detail a comprehensive plan with specific dates to indicate when pieces of equipment were to be replaced.
- We viewed servicing records for the MRI scanner. We also viewed fault logs which were in every room and also engineer handover forms which were detailed and comprehensive. Fault logs for equipment and service reports were emailed to the imaging lead for monitoring. The equipment list had a named person for servicing and repairs. Staff told us the department had very good relationship with manufacturers and they usually came the next day if a fault was reported.
- At the time of our inspection the MRI scanner was not in use due to a breakdown. To prevent delays in scans, staff told us they could rebook scans at other BMI hospitals.
- We checked the emergency trolley in the imaging department and found that it was secured with a plastic snap lock, so it was clear if someone had accessed the resuscitation equipment. Equipment on the top of emergency trolley was checked daily and equipment in the drawers were checked on a weekly basis with expiry dates documented on the record check sheets which were signed to confirm checks had been made. We checked various consumables and found that they were sealed and in date. We saw that spill kits were also available.
- As at September 2019, the imaging department completed a patient equipment audit and achieved a compliance rate of 100%. The audit checked 16 items including PPE, cleaning schedules and single use detergent and disinfectant wipes.
- Medicines rooms were locked to prevent unauthorised entry. Linen cupboards and storage rooms were appropriately stocked and tidy. We checked consumable equipment cupboards and found that all items we sampled were in date and packaging was intact, indicating it was sterile and safe for use in patient care.
- Room temperatures were recorded and monitored daily. We reviewed room temperature records and saw temperatures had been checked and were within the expected range.
- Cleaning chemicals subject to the Control of Substances Hazardous to Health Regulations 2002 (COSHH) were stored in a locked cupboard. We reviewed the COSHH folder and found all assessments were up to date and signed by staff members.
- Oxygen tanks were stored securely and were in date. We inspected two sharps bins and found them to be correctly labelled and not filled above the maximum fill line. We saw that the department had non-magnetic portable fire extinguishers which would not damage scanning equipment.
- Waste management was handled appropriately, with different colour coding for general waste, and clinical waste. All clinical bins were seen to be operated with lids and were not overfilled. Waste management and removal including those for contaminated and hazardous waste was in line with national standards.

Assessing and responding to patient risk

- **Staff completed updated risk assessments for each patient and removed or minimised risks. Ionising radiation risks were managed well. Staff identified and quickly acted upon patients at risk of deterioration.**

Good

Diagnostic imaging

- Staff assessed patient risk and developed risk management plans in accordance with national guidance. For example, the service had safety questionnaires that patients completed before they underwent radiological testing.
- The department used a magnetic resonance imaging patient safety questionnaire. Risks were managed positively and updated appropriately to reflect any change in the patient's condition including managing a claustrophobic patient. For radiological examinations requiring contrast (dye), patients completed a questionnaire to identify if they had any renal problems which may prevent them receiving contrast. Any known patient allergies were noted on a patient's record.
- Patient referrals were checked at the point of referral for any potential safety alerts that required further investigation. For example, whether the patient had any implants or medical devices such as pacemakers.
- The service had processes to confirm the right person got the right radiological scan at the right time. The imaging department had implemented the pause and check process before every patient examination to confirm the delivery of safe and effective patient care. This included a six-point check. The six-point check included examination justification, patient's recent imaging, patient's identity (name, date of birth, postcode), pregnancy status, confirmation that the patient expected the diagnostic testing procedure and a check as to whether there were any known contra-indications to performing the requested examination/treatment.
- The service had two permanent radiographer staff members who provided a radiation protection supervisor role. This meant that they had received additional training in the Ionising Radiation Regulations 2017 and were responsible for ensuring compliance with the regulations and the local rules.
- The service had access to a medical physics expert which was provided through a service level agreement with an external organisation. Staff could access them if there were radiation concerns relating to the equipment. Staff were aware of how to contact the radiation protection advisor for concerns in relation to compliance with the regulations or incidents involving radiation exposure. Contact details for the radiation protection advisor and radiation protection supervisors were on the staff information board.
- The service used the World Health Organisation (WHO) five steps to safer surgery checklist where invasive procedures were used in the imaging department. As at September 2019, the department achieved 100% compliance in the WHO checklist audit.
- There was signage outside of the scanning rooms which identified radiation risks and indicated when scanning was in progress.
- We observed posters in waiting areas which provided patients with information about pregnancy and diagnostic imaging.
- We saw that individual risk assessments for staff members had been completed including for members of staff who were pregnant.
- When patients were brought from inpatient wards, we saw that staff shared key information to keep patients safe when handing over their care to others.
- Staff knew how to respond to any sudden deterioration in a patient's health. There was an emergency button in all rooms in the department which staff could press for assistance from the crash team. A resident medical officer was on site 24 hours a day and could be called upon for assistance. Staff told us that if a patient deteriorated, they would call the crash team and 999 to transfer the patient to a local NHS hospital.
- All radiographers undertook adult immediate life support training and paediatric basic life support training. At the time of our inspection two radiographers were booked to complete the training and two healthcare assistants were being booked to attend adult immediate life support training and paediatric life support training.
- There were procedures in place for removal of a patient that became unwell and staff were able to describe incidents where patients were removed from scanners in an emergency. However, staff were unable to tell us when they last practised an evacuation of a patient from a scanner. After the inspection the provider told us that they planned to hold a learning session in November 2019 to cover MRI safety with the imaging and hospital crash teams.
- Staff were able to explain the process to escalate unexpected or significant findings at examination and upon reporting. In the case of NHS patients, an urgent report request was sent to the external reporting provider. If the patient was a private patient, the reporting radiologist was contacted by a member of staff to advise them of the urgent report to ensure it

received prompt attention. The reporting radiologist would then inform the patient's consultant (in and out of hours) using the situation, background, assessment and recommendation (SBAR) communication tool.

- We saw that a children's environmental risk assessment had been completed daily in the imaging department main patient waiting area and imaging rooms. The assessment looked at areas such as the cleanliness of toys and safety aspects such as sharps bins and were fully completed.

Radiography staffing

- **The service had enough staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix, and gave bank, agency and locum staff a full induction.**
- The service had enough staff of relevant grades to keep patients safe. The imaging lead calculated and reviewed the number of radiographers and healthcare assistants needed for each shift in accordance with national guidance. The department was staffed with eight senior radiographers, an imaging lead, an interim imaging manager and an administrative team who were managed by a separate department. Where there were vacancies, the service filled these with regular bank or agency staff who were familiar with the department. They would also receive a full induction to ensure they understood the service. No agency staff were used in June, July and August 2019.
- At the time of our inspection there were three vacancies including the imaging manager. The associate director of clinical services was overseeing the imaging department as the interim manager. They were supported by the imaging lead and a clinical services manager for the imaging department at another BMI hospital who visited the site weekly. The head of diagnostics for BMI Healthcare also visited the department once a week and supported the service. The senior management team told us that they were actively recruiting to the imaging clinical services manager post.
- The rota was monitored by the imaging lead a month in advance as activity could be planned ahead so staff could be accurately allocated. Rotas were displayed on the staff information board in the department as well as information on staff members and their roles.
- Radiographer staff provided a 24 hour on call service, seven days a week for urgent imaging requests. On call arrangements were arranged so radiographers rotated and covered once a week and one in five weekends. Staff told us this was manageable, and it was always easy to contact one another to arrange cover if necessary.
- Staff we spoke with felt that staffing was managed appropriately however some staff told us that additional staff would benefit the department but were aware that the hospital were advertising roles and actively recruiting.
- There was a lone working hospital policy in place for staff. However, at the time of our inspection, we did not see the risk assessment associated with staff lone working in the department.

Medical staffing

- **The service had enough staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Medical staff received a full induction.**
- There was a resident medical officer on site 24 hours a day and could provide medical support to the diagnostic imaging department upon request.
- Radiologists worked at the hospital under practising privileges. All radiologists had substantive contracts as well as working within local NHS trusts and there was at least one radiologist on site at all times. There was a radiologist rota on the staff information board, so staff knew who to contact. The service also had access to radiologists at another BMI hospital or local NHS trust. However, while there was access to a radiologist out of hours through an external provider, there was no on-call radiologist rota. We were told the service was in the process of drafting a standard operating procedure with an external provider to provide this arrangement to enable radiologist reporting out of hours for patients requiring emergency imaging.
- Consultants, anaesthetists and radiologists worked under BMI practising privileges agreements. Under practising privileges, a medical practitioner is granted

permission to work within an independent hospital. Practising privileges were granted to consultants by the medical advisory committee. Consultants with practising privileges had their appraisal, mandatory training and revalidation undertaken by their NHS trust. However, BMI The Clementine Churchill Hospital monitored annual compliance and followed up with staff when updates were required.

- All consultants nominated a standby who would cover for them during periods of absence or annual leave.

Records

- **Staff kept detailed records of patients' care and treatment. Records were clear, up to date, stored securely and easily available to all staff providing care.**
- The hospital used paper records to record patient needs, care plans and risk assessments. All referrals and patient checks were scanned onto the computerised radiology information system (CRIS). Letters were sent to a patient's general practitioner (GP) with information around the outcome of scans.
- We reviewed 5 sets of patient records and referral forms and found that they were comprehensive and detailed. Patients completed a safety consent checklist form consisting of the patients' answers to safety screening questions and recorded the patients' consent to care and treatment. Referral forms included a detailed set of safety questions such as whether the patient had any allergies, whether the patient was diabetic and whether the patient had a pacemaker. The referral form also included a section to be signed by a chaperone, comforter or carer which checked that the person accompanying the patient was not pregnant. The form also flagged any phobias the patient had so a suitable appointment length could be arranged where the patient could spend time familiarising themselves with the scanner room before starting their procedure.
- Clinical practice and documentation audits for May 2019 showed 100% compliance. The audit looked at areas such as whether the date of the completed examination was clearly identified, whether patient records clearly identified the area that was requested to be examined, whether an anatomical marker was present within the field of view, whether the patient's ID was clearly demonstrated on the images produced and whether the view taken as part of the examination were correct as per protocol.
- We observed staff logging off computers after use. Information governance formed part of mandatory training for administrative, nursing and medical staff.
- The quality of images was peer reviewed locally by the imaging lead. Any deficiencies in images were highlighted to the member of staff for their learning.
- The service did not have teleradiology capability where images could be shared electronically to other locations. Staff told us it was not always easy to get quick access to other hospital records especially NHS records without first getting written consent from patients. However, staff were able to send images from BMI The Clementine Churchill Hospital easily to NHS trusts through the secure picture archiving and communication system (PACS) without a problem.

Medicines

- **The service used systems and processes to safely prescribe, administer, record and store medicines.**
- Staff followed systems and processes when safely prescribing, administering, recording and storing medicines.
- The hospital's pharmacy team provided guidance and support to the imaging department regarding all issues related to medicines management. Staff told us they could contact the pharmacist if they had any concerns regarding medicines patients were taking.
- Patients received a letter prior to their procedure advising them to continue with their usual medicines regime. All patient allergies were documented and checked on arrival at the hospital. When contrast was used, batch numbers were recorded in a patient record.
- The service used contrast media (dye) which are chemical substances used in some MRI scans. Medicines were stored in locked rooms and access was restricted to authorised staff only. There were no controlled drugs in the department. We checked a sample of medicines and found they were in date.
- Room temperatures and fridge temperatures were recorded on a daily basis. We checked the drugs fridge temperature and ambient room temperature during our inspection and found them to be within expected range. We were told that in the summer in hotter weather, the room temperature in the room where drugs were stored

would exceed the expected range. This was recorded on the risk register and to mitigate this, the pharmacy manager monitored the room temperature daily and moved drugs if required. The pharmacy manager also short-dated the drugs to ensure they were not left unused for long periods.

- The service completed medicines management audits. Audit results for June 2019 showed 91% compliance rate. We saw the action plan following this audit which identified that the department needed to keep an up to date patient group direction (PGD) folder with a sign off sheet for radiographers who administer PGDs. A Patient Group Direction (PGD) is a written instruction for the administration of medicines to individually named patients where each patient on the list has been individually assessed by that prescriber. During the inspection we saw that this had been completed. The audit also found that there was no standard operating procedure covering the injection of drugs/contrast injection by radiographers. We saw that this had now been completed.

Incidents

- **The service managed patient safety incidents well. Staff recognised and reported incidents and near misses. Managers investigated incidents and shared lessons learns with the whole team and the wider service.**
- Staff were aware of their responsibilities for reporting incidents and near-misses and were able to explain how this was done. Staff told us they were encouraged to report incidents using the electronic incident reporting form and generally received feedback on the incident they reported.
- Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event. From September 2018 to August 2019 to June 2018, the hospital reported no incidents classified as never events for diagnostic imaging services. In the last 12 months there were five incidents involving ionising radiation however none of these were required to be reported to CQC and the Health and Safety Executive.
- National patient safety alerts (NPSA) that were relevant to the service were communicated by email to all 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. Staff we spoke with were able to explain the duty of candour fully.
- Managers investigated incidents thoroughly and involved patients and their families in the investigations. Learning from incidents was shared at daily "comm cell" meetings and at staff meetings. "Comm cell" meetings were held every morning and attended by heads of department and the senior management team. Incidents, complaints, policy updates, expected admissions, and risks were discussed at the meeting and information was cascaded down through imaging team meetings as well as by email. The pharmacy lead attended "comm cell" meetings and shared information on changes to guidelines and policies. They also produced a monthly newsletter which was emailed to all staff with key information around updates, audit results, safety alerts and learning from medicines management incidents.
- We viewed monthly imaging department team meeting minutes and saw that the meeting discussed incidents with lessons learned within the imaging service as well as those that occurred within the hospital outside of the service. Staff we spoke with were able to describe the latest incident and learning to prevent the same incident from happening again.
- Staff had access to a corporate BMI counselling telephone line which was available 24 hours day, 365 days of the year.

Are diagnostic imaging services effective?

We do not rate effective for this service.

Evidence-based care and treatment

- **The service provided care and treatment based on national guidance and evidence-based practice. Managers checked to make sure staff followed guidance. Staff protected the rights of patients subject to the Mental Health Act 1983.**
- Staff used the Society and College of Radiographers 'pause and check' system which was a six-point check to

help combat errors that attributed to incidents. Checks included demographic checks to correctly identify the patient, as well as checking with the patient the site/ side to be imaged, the existence of previous imaging and for the operator to ensure that the correct imaging modality is used.

- Care and treatment were delivered, and clinical outcomes monitored in accordance with guidance from the National Institute for Health and Care Excellence (NICE). NICE guidance was followed for diagnostic imaging pathways as part of specific clinical conditions. We saw also posters with exposure guidelines in control rooms.
- Staff had access to policies and procedures based on national guidance on the hospital intranet. Outcome data was reviewed at clinical governance meetings and "comm cell" meetings. The quality and risk manager shared updates on policies at "comm cell" meetings. Staff also received email alerts when changes had been made to policies.
- The lead for general or CT/MRI conducted peer reviews. There was a formal process for radiology discrepancies which fed into formal discrepancy meetings. The service had designed a proforma for radiologist peer review however this had not yet been implemented at the time of our inspection.
- Staff assessed patients' needs and planned and delivered patient care in line with evidence-based, guidance, standards and best practice. For example, staff followed the MHRA safety guidelines for magnetic resonance imaging equipment in clinical use.
- Audits were carried out annually and as required depending on results, to assess clinical practice in accordance with local and national guidance. Audit results were reviewed by the senior management team, clinical governance committee and presented to the audit meeting.
- Dose limits were measured in every room and audited annually.
- The service had local rules based on the Ionising Radiation Regulations (IRR) 2017. Local rules were displayed throughout the department and had been signed annually by staff. All local rules were displayed and in date.
- A review was carried out by the radiation protection advisor to assess compliance with the Ionising Radiation Regulations 2017 (IRR17) and the Ionising Radiation (Medical Exposure) Regulations 2017 (IRMER17). The report stated that there was good awareness of radiation protection and regulatory requirements, that documentation was readily available and that most of the outstanding actions from the previous audit 15th August 2018 had been addressed. Recommendations from the audit related mainly to minor changes to current documentation to comply with the regulations. We saw that the service had produced an action plan which had a red, amber, green (RAG) rated priority level for the recommendation, action to be taken, action owner and target dates.

Nutrition and hydration

- **The service assessed people's nutrition and hydration needs. The service made adjustments for patients' religious, cultural and other needs.**
- Patients awaiting their appointment had access to drinking water and a tea and coffee machine which was free of charge in the patient waiting area.
- If clinics were running late, and for patients who were not under fasting instructions, staff signposted patients to the hospital's restaurant for hot and cold food options or the snack kiosk for refreshments.

Pain relief

- **Staff assessed and monitored patients regularly to see if they were in pain and gave pain relief in a timely way. They supported those unable to communicate using suitable assessment tools and gave additional pain relief to ease pain.**
- Staff assessed patients' pain using a recognised tool and consultants were able to prescribe pain relief in line with individual needs and best practice. Patients were asked to describe their pain with a score of zero (no pain) to three.
- Where appropriate, some clinics used a pain diary where patients could record their level of pain before treatment, 15 minutes after the procedure, one hour, one day, one week and two weeks following the procedure which they could then discuss with their consultant.

Patient outcomes

Good

Diagnostic imaging

- **Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for patients. The service had not been accredited under relevant clinical accreditation schemes.**
- Managers used information from the local audits to improve care and treatment. The service had a programme of audit to check the quality of procedures and the safety of the service. The service had a clinical audit schedule and audited individual areas including, imaging medicines management, World Health Organisation (WHO) five steps to safer surgery checklist, patient documentation, picture and archiving service (PACS) system and imaging in theatres.
- For the month of June 2019, the department achieved 100% compliance in PACS and computerised radiology information system (CRIS) audit which looked at diagnostic workstations, software, data security, downtime procedures. The imaging in theatres audit which looked at general, sentinel node service, optical radiation (laser) applicable to theatre, physiotherapy and outpatient's services was 100% compliant. The department also achieved 100% in the standard precautions infection, prevention and control audit.
- The imaging service had clear instructions, including pictures on how to perform quality assurance (QA) outcomes and how often. We saw tick sheets for all equipment were complete and up to date.
- Audit meetings took place monthly and was attended by the executive director, director of clinical services, quality and risk manager, associate director of clinical services, clinicals services manager for pharmacy, senior pathology coordinator and endoscopy lead. The meetings were intended to be an open forum environment and leaders told us that going forward, it would be opened to all clinical staff.
- The hospital was meeting the six-week diagnostic test national standard. Patients were given appointments within 48 hours of an imaging request being made and this was monitored at the daily "comm cell" meetings. X-rays were performed on the day of the referral.
- Imaging reports were produced within 24 hours for inpatients, 48 hours for private outpatients and three-five days for NHS patients. Turnaround times were reported on monthly at clinical governance meetings. During the inspection we saw results for 48-hour turnaround times for September which showed compliance of 76% for MRI 81% for CT, and 83% for x-ray which showed they did not meet their target. However, we did not see any action plans on how to improve to meet the target.
- The hospital did not participate in the Imaging Diagnostic Services Accreditation scheme.

Competent staff

- **The service made sure staff were competent for their roles. However, we found some competencies had not been signed off. Managers appraised staff's work performance and held supervision meetings with them to provide support and development.**
- Staff were experienced, qualified and had the right skills and knowledge to meet the needs of patients. The service used regular agency staff to ensure continuity of care. There were specific induction packs for agency staff.
- New staff received a comprehensive week-long hospital induction and were assigned a mentor for three months to provide guidance in the department. New staff also received competency booklets which were signed off by senior members of staff once a competency had been achieved. All staff were required to complete the BMI mandatory training programme as well as role specific training to support ongoing competency and professional development.
- Radiographers were members of the Society and College of Radiographers and were able to keep up to date with updates and new developments.
- However, we found that not all competencies were evidenced on paper. For example, we found a staff member's MRI competency sheet had not been signed off and we saw incomplete patient group directions (PGD) where not all staff had signed against to show they were competent to carry out procedures. Where staff had signed against competencies, these had been done recently in September and October.
- Staff at all levels told us that their training needs were met and since the change in management, managers were willing to support their development. Healthcare assistants told us they were being supported to undertake assistant practitioner training.
- Staff received in-house radiation protection training and were encouraged to attend conferences and take on development opportunities such as attending management courses and national radiology

management conferences. All radiographers undertook adult immediate life support training and paediatric basic life support training. Healthcare assistants were also booked to complete this training.
- Consultants also delivered teaching sessions for staff on site and the hospital arranged continuing professional development events for staff. Senior leaders told us that they were planning to focus on continuing professional development courses for radiation protection in 2020.
- The hospital's appraisal year ran from November to October. In the reporting period all staff in the imaging department had completed their year-end appraisal. Staff told us their appraisals were useful and they could talk about development opportunities at these meetings.
- All consultants under practising privileges received an induction pack which included details on what was required of them to practise at BMI. Each application for practising privileges was assessed by the Medical Advisory Committee (MAC) and we saw evidence of this in the MAC minutes we reviewed.
- All radiographers were registered with the Health and Care Professions Council (HCPC) and met HCPC regulatory standards to ensure the delivery of safe and effective services to patients.
- Managers made sure staff attended team meetings and emailed the minutes of the meetings to the team for those who could not attend.

Multidisciplinary working

- **Doctors, nurses and other healthcare professionals worked together as a team to benefit patients. They supported each other to provide good care.**
- The hospital had good relationships with other external partners and undertook scans for local NHS providers and private providers of health insurance schemes.
- Staff told us there was good communication between services and they could contact referrers for advice or clarification.
- We saw evidence of good working relationships between nurses and medical staff. We saw positive relationships between radiographers and the administrative team. Administrative staff told us they worked well with radiographers and felt comfortable asking questions or queries relating to referrals. Healthcare assistants told us consultants were friendly and approachable. Radiographers told us they had good relationships with radiologists and could contact them at any time.
- The daily "comm cell" meetings were attended by a multidisciplinary team of staff including pharmacists.
- There were daily safety huddles in the department which were attended by the full team in the imaging department. Information from the "comm cell" meetings were disseminated to the team at huddles.
- Staff told us they had good relationships with the radiation protection supervisors and radiation protection advisor and that their details were displayed on the staff information board if they needed to be contacted.
- Senior managers told us that clinical services managers at other BMI imaging departments frequently contacted one another for advice and support. At the time of our inspection a clinical services manager from another BMI hospital was supporting the team at BMI The Clementine Churchill Hospital. They reported that if staff had any queries, they could contact them by telephone at any time.

Seven-day services

- **Key services were available seven days a week to support timely patient care.**
- Appointments were flexible to meet the needs of patients, and appointments were available at short notice.
- The service operated from Monday to Friday 8am to 9pm. On Saturdays, general x-ray and ultrasound was open from 8am to 2pm and MRI was operated from 8am to 8pm on Saturday and Sunday. SPECT CT (single-photon emission computed tomography) was open from Monday to Friday 9am to 5pm.
- Breast clinics were held on Mondays 9am to 5pm, Wednesdays 6pm-8pm and Saturdays 9am to 2pm to allow for greater flexibility for patients to choose a time that suited them. All new patients could have a mammogram, ultrasound and see the consultant all on the same day.
- For inpatients, there was access to 24-hour diagnostic imaging on site (with the exception of MRI and SPECT CT). The hospital also had access to an on-call radiographer.

Health promotion

Good

Diagnostic imaging

- **The imaging department displayed information and advice to encourage patients to lead healthier lives.**
- There was information on diagnostic imaging procedures available in the patient waiting area. There were information leaflets and posters displayed in the waiting area about what would happen during a scan, what preparation was required prior to a scan and self-care advice following a scan.
- We saw leaflets about the flu vaccination and leaflets on a breast health awareness evening which was being held by one of the consultants at the hospital.

Consent and Mental Capacity Act

- **Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients' consent. They knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health.**
- All staff understood the requirements of the Mental Capacity Act 2005. Staff completed mandatory training on the Mental Capacity Act and Deprivation of Liberty Safeguards. Staff training for the Mental Capacity Act was incorporated within the consent module. Staff understood how and when to assess whether a patient had the capacity to make decisions about their care.
- We saw that staff gained consent from patients for their care and treatment in line with legislation and guidance. Staff we spoke with understood the need for consent and gave patients the option of withdrawing consent and stopping their scan at any time. The service used consent forms that all patients were required to sign at the time of booking in at the service. Staff made sure patients consented to treatment based on all the information available. Staff clearly recorded consent in the patients' records.

Are diagnostic imaging services caring?

Good

We rated caring as **good.**

Compassionate care

- **Staff treated patients with compassion and kindness, respected their privacy and dignity and took account of their individual needs. However, we observed that when inpatients were taken for scans, they had to be taken through the general waiting area and reception area which did not maintain their privacy.**
- Staff promoted privacy and patients were treated with dignity and respect. We saw staff ensuring the inpatients being taken for scans were covered with blankets. We saw that due to the layout of the diagnostic imaging department, inpatients were wheeled through the main patient waiting area on beds for their scans which did not maintain their privacy.
- Patients had designated changing rooms and were provided with gowns while having their scan. In nuclear medicine, a privacy screen could be put up so patients could change in the scanning room, so they did not need to walk to the scanner in their gowns. In mammography, staff told us that patients could change in the scanning room and explained that they would leave the room to allow the patient some privacy to change into their gowns.
- Feedback from patients confirmed that staff treated them well and with kindness. Comments from patients included, 'All staff are very polite and professional' and 'Very caring'.
- The service had an up to date chaperone policy. Patients were asked at the time of booking if a chaperone was required. There were posters in the department informing patients on requesting a chaperone.
- The BMI friends and family test scores were consistently high. The test is a satisfaction survey that measures patients' satisfaction with the healthcare they have received. In September 2019, the results for the service ranged from 98-100% for NHS patients and 92-100% for private patients.
- However, the hospital patient-led assessment of the care environment audit (PLACE) showed the hospital scored 65% for privacy, dignity and wellbeing. This was worse than the national average of 84.2%. We did not see the action plan during our inspection in response to this score however patients we spoke with said their privacy and dignity was respected.

Emotional support

Good

Diagnostic imaging

- **Staff provided emotional support to patients, families and carers to minimise their distress. They understood patients' personal cultural and religious needs.**
- We spoke to a patient who told us that staff explained how a scan was undertaken and that they were able to see the scanner before their procedure to reduce their anxieties and fears.
- Staff told us that if patients expressed concerns or fears around procedures and scans, they took the time to explain how scans were undertaken and would ask the patient to come in a bit earlier so they could see the scanner machine. For patients who had a fear of enclosed spaces, staff asked patients to come into the department before their appointment so they could see the scanner, the room and try lying in the scanner to see if they were comfortable in the space.
- Staff were passionate about their work and focused on delivering patient centred care. We observed staff spending time chatting with patients before and after scanning procedures. There was good rapport between staff and patients.
- Staff supported people through their scans, ensuring they were well informed and knew what to expect. Staff provided reassurance and support for nervous, anxious, and claustrophobic patients. They demonstrated a calm and reassuring attitude so as not to increase patients' anxiety. Staff described how they would provide ongoing reassurance throughout a scan and updated the patient on how long they had been in the scanner and how long was left.
- Staff supported patients who became distressed in an open environment and helped them maintain their privacy and dignity. There were empty consultation rooms which staff told us they could use if a patient became distressed.
- Family members or carers were able to accompany patients that required support.

Understanding and involvement of patients and those close to them

- **Staff supported and involved patients, families and carers to understand their condition and make decisions about their care and treatment.**
- Staff involved patients and those close to them in decisions about their care and treatment. Patients told us they felt comfortable asking consultants, nurses and radiographers questions and felt involved in their treatment plans.
- Staff recognised when patients or relatives and carers needed additional support to help them understand and be involved in their care and treatment. Staff enabled them to access this, including access to interpreting and translation services.
- Patients we spoke with told us that they had received leaflets with information about how to prepare for their appointment prior to attending their appointment. Information on the costs of procedures were provided at the point of booking.
- We saw staff introducing themselves to patients and taking the time to answer any questions they had about their care. We saw staff speaking with patients, explaining their role and what would happen next.
- Staff worked with patients to promote their understanding and empowered them to play an active role in their treatment and care. Staff showed us leaflets which patients took home with them after their scan which informed them aftercare advice and any potential reactions they could have to contrast that was given and what to do, who to contact in the event of such reactions.
- Patients and their families could give feedback on the service and their treatment and staff supported them to do this. There was comment box in the waiting area.

Are diagnostic imaging services responsive?

Good

We rated responsive as **good.**

Service delivery to meet the needs of local people

- **The service planned and provided care in a way that met the needs of local people and the communities served. It also worked with others in the wider system and local organisations to plan care.**
- The diagnostic imaging department at BMI The Clementine Churchill Hospital provided a range of services such as general X-ray imaging, OPG dental

imaging, Interventional and diagnostic ultrasound, digital full field mammography, computerised tomography (CT), magnetic resonance imaging (MRI), radiographic imaging in theatre, SPECT CT/nuclear medicine (single-photon emission computed tomography), fluoroscopy and dexa scanning. The service operated from Monday to Friday 8am to 9pm. On Saturdays, general x-ray and ultrasound was open from 8am to 2pm and MRI was operated from 8am to 8pm on Saturday and Sunday. SPECT CT was open from Monday to Friday 9am to 5pm. For inpatients, there was access to 24-hour diagnostic imaging on site (with the exception of MRI and SPECT CT). The hospital also had access to an on-call radiographer.

- Breast clinics were held on Mondays 9am to 5pm, Wednesdays 6pm-8pm and Saturdays 9am to 2pm to allow for greater flexibility for patients to choose a suitable time. A breast surgeon worked with radiologists and all new patients could have a mammogram, ultrasound and see the consultant all on the same day. The hospital had a contract with a local department store where staff could attend breast screening at the BMI The Clementine Churchill Hospital.
- The facilities and premises were appropriate for the services that were planned and delivered. There were toilets, changing rooms and drinks machines for patients. Car parking on the premises was free of charge.
- Information was provided to patients before their appointments. Appointment letters contained information such as contact details, directions to the department and information about any tests or intervention including if samples or preparation such as if fasting was required. Patients could request to receive appointment reminders by text or phone call.
- All patients were able to choose an appointment date and the service offered flexible appointment times to all patients.
- There was a main patient waiting area in the general reception for the imaging department as well as smaller waiting areas in SPECT CT and MRI. The main waiting area was furnished with high backed seats and there was access to a water machine and hot drinks machine. Patient information leaflets were also available as well as newspapers and magazines for patients. There was also a television in the waiting room.
- There were maps of the floor level you were on which highlighted facilities such as the disabled toilets, baby changing toilets and vending machines. However, patients we spoke with told us that signage to the department was small and sometimes hard to see.
- The imaging department monitored the length of time patients waited to be seen by consultants and receptionist staff kept patients informed when clinics were running late.

Meeting people's individual needs

- **The service was inclusive and took account of patients' individual needs and preferences. Staff made reasonable adjustments to help patients access services. They coordinated care with other services and providers.**
- Services were planned to take account of the needs of different people. Staff received training in equality and diversity and had a good understanding of cultural, social and religious needs of patients and demonstrated these values in their work. Patients with reduced mobility could easily access the imaging department which was on the ground floor and corridors were wide enough to accommodate wheelchairs. Staff told us they checked with patients if they required a female interpreter.
- Staff could arrange interpreting services to support patients and their families whose first language was not English. Staff confirmed that it was easy to book interpreting services which could be arranged face to face, or by telephone. Interpretation services were made available to the staff through a service level agreement with an external company. Interpretation requirements were identified at the point of booking. There was also an on-site Arabic speaking interpreter available within the hospital.
- Leaflets about diagnostic procedures were available in the patient waiting area, although they were all in English. Following the inspection, we were told that leaflets in different languages were available on request.
- Posters informing patients that they could request a chaperone were displayed in the waiting areas however these posters used small fonts and were hard to see.
- The department had a hearing loop available for patients who had a hearing impairment. There was a sign at the reception desk notifying patients of the portable induction loop system available.

Good

Diagnostic imaging

- The service engaged with patients who were anxious, nervous or phobic. For example, patients who informed the service that they were nervous or phobic were able to visit the department before their appointment and familiarise themselves with the room and scanner so they would know what to expect and would feel more comfortable on the day of their appointment. Staff were also able to speak to the patient during scans through a microphone.
- The service did not have capability to cater for bariatric patients. However, they told us patients would be sent to a nearby BMI hospital which had a wide bore scanner that could accommodate these patients.
- While the service rarely saw patients with learning disabilities or dementia, staff told us patients could bring relatives or carers with them to support them during a scan. Staff told us they would make sure in these cases, carers and relatives were appropriately screened to ensure they could safely support their loved one. The hospital had dementia champions who could also be called to support patients living with dementia who were attending the imaging department.
- There were no signs or boards to inform patients of waiting times once they arrived for their appointment. However, nurses would regularly verbally communicate this information in the waiting area, and patients were informed of delays on arrival.
- There were porters available at the reception to collect patients from cars if required and take them to their appointment.
- Patients awaiting their appointment had access to drinking water and a tea and coffee machine which was free of charge in the patient waiting area. There was a restaurant on site for hot and cold food options and a snack kiosk for light refreshments.

Access and flow

- **People could access the service when they needed it and received the right care promptly.**
- All referrals were triaged by radiographers who reviewed and confirmed patient suitability for scans. Patients were given a choice of appointment times that they could arrange to suit their schedules. All patients who were referred for diagnostic imaging were given appointments within 48 hours of the request being made and this was monitored at the daily "comm cell" meeting. Patients who required x-rays could have them performed on the day of referral.
- The hospital did not formally monitor the length of time patients waited to be seen. The provider told us that if a patient was waiting for more than 15 minutes, reception staff would proactively check for delays and chase up appointments. The imaging department had plans to implement a formal monitoring initiative as part of the departmental action plan, but this was not yet in place at the time of our inspection.
- Between October 2018 and October 2019, there were 23 scans which were cancelled for non-clinical reasons. Non-clinical reasons included equipment faults, missing consumables, practitioners such as radiologists not being available. Patients who had their scan cancelled would be rebooked on the same day or a follow up telephone call would be made to arrange a new appointment date.
- The service monitored did not attend rates. Between May 2019 to October 2019, DNA rates averaged 0.2%. If a patient did not attend their appointment, the imaging administration team made three attempts to contact a patient and offer a new appointment date. BMI The Clementine Churchill Hospital had also introduced a local initiative whereby patient DNA rates were recorded in a local log and recorded additional details such as DNAs for modality, DNA or self-cancellation, previous DNA, flags for NHS referral time breaches. This information enabled managers and teams to better monitors and be more responsive to DNAs and follow-ups.
- The BMI national enquiry centre (NEC) booked private patients' appointments as well as medical secretaries. Patients were offered to be seen at BMI The Clementine Churchill Hospital but were also offered an appointment at different BMI hospitals when appointments could be booked in sooner.
- Administrative staff booked in all NHS patients. These patients were referred to the hospital by their GP who sent a letter of referral to the hospital. There was no set criteria for patient eligibility. However, patients with co-morbidities such as mental ill health or high body mass index were referred to other hospitals.
- Appointment slots ranged from 30 minutes to an hour depending on the type of scan. Staff would also book in extra time if a patient was nervous or phobic so time could be spent ensuring the patient was comfortable before starting the procedure.

- Patients travelled to their appointment by public transport or their own car. Patients we spoke with said that transport links were good and that the parking at the hospital site was free with enough parking spaces.
- 60% of patients who attended the service were non-NHS funded patients. Between October 2018 and September 2019 there was a total of 19,183 non-NHS funded patient attendances and 8,171 NHS funded patient attendances.

Learning from complaints and concerns

- **It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff. The service included patients in the investigation of their complaint.**
- Patients we spoke with knew how to make a complaint and felt comfortable raising any concerns they had with staff.
- Managers investigated complaints and identified themes. Staff we spoke with said that the main complaint received in the imaging department were around waiting times and communication. We looked at the complaints log for the imaging department. In the last six months, the service received 21 complaints which were responded to within 20 days which was in line with the BMI complaints policy.
- We saw evidence that complaints were investigated, learning was identified, and the hospital apologised to patients when something went wrong. Managers shared feedback from complaints with staff and learning was used to improve the service. For example, from learning from complaints the hospital had developed quality initiative which included the reconfiguration of the patient journey and administrative pathway through imaging to improve responsiveness to concerns around experience, access and timing and fees. The hospital had also introduced a patient information leaflet and confirmation of appointment correspondence for imaging to improve communication from the hospital and strengthen informed consent practice.
- Complaints were overseen by the executive director and the quality and risk manager supported by the customer services team. Feedback was shared at "comm cell" meetings. Complaints were also discussed at senior management team meetings, the clinical governance meetings and medical advisory committee. We saw evidence of discussion of complaints in the minutes of these meetings. The senior management team also shared complaints with the clinical commissioning group.
- There were several ways patients and relatives could send feedback including filling in feedback forms which they could put into the comment box in the patient waiting area.
- Patients were also provided with information on how to make a complaint to the Independent Healthcare Sector Complaints Adjudication Service (ISCAS) and the Parliamentary and Health Services Ombudsman (PHSO) if they were not satisfied with the hospital's complaints process.

Are diagnostic imaging services well-led?

Good

We rated well led as **good.**

Leadership

- **Leaders had the integrity, skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff. They supported staff to develop their skill and take on more senior roles.**
- At the time of our inspection, the service did not have a substantive clinical services manager and the associate director of clinical services had temporarily taken up the role. They were supported by the imaging lead, CT/MRI lead and a clinical services manager from another BMI Hospital who provided operational support. The lead radiologist was also a member of the medical advisory committee. The BMI Healthcare head of diagnostics had a strategic role for 50 BMI hospital sites and visited the BMI The Clementine Churchill Hospital once a week to provide technical support and advice. The associate director of clinical services who was acting as the service manager reported directly to the clinical services director for the hospital and any concerns which required escalation were reported to the executive director of the hospital as necessary.
- The senior management team consisted of the executive director, director of clinical services, director of operations and quality and risk manager. The

executive director who was the CQC registered manager reported to London and South East Region executive director and was supported by the regional team and medical director where required. Day to day leadership was managed by the senior management team on site. The senior management team attended daily "comm cell" meetings where incidents, complaints, patient satisfaction scores and mandatory training rates were discussed with the heads of department.

- While staff spoke of a period of instability with changes in management within the imaging service, all staff spoke highly of the current team who were now overseeing the management of the department. Staff told us that the imaging lead, associate director of clinical services and the clinical services manager from the other BMI hospital were approachable and supportive.
- Staff told us that since the change in management within the department, there was now a more cohesive and inclusive working environment. Staff told us they now attended regular team meetings and were kept informed of any changes, audits and future plans of the service.
- All staff without exception, including administrative staff spoke of good teamwork within the department and told us that they were now being supported to explore development opportunities. Staff also described management as being flexible to their individual staff needs.
- Staff commented on the visibility of the senior management team and told us that they often saw the executive director in the imaging department. They told us that the executive director had an open-door policy and told us they felt able to approach them if they had any concerns.
- There was inclusive and effective leadership at all levels. Senior leaders we spoke with demonstrated high levels of experience, capacity and capability needed to deliver sustainable care. The imaging department management team had a strong understanding of issues, challenges and priorities in their service.

Vision and strategy

- **The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. Leaders and staff understood and knew how to apply them and monitor progress.**
- The hospital had a clear vision and a strategy to turn the vision into action. The hospital's vision was to be the hospital of choice in Harrow and to attract patients, staff and consultants through delivering the best care, experience and outcomes
- The hospital's five-year business development plan had been developed by the senior management team. The BMI strategy for 2015-2020 identified eight objectives which included information, efficiency, growth, communication, patients, facilities, people and governance and these were underpinned by a clinical and non-clinical strategy.
- Staff we spoke with were aware of the hospital's vision, including their role in achieving them.
- There were plans to refurbish parts of the hospital to improve patient experience. Staff we spoke with knew about plans to refurbish areas of the hospital. Staff in the imaging department were aware of plans to replace the CT scanner next year.
- Seniors leaders spoke of key areas of development within imaging such as cardiology and the ability to carry out cardiac imaging. They told us that once the new CT scanner is installed early next year, there will be capability to undertake cardiac imaging. They spoke of plans of having a catheterisation lab which is an examination room with diagnostic imaging equipment used to visualise the arteries of the heart and the chambers of the heart and treat any abnormality found.
- The head of diagnostics at BMI spoke of their work in raising the profile of the BMI imaging departments to hospital executive directors and worked with executive directors and senior management teams at BMI hospital sites to ensure that imaging was included in the clinical strategy.

Culture

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

- Leaders within the service promoted a positive culture that supported and valued staff which created a sense of common purpose based on shared values. Staff described a supportive team and a patient-focused environment.
- Staff were passionate about their work in the imaging department and there was an open and honest culture within the team. Staff were knowledgeable about the duty of candour and knew about the hospital's processes and procedures and could give examples of how they applied the duty of candour and the learning that was shared from an incident.
- Staff told us they felt respected and valued by the hospital and felt proud to work in the imaging department at BMI The Clementine Churchill Hospital.
- Staff we spoke with told us they were happy in their roles and commented on the 'family feel' of the hospital and their department. They told us any issues they escalated were resolved quickly and constructively and that there was a culture of collective responsibility.
- The service promoted equality and diversity which was part of mandatory training. We reviewed the BMI equality and diversity protocol which contained clear references to protected characteristics.
- BMI adhered to the annual regulatory reporting requirements of the Workforce Race Equality Standards (WRES) working in partnership with the NHS England WRES Implementation Team as an independent healthcare provider.

Governance

- **Leaders operated effective governance processes, throughout the service and with partner organisations. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.**
- Governance structures were in place for imaging services. Staff we spoke with had a good awareness of governance arrangements and knew how to escalate their concerns.
- All staff were clear about their roles and understood what they were accountable for and to whom. Staff working with radiation were provided with appropriate training in the regulations, radiation risks, and use of radiation.
- Local governance processes were achieved through monthly team meetings. Imaging team meetings were held monthly and attendance included the associate director of clinical services (acting as the clinical services manager for the imaging department), the clinical services manager for another BMI hospital, imaging lead, radiographers and healthcare assistants. viewed the meeting minutes which showed that the meeting discussed mandatory training performance, incidents and lessons learned, complaints and feedback, risk register, safeguarding, audits and action plans, and actions arising from the meeting.
- Staff regularly received corporate clinical governance and quality and risk bulletins by email. These bulletins contained information on safety alerts, never events, incidents, cancellations, medicine management, patient safety alerts, medical device alerts, lessons learned and latest NICE guidance. NICE guidance related to imaging was discussed at clinical governance meetings and monitored at a corporate level by the head of diagnostics. The head of diagnostics also disseminated information on updates and Medicines and Healthcare products Regulatory Agency (MHRA) alerts to all BMI imaging teams as and when they came through.
- "Comm cell" meetings were held every morning and attended by heads of department and the senior management team. Incidents, complaints, policy updates, expected admissions, and risks were discussed at the meeting and information was cascaded down through imaging team meetings as well as by email.
- Heads of departments met every month. Meetings discussed the risk register and feedback from complaints. The heads of departments meetings fed into the clinical governance meetings. We saw minutes of the clinical governance meetings which included feedback from the national clinical governance committee, discussion of monthly clinical quality dashboards, a review of incidents and investigations, policy updates, risk register updates and audit feedback. There was also a governance report that was completed by the quality and risk manager monthly and was fed back corporately.
- All staff were able to access policies and procedures and all staff had access to the BMI intranet.
- At the time of our inspection the service was in the process of developing a proforma for radiologist peer review; however, this had not yet been implemented.
- There was a national radiation protection framework for the organisation which the local radiation protection committee for the hospital fed into. The radiation

protection committee met annually and was attended by the executive director, director of clinical services, quality and risk manager, associate director of clinical services, radiation protection advisor, radiation protection supervisors, clinical services managers and medical physics expert. We saw the minutes to the meetings which showed discussion around laser safety, policies and procedures, updates from the radiation protection advisor, equipment updates, training update and incidents. Information from the national and regional radiation protection committees was shared with the service lead who disseminated this to the team.

- The Medical Physics Expert role and radiation protection advisor was provided through a service level agreement with an external provider. We checked the service level agreement and found it was up to date.

Managing risks, issues and performance

- **Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events. Staff contributed to decision-making to help avoid financial pressures compromising the quality of care.**
- The imaging department kept its own risk register which was maintained by the imaging clinical services manager (who was the associate director of clinical services at the time of our inspection). Risks on the risk registers were reviewed regularly and discussed at clinical governance meetings, heads of department meetings and team meetings. Each risk was given a rating, review date, and set of control measures.
- The issues and risks which managers identified were in line with what we found on inspection and there was alignment between these, and the risks outlined on the risk register. Risks for the imaging department included the age of equipment, which was due for replacement, layout of the imaging department, design of the viewing area, the temperature of the room containing medicines getting too hot in the summer months, staffing and security around access to MRI. Action plans were in place to address these risks and formal reviews were scheduled to monitor progress.
- There was a formal audit plan in place in the imaging department which outlined the frequency of the audits and dates of the audits. Audit results were fed back at the clinical governance meetings, heads of department meetings as well as discussed at team meetings.
- Performance was monitored locally however the service did not formally benchmark performance against other BMI sites. The imaging lead told us they did informally look at results from other BMI hospital sites in team meetings. Information on turnaround times, 'did not attend rates', patient engagement scores, incidents, complaints, mandatory training levels were recorded and discussed at team meetings.
- The imaging department had a "comm cell" board which displayed information such as staff rotas, telephone numbers for the radiation protection advisor and radiation protection supervisors, mandatory training levels, quality assurance outcomes, incidents and occupational health advice information for staff. Information on this board was updated daily.

Managing information

- **The service collected reliable data and analysed it. Staff could find the data they needed in easily accessible formats, to understand performance, make decisions and improvements. The information systems were integrated and secure. Data or notifications consistently submitted to external organisations as required.**
- There were effective arrangements to ensure the confidentiality of patient identifiable data. Paper referral forms that were brought in by patients were placed face down in a tray at reception so that patient identifiable data could not be seen. Paper based patient records were stored securely and electronic information was only accessible by authorised staff members.
- There were computer stations throughout the department and staff told us there were sufficient numbers of computers to access when they needed. We observed staff logging off after using computers.
- Staff commented that the IT system was user friendly and showed us they could easily find policies on the hospital intranet.
- The hospital now had an electronic incident reporting system which made it easier for the hospital to effectively monitor and assess risks and trends. Staff told us that the electronic system was easy to use.

- Information from scans were sent to referrers to give timely advice and interpretation of results. Staff could also request access to previous patient images and could add images to NHS patient records to ensure patients received continuity of care in imaging.
- Service leads and the senior management team monitored quality and risk information at clinical governance meetings where audit results, risks and incidents were discussed.
- We saw that access to the manager's office in the imaging department which contained confidential information and records was by keypad lock to prevent unauthorised access.
- The hospital had Wi-Fi for public use. Patients and visitors we spoke with said they were able to access the Wi-Fi service.

Engagement

- **Leaders and staff actively and openly engaged with patients, staff, equality groups, the public and local organisation to plan and manage services. They collaborated with partner organisations to help improve services for patients.**
- Patients and relatives were encouraged to share their views on the quality of the service through feedback comment cards. There was a comment box in the main patient waiting area where staff could submit their comments. There was a 'you said, we did' board on in the main patient waiting area displaying how the service had made changes in response to patient feedback. In response to a patient comment about staff not always picking up the phone when patients called the department, staff told us that now all telephones in the department rang to allow for any staff member to be able to pick up the phone and reduce the time a patient waited to get through to a staff member.
- The hospital monitored feedback from the BMI friends and family test results. Comments from the survey were discussed at "comm cell" meetings and team meetings.
- The executive director produced a monthly newsletter which was emailed out to all staff. The newsletter covered areas such as governance, operational updates, key learning from incidents, policy updates as well as listing new starters and leavers. BMI corporately also sent an email to staff members with information and updates across the whole organisation.
- Staff told us there were a number of events that were held for staff to take part in to focus on their wellbeing such as Pilates sessions. There was also an occupational health advice line that staff could utilise.
- Staff were engaged in the planning and delivery of the service. Staff told us that they felt able to suggest new ideas to their managers and that they were listened to. Staff we spoke with knew of future plans of the service such as the replacement of the CT scanner in the new year.
- Staff told us about long service awards where staff were recognised for their service at the organisation. They also told us of staff forums that were held by the executive director where they could raise any issues and receive updates and information about the hospital. After the inspection, the hospital told us there were two staff forums held by the executive director and senior management team called 'Tea with the SMT' and 'Squeeze the Day with the SMT' where staff could raise any issues and receive updates and information about the hospital.
- The hospital took part in a BMI engagement staff survey in 2018. The overall engagement score for BMI The Clementine Churchill Hospital was 61/100 which was significantly higher than the score of 51/100 achieved in 2017 but lower than overall BMI Healthcare score of 63/100. The 2018 survey showed that 45% of employees gave positive responses to the survey questions. This was a significant improvement from 28% of employees in 2017 who answered positively to the engagement questions. The 2018 survey showed that 13% of employees answer negatively to the engagement questions which was also an improvement from 16% of employees in 2017.

Learning, continuous improvement and innovation

- **All staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them. Leaders encouraged innovation and participation in research.**
- Staff were committed to continuous learning. Staff told us they were supported by their managers to develop their leadership skills and access development opportunities. Staff told us since the change in management, they have been able to access additional courses and were encouraged to attend conferences and management courses.

Good

Diagnostic imaging

- The service sought new ways to improve services for patients. The imaging department had produced a leaflet which patients took home with them after their scan which informed them around aftercare advice and any potential reactions they could have to the contrast that was given and what to do, who to contact in the event of such reactions.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

Critical Care:

- The provider must ensure that a consultant in intensive care medicine is immediately available 24 hours a day seven days a week.
- The provider must ensure the intensive care unit is not left without medical cover when the resident medical officer is called out to emergency resuscitation or outreach calls. The provider must ensure there is a documented escalation procedure in place to show how the ward is medically covered if the resident medical officer is called away from the unit.
- The provider must ensure all consultant led ward rounds are undertaken twice a day and documented.

Action the provider SHOULD take to improve

Surgery:

- The provider should ensure all BMI policies align.
- The provider should ensure there is an anaesthetist rota as per BMI policy.
- The provider should improve provision for patients with learning disabilities.
- The provider should staff pre-operative assessment adequately to meet workload demands.
- The provider should continue to improve access to private patient notes.
- The provider should improve staff knowledge on the role of the freedom to speak up guardian.
- The provider should put signage up to inform visitors on wards to wash their hands.

Critical care:

- The provider should continue to implement plans to reduce the use of agency on the intensive care unit.
- The provider should ensure agency nursing levels are not above the recommended 20%.
- The provider should provide a follow up clinic where discharged patients could reflect upon their critical care experience and be assessed for progress, in line with Guidelines for the Provision of Intensive Care Services. Any follow up clinic should examine how international patients could be included in and provided with an opportunity for follow up.
- The provider should ensure the HBN-0402 building standards are considered in future developments.
- The provider should ensure physiotherapy and pharmacy staff attend daily ward rounds on the intensive care unit.
- The provider should ensure the pharmacy team have suitable a post-graduate qualification in critical care for pharmacy.

Outpatients:

- The provider should ensure that all patients records are filed in a safe way so that staff can always access essential information that may affect a patient's treatment.

Diagnostic imaging:

- The provider should improve signage and ensure measures are taken to prevent unauthorised people from entering the MR controlled access area.
- The provider should improve the layout of the main imaging patient waiting area to maintain the privacy and dignity of patients.
- The provider should ensure staff take part in regular evacuation practise in the event a patient collapses or falls unwell in a scanner.
- The provider should ensure all staff competencies are fully evidenced and all patient group directions are signed by the relevant staff members.
- The provider should ensure that there is a comprehensive equipment replacement programme for the department.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing The provider did not deploy enough suitably qualified, competent, skilled and experienced staff to meet regulatory requirements because: • We were told consultants were available 24 hours a day on-call and within 30 minutes. The national guidance says that a consultant in intensive care medicine must be immediately available 24 hours a day seven days a week. The consultant responsible for out of hours must be able to attend within 30 minutes. On the intensive care unit, consultants were following the out of hours 30 minute standard for the whole day and therefore consultant support was not immediately available during the daytime. • The resident medical officer (RMO) provided medical cover on the intensive care unit during the daytime and was also part of the outreach and resuscitation team. Therefore, this meant that the intensive care unit could have periods of no medical cover when/if the RMO was called to do outreach and resuscitation. There was also no documented escalation procedure in place to show how the ward was medically covered if the RMO was called out. • We reviewed five patient records and found no evidence of ward rounds in two out of five records. National guidance says consultant led ward rounds must be undertaken twice a day. This was a breach of regulation 18 (1)