BMI Bishops Wood 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	Requires improvement
Are services safe?	**Requires improvement**
Are services effective?	**Requires improvement**
Are services caring?	**Good**
Are services responsive?	**Good**
Are services well-led?	**Good**

Summary of findings

Letter from the Chief Inspector of Hospitals

BMI Bishops Wood Hospital is a 42 bedded independent acute care hospital which is built in the grounds of Mount Vernon Hospital - a facility operated by an NHS trust. The hospital provides services to adults and children over the age of three.

Services are provided by UK registered health professionals and support teams. The hospital specialises in cancer services and also offers treatment for a variety of musculo-skeletal conditions including offering physiotherapy and imaging services.

We inspected core inpatient services of medical care, surgery and outpatients and diagnostic imaging.

We rated this hospital as requires improvement overall. We rated it good for caring, responsive and well led and requires improvement for safe and effective . We rated surgery and outpatients and diagnostic imaging as good, and medical care as requires improvement.

We found areas of good practice including the following:

- Staff understood and fulfilled their responsibilities to raise concerns, report incidents and near misses.
- We saw that the environment was clean and well maintained and we saw that equipment worked well and was clean.
- Staff had a good understanding of what was meant by safeguarding and their responsibilities to protect vulnerable patients.
- Staff undertook appropriate mandatory training for their role. Staff received good support for continuing professional development (CPD).
- Care and treatment was mainly planned and delivered to patients in line with current evidence based guidance, standards and legislation.
- There was good multi-disciplinary working in most areas of the hospital and good relationships with local acute trusts.
- A range of evidence based practice was observed, such as the use of enhanced recovery programmes.
- Staff positively interacted with patients and treated them with kindness and compassion.
- The service met national waiting times for patients to wait no longer than 18 weeks for treatment after referral.
- Patients were involved and encouraged to be active partners in their care and in making decisions.
- BMI Bishops Wood had largely a clear vision for the organisation and a clear strategy for achieving this vision.
- However we found evidence of poor practice including the following:
- We had concerns about the prescribing and administering of chemotherapy at BMI Bishops Wood hospital.The prescribing and administering of chemotherapy at BMI Bishops Wood hospital was unsafe and put patients at risk.
- Staff were not always acting in compliance with prescribing guidelines.We wrote to the provider with our concerns prior to report publication. The provider has given us an action plan much of which is to be completed in the future and we will return to check on this.
- Despite dedicated Macmillan nurses, we found deficiencies in end of life care with no vision and strategy, poor clinical governance, no risk management in place, lack of multi-disciplinary working , lack of performance measures and audit in place, and lack of patient assessment and care planning.
- Not all rooms on the medical ward were compliant with Health Building Note (HBN) 00-09 as they had carpet in them. In addition, not all rooms on the medical ward had a designated hand washing basin for staff and this was not compliant with hand hygiene protocols.

Summary of findings

- In surgery a number of environmental concerns posed infection prevention and control risks to patients:
- The theatres sluice did not have a hand washing sink for staff therefore they had to use the same sink in which used surgical instruments were rinsed in.
- Used endoscopy equipment was carried through the theatres (when not in use) to the used equipment storage area.
- The rate of surgical site infections in four key areas was worse than the average performance in other independent acute hospitals.
- Patient rooms on Northwood did not have designated hand wash sinks, which meant staff washed their hands in patient basins.

Importantly the provider must undertake the following improvements:

- The provider must ensure that prescribing and administering of chemotherapy at BMI Bishops Wood is in line with best practice guidelines. This includes ensuring that all clinicians with practicing privileges and all staff who have independent prescribing status as well as all staff without that status adhere strictly to those guidelines.
- The provider must improve its governance arrangements for end of life care to ensure clinical governance, risk management, patient assessment and care planning processes, multi- disciplinary working and adequate performance measurement and audit are in place.

In addition the provider should undertake the following improvements:

- The provider should ensure that rooms in the medical ward are compliant with Health Building Note (HBN) 00-09.
- The provider should ensure that all patient rooms on all wards have designated hand washing basins for staff to ensure compliance with hand hygiene protocols.
- The provider should ensure that the theatres sluice has a separate hand washing sink for staff to prevent them having to use the same sink in which used surgical instruments are rinsed in.
- The provider should prevent used endoscopy equipment being carried through the theatres (when not in use) to the used equipment storage area.

The above lists are not exclusive and the provider should study the report in detail to develop its action plan to ensure improvements.

Professor Sir Mike Richards

Chief Inspector of Hospitals

Overall summary

Summary of findings

Contents

Care Quality Commission

Requires improvement

Bishops Wood Hospital

Services we looked at

Medical care; Surgery; and Outpatients and diagnostic imaging.

Summary of this inspection

Background to BMI Bishops Wood Hospital

BMI Bishops Wood Hospital is a 42 bedded independent acute care hospital which is built in the grounds of Mount Vernon Hospital - a facility operated by an NHS trust. The hospital provides services to adults and children over the age of three.

Services are provided by UK registered health professionals and support teams. The hospital specialises in cancer services and also offers treatment for a variety of musculo-skeletal conditions including offering physiotherapy and imaging services.

Pinner Park Oncology Ward (which will be referred to as Pinner Ward in this report) is the medical ward at BMI Bishops Wood. Pinner Ward is one of the two inpatient wards located on the first floor of the hospital. There are 42 beds spread between the surgical ward (Northwood) and the medicine ward (Pinner). The 42 beds are made up of 29 inpatient beds, five day case beds, one enhanced recovery bed and seven chemotherapy day rooms. Beds on the surgical ward can be used to admit medical patients if all medical beds are full and vice versa. Staff from the medical ward are responsible for any medical patients on the surgical ward. The medical ward is open 24 hours a day, seven days a week.

There are two multi-specialty theatres available, both with laminar flow, and there is also a minor procedures theatre.

There is an on site pharmacy at the hospital.

BMI Bishops Wood had ongoing refurbishment plans at the time of our inspection.

Our inspection team

Our inspection team was led by an Inspection Manager and included CQC inspectors and a combination of specialists including an oncologist, orthopaedic and outpatient doctors, end of life and outpatient specialist nurses.

Why we carried out this inspection

We carried out this inspection as part of CQC's comprehensive inspection programme.

How we carried out this inspection

We carried out the announced part of the inspection on 25 and 26 October and 25 November 2016. We also carried out unannounced inspections during November. We spoke with patients and members of staff including managers, nursing staff, allied health professionals, pharmacy and support staff. We observed how patients were being cared for and reviewed patients' clinical records. We spoke with 28 patients, 12 relatives of patients and 32 members of staff.

Prior to the inspection we reviewed a range of information we had received from the hospital. We also distributed comment cards for patients to complete and return to us.

Summary of this inspection

Information about BMI Bishops Wood Hospital

Outpatient department specialties with percentage activity shown

The top five outpatient specialities accounted for over 50% of outpatient appointments.They were: Orthopaedics (23%); Opthalmology (9%); Ear nose and throat (9%); Dermatology (7%); and Oncology (5%) - percentages rounded. Pre- assessment and nurse led clinics accounted for 11% of patients seen in outpatients.

Number of doctors with practising privileges: 246

Number of practising privileges removed or suspended July 2015-June 2016 : 0

Day patient attendances July 2015- June 2016: 4977

Number of inpatients July 2015-June 2016 : 1211

Number of outpatient attendances July 2015-June 2016 : 29723

Total of all attendances: 35931 (including 1431 children up to age 18 - i.e. 4%)

Never Events: There was one Never Event in the reporting period (Jul 15 to Jun 16). This was for the removal of the wrong tooth of a patient.

C.Diff: No incidents of C. diff occurred in the reporting period (July 2015 to June 2016).

MRSA or MSSA: No incidents occurred of MRSA or MSSA in the reporting period (July 2015 to June 2016).

E-Coli: There were four incidents of E-Coli in the reporting period (July 2015 to June 2016):- One in the period July 2015 to September 2015 and three in the period January 2016 to March 2016.

What people who use the service say

Friends and Family Test scores:

FFT scores were lower than the England average across the period January 2016 to June 2016.Response rates were above the England average of NHS patients across the period January 2016 to June 2016.

NHS Choices Friends and Family test - inpatients:

98% of 55 respondents recommend this hospital.

Patient and relatives comment cards:

We received 96 completed "Tell us about your care" comment cards where we asked patients and relatives to tell us about their experience of care at BMI Bishops Wood Hospital. 86 were wholly positive and contained comments ranging from good to excellent in relation to the professional, caring and supportive members of staff and positive comments in relation to the standard of care and service in an hygienic environment. The remaining ten were also largely positive but raised individual issues such as the need to modernise patient bedrooms and some delays to treatment after arriving for appointment. One person complained about delay in answering call bells and there were also issues about car parking difficulties at the hospital.

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

Requires improvement

- We had concerns about the prescribing and administering of chemotherapy at BMI Bishops Wood hospital.The prescribing and administering of chemotherapy at BMI Bishops Wood hospital was unsafe and put patients at risk.
- We found that part bags of chemotherapy were administered to patients where a reduced dose of chemotherapy was required. The use of part bags introduced high risk of error with potentially serious consequences for patients. There was a risk that a patient could end up being given the full dose due to human error or machine malfunction. Staff told us part bags were administered three times a month on average.We were not assured that the processes for authorisation of changes in chemotherapy prescriptions at the time of our inspection were sufficiently robust.
- We wrote to the provider with our concerns prior to report publication. The provider has given us an action plan much of which is to be completed in the future and we will return to check on this.
- Not all rooms on the medical ward had a designated hand washing basin for staff and this was not compliant with hand hygiene protocols.
- in surgery a number of environmental concerns posed infection prevention and control risks to patients:
- The theatres sluice did not have a handwashing sink for staff therefore they had to use the same sink in which used surgical instruments were rinsed in.
- Used endoscopy equipment was carried through the theatres (when not in use) to the used equipment storage area.
- Patient rooms on Northwood did not have designated hand wash sinks, which meant staff washed their hands in patient basins.
- Carpeted floors in patient rooms were not in line with infection prevention and control guidance due to the difficulties with sufficiently cleaning this type of flooring.
- However:
- Staff understood and fulfilled their responsibilities to raise concerns, report incidents and near misses.
- Most patient areas were visibly clean and equipment had been checked in line with the hospital's policy.

- There were high compliance rates in relation to hand hygiene ,infection prevention and control and sharps audits.
- Staff had a good understanding of what was meant by safeguarding and their responsibilities to protect vulnerable patients.
- Medicines were stored securely and well managed. However we had concerns around administration of chemotherapy.
- Staff undertook appropriate mandatory training for their role. Staff received good support for continuing professional development (CPD).
- Patients were protected from the risk of abuse and avoidable harm.
- Staffing levels and skill mix were appropriate for both outpatients department and diagnostic imaging services.

Are services effective?

Requires improvement

- We were concerned about the lack of formal assessments care plans, audit and performance measurement in end of life care (EOL).
- The EOL service was not using current evidence based guidelines to develop the service.
- The EOL service was not meeting NICE guidance (NG31) Care of Dying Adults in last days of life, as there were no advanced care plans and no planning documents in place.
- The EOL service did not achieve the priorities for care of the dying person set out by the NHS England Leadership Alliance for the Care of Dying Persons.
- General nurses had not been trained to identify patients in the last 12 months of life nor were they trained in advanced care planning.
- However:
- Care and treatment was mainly planned and delivered to patients in line with current evidence based guidance, standards and legislation.
- There was good multi-disciplinary working.in most areas and relationships throughout the hospital and local acute trusts.
- Pain was well managed and staff were quick to respond to requests for pain relief.
- A range of evidence based practice was observed, such as the use of enhanced recovery programmes.
- Procedure specific data, mortality rates, unplanned readmissions to hospital and unplanned returns to theatre indicated that patient outcomes in surgery were good.
- Staff were competent, and supported to identify their learning and development needs.

Summary of this inspection

Are services caring?

Good

- Patients and relatives gave mostly positive feedback about the care and treatment offered by staff on the ward.
- Staff treated patients with dignity and respect.
- We found staff responded compassionately when patients needed help and supported patients emotionally.
- Staff positively interacted with patients and treated them with kindness and compassion.

Are services responsive?

Good

- The hospital provided a seven-day service for inpatients with effective on-call arrangements to meet patient needs.
- Services were planned and delivered in a way which met the needs of the local population.
- The service met national waiting times for patients to wait no longer than 18 weeks for treatment after referral.
- Patients were involved and encouraged to be active partners in their care and in making decisions.
- Staff supported and organised support groups and fundraising events for oncology patients.
- Children and young people could be accommodated by the service and specific arrangements were in place to ensure the care they received was appropriate.

Are services well-led?

Good

- Despite dedicated Macmillan nurses, leadership in End of Life Care was inadequate with no vision and strategy, poor clinical governance, no risk management in place, lack of multi-disciplinary working , lack of performance measures in place, and lack of patient assessment and care planning.
- BMI Bishops Wood had largely a clear vision for the organisation and a clear strategy for achieving this vision.
- There was a clear governance structure to support the delivery of the strategy and good quality care in most areas.
- Staff were aware of the values of the organisation and were passionate about good patient care.
- Staff feedback about the leadership team was positive and managers were described as approachable and friendly.

Summary of this inspection

- However, despite dedicated Macmillan nurses, leadership in End of Life Care had no vision and strategy, poor clinical governance, no risk management in place, lack of multi-disciplinary working , lack of performance measures in place, and lack of patient assessment and care planning.

Detailed findings from this inspection

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Medical care	Requires improvement	Requires improvement	Good	Good	Requires improvement	Requires improvement
Surgery	Requires improvement	Good	Good	Good	Good	Good
Outpatients and diagnostic imaging	Good	N/A	Good	Good	Good	Good
Overall	Requires improvement	Requires improvement	Good	Good	Good	Requires improvement

Notes

Requires improvement

Medical care

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

Information about the service

Medical services are those services that involve assessment, diagnosis and treatment of adults by means of medical interventions rather than surgery. Endoscopy or chemotherapy treatments undertaken as a day case are also included within medical care.

BMI Bishops Wood medical services consisted of oncology chemotherapy treatment, an endoscopy service, palliative and end of life care. Palliative and end of life care will be reported separately under the end of life care service report. The endoscopy service was part of services provided under the surgery service but will be reported in this medical report.The hospital provides care to a small number of patients who proceed to end of life.

Pinner Park Oncology Ward (which will be referred to as Pinner Ward in this report) is the medical ward at BMI Bishops Wood. Pinner Ward is one of the two inpatient wards located on the first floor of the hospital. There are 42 beds spread between the surgical ward (Northwood) and the medicine ward (Pinner). The 42 beds are made up of 29 inpatient beds, five day case beds, one enhanced recovery bed and seven chemotherapy day rooms. Beds on the surgical ward can be used to admit medical patients if all medical beds are full and vice versa. Staff from the medical ward are responsible for any medical patients on the surgical ward. The medical ward is open 24 hours a day, seven days a week.

At the time of our inspection the same ward manager managed both the medical and surgical ward.

The medicine ward treats oncology patients as well as other medical patients. However during our inspection all patients seen and admitted to Pinner Ward were oncology patients. Patients can be admitted overnight or come in as day case chemotherapy patients. No children are admitted or treated on the medical ward.

The hospital does not have a dedicated endoscopy unit.Endoscopy is performed in minor theatres then the patient is transferred to recovery then to the ward, then discharged.

Requires improvement

Medical care

Summary of findings

We rated the service requires improvement overall because:

- We had concerns about the prescribing and administering of chemotherapy at BMI Bishops Wood hospital. Staff did not always use proformas when prescribing chemotherapy on paper form. We were not assured that prescribing guidelines were being followed at the time of our inspection. Chemotherapy on the ward was stored in the general use medicines refrigerator. This was not in line with good practice.
- Not all rooms on the medical ward were compliant with Health Building Note (HBN) 00-09 as they had carpet in them.
- The endoscopy suite had one entrance/exit and this was not in line with best practice for endoscopy.
- Medical records did not always meet satisfactory standards. The handwriting was not always legible.
- There were no care plans in patients records which meant that there was not always a clear plan that all professionals could access and be informed about the patient and the plan of care.
- Staff did not always complete root cause analysis documents appropriately and failed to set out the root cause of the incident being investigated or identify lessons learnt.
- At the time of the inspection the service was not meeting NICE guidance (NG31) Care of dying adults in last days of life, as there were no advanced care plans and no planning documents in place.

- However,staff understood and fulfilled their responsibilities to raise concerns, report incidents and near misses.
- All patient areas were visibly clean and equipment had been checked in line with the hospital's policy.
- Staff understood the duty of candour and the need to be open and honest.

- With the exception of end of life care,treatment and care was mainly planned and delivered to patients in line with current evidence based guidance, standards and legislation.

- There was good multi-disciplinary working and relationships throughout the department, with the rest of the hospital and local acute trusts.

- The hospital provided a seven-day service for inpatients with effective on-call arrangements to meet patient needs.

- Staff treated patients with dignity and respect and compassion.

- The service met national waiting times for patients to wait no longer than 18 weeks for treatment after referral.
- The hospital provided a seven-day service for inpatients with effective on-call arrangements to meet patient needs.
- There was a clear governance structure to support the delivery of the strategy and good quality care.

Requires improvement

Medical care

Are medical care services safe?

Requires improvement

1. We rated safe as requires improvement because:

- We had concerns about the prescribing and administering of chemotherapy at BMI Bishops Wood hospital.The prescribing and administering of chemotherapy at BMI Bishops Wood hospital was unsafe and put patients at risk.
- We found that part bags of chemotherapy were administered to patients where a reduced dose of chemotherapy was required. The use of part bags introduced high risk of error with potentially serious consequences for patients. There was a risk that a patient could end up being given the full dose due to human error or machine malfunction. Staff told us part bags were administered three times a month on average.We were not assured that the processes for authorisation of changes in chemotherapy prescriptions at the time of our inspection were sufficiently robust.Following the inspection, the provider told us they carried out an audit review of all the patient chemotherapy regimes and that their findings demonstrate that during the period June 2016 to October 2016 they had four part bag administrations which equates to 0.46% of the total chemotherapy patient numbers.The provider also told us hey had ceased administering part bags of chemotherapy.
- We wrote to the provider with our concerns prior to report publication. The provider has given us an action plan much of which is to be completed in the future and we will return to check on this.

Incidents

- Between July 2015 and June 2016 there were 233 clinical incidents and 44 non clinical incidents reported by the hospital as a whole. Of the 233 incidents reported by the hospital 41 of these related to the medical ward.
- Staff we spoke with were familiar with the process for reporting incidents, near misses and accidents using the paper reporting system. . Forms were handed over to the ward manager who passed them on to the Quality and Risk lead for investigation. Incidents were then entered onto the electronic incident reporting system.
- We found that there were systems and processes in place for incident reporting and we found there was a culture of incident reporting on the medical ward. Staff told us they were encouraged to report incidents. However, staff told us they did not always get feedback on the outcome of incidents and that they did not hear about incidents that happened in other BMI hospitals.
- During the inspection we found that lessons learnt from other BMI hospitals from incidents and other issues were highlighted in the monthly clinical governance bulletin. We saw a notice board located in the nursing office which had the bulletin attached for staff to access.However, not all staff were aware of the bulletin or its contents.
- The executive director had oversight for the management of incidents. The director of clinical services was responsible for investigating clinical incidents and the quality and risk lead investigated all non-clinical incidents. Learning from incidents was shared at monthly clinical governance meetings. We reviewed the integrated clinical governance meetings of May and July 2016 which included a discussion of incidents and actions taken.
- Staff reported getting feedback from incidents through email, staff meetings, board huddles, (these are brief and routine meetings for sharing information about potential or existing safety problems facing patients and staff), and during handovers. Some staff were able to tell us of incidents they had reported for example, patient falls or drug errors. However some staff told us they had not always received feedback on incidents they reported.
- Staff told us if a patient was given a part bag of chemotherapy, when originally a full bag had been prescribed, it would not be recorded as an incident.
- Mortality and morbidity discussions took place as part of the monthly clinical governance meetings.
- From April 2015, NHS providers were required to comply with the Duty of Candour Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. 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 were aware of the principles of duty of candour and spoke about being open and honest when things went wrong. One out of the fifteen staff we spoke with did not know what the duty of candour was.

Clinical Quality Dashboard or equivalent (how does the service monitor safety and use results)

- BMI Bishops Wood collected data in relation to key performance safety areas for example, venous thromboembolism (VTE) and falls. VTE is the formation of blood clots in the vein. The hospital reported one incident of VTE between July 2015 and June 2016. A VTE risk assessment tool was included in the hospital patient care records. The hospital reported 100% screening rates for VTE between July 2015 and June 2016.
- Senior clinical staff maintained quality measurement and performance dashboards for each service. They discussed outcomes at Head of Department and clinical governance meetings and made comparisons with other BMI healthcare hospitals. Clinical staff had access to these performance dashboards.

Cleanliness, infection control and hygiene

- There were no incidents of hospital acquired Methicillin-resistant Staphylococcus aureus (MRSA) on the medical ward.
- The hospital did not report any incidents of hospital acquired Clostridium difficile (C.Diff) between July 2015 and June 2016.
- There were five incidents of Escherichia coli (E.coli) on the medical ward between January 2016 and September 2016.Three of these had been investigated and a root cause analysis completed for each.However, no root cause analysis had been completed for the two incidents in March and September 2016.Staff did not always complete root cause analysis documents appropriately. Two of the root cause documents we looked at during the inspection had not stated any lessons learnt but only what treatment the patients had received.
- BMI Bishops Wood refurbished the medical ward in 2015. This had involved the installation of vinyl flooring to patient rooms. However, at the time of our inspection 23 patient rooms had carpets on the floor in them. The hospital was not compliant Health Building Note (HBN) 00-09 which states that carpets should not be used in clinical areas including all areas where frequent spillage is anticipated. There was a risk of cross infection.This risk had been recorded in the hospital's risk register. There is an ongoing refurbishment plan which will include replacement of the carpet in inpatient rooms.
- There were no designated hand wash sinks in the patient rooms that had not been refurbished. This meant staff washed their hands in patient basins and this was not compliant with hand hygiene protocols. The seven chemotherapy rooms and the rooms that had undergone refurbishment were compliant with this protocol.
- In addition, the risk register indicated there were non-compliant sinks presenting with significant risk of increased microbial contamination which meant that hands could easily be contaminated during hand washing. There were 29 sinks to be replaced in the hospital including on the medical ward. After the inspection, the provider subsequently provided a document showing instructions to staff owing to the lack of hand wash basins in patient rooms.
- The endoscopy suite had one entrance/exit and this was not in line with best practice for endoscopy. Staff carried used endoscopy equipment through theatres to access the sluice area and this presented as an infection risk. Also, staff rinsed used endoscopy equipment in the same sink staff used to wash their hands. This was not compliant with hand hygiene protocols which require a designated hand washing sink. We also found that used equipment was covered with red plastic and stored on the counter top and this was not in line with best practice.
- The hospital identified a risk in relation to endoscopy. There was a risk of infection due to high water count and ageing equipment. As a result it outsourced its endoscope decontamination in order to mitigate the risk. The hospital had regular disinfection of water and regular lab test monitoring to mitigate the risk.
- During our inspection we observed staff adhering to the ‘bare below the elbows’ policy. Personal protective equipment such as disposable gloves and aprons were readily available in all areas.
- The infection control report for September 2016 showed that a hand hygiene audit and a sharps audit was

carried out .There was 96% compliance on the medical ward for the sharps audit and 100% compliance for hand hygiene audit. There was 100% compliance in the hand hygiene audits for the medical ward in May, June and August 2016.The hand hygiene audits looked at whether hand hygiene was complied with before patient contact, before any aseptic task, after body fluid exposure, after touching a patient and after touching patient environment.Following the inspection the provider provided a risk assessment which detailed how the hospital mitigated the potential risk of cross contamination.This included making personal protective clothing available outside patient rooms, placing alcohol gel inside patient rooms, face to face hand hygiene training of staff and reminding staff to adhere to the hospital hand hygiene policy.

- The BMI Bishops Wood Hospital participated in 'Patient-Led Assessments of the Care Environment' (PLACE). PLACE are a self-assessment of non-clinical services, which contribute to healthcare, delivered in both the National Health Service (NHS) and independent or private healthcare sectors in England. The programme encourages the involvement of patients, the public and stakeholders, both nationally and locally, who have an interest in healthcare and assessing providers. PLACE assessment results showed that in August 2016 the hospital scored 98.7% for cleanliness which was above both BMI averages (97%) and the national average of 98.1%.

Environment and equipment

- The medical ward (Pinner) was located on the first floor of the hospital. It was adjacent the surgical ward (Northwood.) The wards were in the same area and accessible by the same entrance.
- Patients on the medical ward could be admitted to the surgical ward if the medical beds were full. Surgical patients could also be admitted to Pinner ward. Staff from the medical ward nursed any medical patients on the surgical ward in the event they were admitted there.
- All inpatients were accommodated in en suite private rooms which were located off the main ward corridors. All rooms were equipped with a nurse call bell and emergency buzzers.
- Resuscitation trolleys were located in various areas in the hospital. There was a resuscitation trolley was located in the day unit within easy reach of staff on the medical ward. We checked the resuscitation trolleys during our inspection and found items were in date and the trolleys were ready to use in an emergency. A resuscitation trolley was available in recovery and there was an emergency buzzer in the room.
- Some rooms had been refurbished and had laminate flooring and walk in showers. Non refurbished rooms had en suite bathrooms with bathtubs and there was a risk that patients with mobility difficulties would have difficulty accessing the bathtub.
- A visitors' room was accessible to relatives of patients on the medical ward. The room was clean and tidy. Pinner ward had a reception area where patients reported upon arrival to the unit. The reception area was visibly clean and free from dust.
- Equipment seen on the ward included blood pressure machines, fire extinguishers, and resuscitation trolleys. We saw that equipment had been serviced up to date. Fire extinguishers were in date.

Medicines/Chemotherapy

- We had concerns about the prescribing and administering of chemotherapy at BMI Bishops Wood hospital.Chemotherapy for BMI Bishops Wood was prepared offsite and was ordered in advance. Patients had blood tests done a day or two before their chemotherapy treatments. Based on the results of the blood tests the appropriate chemotherapy dose was ordered by pharmacy. A policy document received from the hospital indicated that a pharmacist technician ordered chemotherapy on a Wednesday and Thursday usually a week in advance.However,following the inspection the hospital told us that chemotherapy was ordered daily.
- During the inspection staff told us that on the day of chemotherapy treatment patients had their blood taken by an oncology nurse looking after them. Bloods were checked against the parameters of the chemotherapy protocols as well as the general well-being of the patient .If the patient fell out of the parameters of the chemotherapy protocol a consultant would be contacted and consulted on whether chemotherapy should continue. If the patient fell within the parameters and if patient was fit chemotherapy would be administered.Following the inspection the provider clarified that their aim was to have patient blood tests carried out one to two days before the treatment was

due and that blood tests were only carried out on the same day as treatment for appropriate patients to ensure they were fit to receive the chemotherapy treatment.

- The prescribing and administering of chemotherapy at BMI Bishops Wood hospital was unsafe and put patients at risk. We found that part bags of chemotherapy were administered to patients where a reduced dose of chemotherapy was required.For example, we identified a 500mg dose of chemotherapy had been given to a patient from a 700mg bag. The use of part bags introduced high risk of error with potentially serious consequences for patients. There was a risk that a patient could end up being given the full dose due to human error or machine malfunction. Staff told us part bags were administered three times a month on average.
- The hospital had a policy on the safe management of chemotherapy.This policy allowed for part bags of chemotherapy to be given to patients in exceptional circumstances.Staff were not able to tell us the exact circumstances under which a part bag could be administered. Following the inspection we requested evidence of risk assessments to support this policy. The hospital sent us a guidance document used by them to support oncology clinical pharmacy services on Pinner Ward.This document did not have any information about the administration of part bags of chemotherapy, risk assessments related to the giving of part bags or information on the circumstances under which part bags could be administered.
- We also found that there was no recording in the patients notes that a part bag of chemotherapy had been administered. Staff told us that this would not be recorded as an incident. This meant there was no paper trail or audit or review.
- We had concerns that not all paper chemotherapy prescriptions altered by Registered Medical Officers (RMOs) were countersigned by a consultant. Where a reduced dose of chemotherapy was required, RMOs could alter paper prescriptions on the verbal instruction of the consultant with the expectation that the consultant would sign to confirm this amendment when they became available onsite. Failure to countersign prescription alterations made by RMOs in the absence of a consultant was not in line with good practice. Also, staff told us that getting hold of consultants to amend chemotherapy prescriptions where a reduced dose was required was often difficult. As a result they asked RMOs to make the amendments.
- We found that the hospital did not always use proformas for paper prescribing of chemotherapy. The hospital had developed a new electronic prescribing system for chemotherapy prescriptions. At the time of our inspection only prescriptions for breast and bowel cancer could be completed electronically. About 60% of chemotherapy prescriptions were still in paper form. Of those paper prescriptions 90% were not on proformas. Pan London Guidelines state: “In those trusts where electronic prescribing system are not normally currently available, chemotherapy should ideally be prescribed by using appropriate prescription proformas."
- During the inspection reference was made by the hospital's electronic prescribing system and the hospital's oncology pharmacist to Royal Surrey protocols which follow Pan London guidelines. The provider subsequently told us that the hospital does not follow Pan London guidelines but instead use the Systemic Anti-Cancer Therapy (SACT) protocols. However, this contradicts the references we found on inspection. Regardless of what system the hospital used, the use of proformas reduces the risk of prescribing errors and by not using proformas, the hospital was not acting in line with best practice guidelines and increased the risk of prescribing errors.
- Staff without prescribing qualifications prescribed on the electronic system.Good guidance states that prescribing of second or subsequent cycles may be delegated to Specialist registrars in training (ST3 or above), non-medical independent or supplementary prescribers. Staff at BMI Bishops Wood did not always follow this guidance. We found evidence of pharmacists who were not independent or supplementary prescribers making dose reductions on the electronic prescribing system for chemotherapy. When we asked why this had been done they had not been able to remember and thought that perhaps the consultant had been busy. In the electronic notes they had documented “20% dose reduction as per consultant”. The pharmacist stated that it was not routine for them to change doses as consultants could access the online system from outside the hospital.

Requires improvement

Medical care

- After the inspection the hospital subsequently told us that BMI had introduced Systemic Anti-Cancer Therapy (SACT) protocols across its business, which have been developed and implemented on an individual tumour type basis. BMI Bishops Wood Hospital utilised these BMI SACT protocols as the reference for prescribing and for the management of patients receiving SACT. While we accept the statement from the provider we noted that The iQemo system definitely referenced the Royal Surrey (Pan London) protocols, and these were routinely referenced by the oncology pharmacist during the inspection.
- During the inspection we found multiple paper prescriptions where chemotherapy had been prescribed by a consultant with no route, volume or diluent. In some cases the missing details had been were filled in by the pharmacist but in some cases we found they had been left blank. This put patients at risk of having chemotherapy administered via the wrong route or being given the incorrect dose.
- Chemotherapy in the ward area was not being stored in a separate refrigerator. It was being stored in general use medicines refrigerator. We raised this with the hospital and following the inspection we received confirmation that new fridge had been ordered. The provider has subsequently confirmed post inspection that a separate fridge was now used to store chemotherapy
- Between April and May 2016 there were four incidents reported on the medical ward relating to chemotherapy. One incident was about a patient having an allergic reaction to chemotherapy treatment and three incidents were about the late ordering of chemotherapy and patients having to either wait or come back on another day.
- Staff had access to anaphylaxis kits (anaphylaxis is an allergic reaction to medication such as chemotherapy) spillage kits and skin irritation packs on the unit. We checked them and they were in date.
- The medicine management audit showed 88% compliance in February 2016 and 97% compliance for May 2016.The medical ward conducted a controlled drugs audit in March and June 2016 and compliance was 100% for both months.
- Medicines management was part of the mandatory training for all staff involved in the handing, preparation and administration of medicines including all registered nurses and pharmacy technicians.
- The hospital used both paper and electronic prescribing. At the time of our inspection the hospital's electronic prescribing system was in use for breast and bowel cancer patients. We found that 60% of chemotherapy prescriptions were still on paper. A paper based medicine administration record chart was in use at this hospital. A pharmacist visited the medical ward each weekday and there was arrangements to contact a pharmacist for advice and to obtain medicines out of hours.
- RMOs followed guidelines on febrile neutropaenic episode policy for antibiotic prescriptions.
- Medicines, including intravenous (IV) fluids were stored securely and we saw controlled drugs were stored and managed appropriately, except chemotherapy which had not been stored in a separate fridge as per medicines storage guidelines for cytotoxic medicines.
- BMI Bishops Wood had a pharmacy on site. The pharmacy department operated between 8am and 5pm Monday to Friday. On call services were provided outside these times. Senior nurses and the on duty RMO had access to the pharmacy out of hours and access to the cupboard where medicines given to a patient on discharge from hospital stay were kept on Pinner ward. The On-call rota was left with reception and a copy was held in the senior nurse file and in pharmacy. The on call pharmacist had to respond within 20 minutes of receiving the call.

Records

- We viewed records for five patents on the medical ward. There were three separate files for each patent (nursing, medical and drug prescription charts). Risk assessments were completed fully. However, staff did not complete care plans in response to findings of risk assessments. Also, patients' records were not always legible and it was difficult to read the name and grade of staff completing the records.
- During the inspection we looked at consent records for four patients on the medical ward. They had been fully completed.
- The hospital's audit programme included an audit of patient records. There was 92% compliance in May 2016, 90% in June 2016 and 89% in July 2016.

Safeguarding

- Safeguarding training was provided as part of the organisation's mandatory training. All staff were required to undertake safeguarding vulnerable adults and children training at level one. Managers responsible for the ward were required to complete safeguarding vulnerable adults and children training at level two. The hospital informed us all registered practitioners were trained to level two for safeguarding vulnerable children.The safeguarding lead had completed level three training. Guidance from the Intercollegiate Document for Healthcare Staff (2014) recommends that all clinical staff working with children, young people and/or their parents/ carers and who could potentially contribute to assessing, planning, intervening and evaluating the needs of a child or young person should be trained to level three for safeguarding vulnerable children. However, the provider informed us that despite advertising services for children aged 3 and upwards on its website, staff on Pinner ward do not care for children or young people under 18 years within their scope of practice.Therefore they do not require safeguarding training for children and young people at level three.
- Staff we spoke with showed a good understanding of safeguarding and how to escalate concerns. This was consistent between different staff groups. Staff were able to tell us who the safeguarding lead of the hospital was.

Mandatory training

- The hospital followed the BMI healthcare mandatory training matrix requirements. All staff, dependent on their role, had a role specific mandatory training. For example, information security, fire safety and moving and handling was applicable to all staff whereas blood transfusion and intravenous administration training was only for staff who required the necessary skills in these areas, for example, oncology staff. Most training was done by e-learning, in some cases followed by workshops and assessments. Staff completed their training during their work time and staff we spoke with said they were up to date with their training requirements.
- The e-learning system emailed staff and the ward manager three months prior to the expiry of their training to remind them of the completion date. Senior staff such as ward managers could access and monitor the progress of the mandatory training for staff on their wards.
- The mandatory training completion rates for the two wards (surgical and medical) were 88.6% as of July 2016. The system used by the hospital did not allow them to analyse training data for the medical ward only. As of October 2016, the mandatory training completion rate had increased to 90.3%.
- In addition to e-learning, face to face mandatory training was provided in house for example, infection control, moving and handling, safeguarding and fire safety.
- All Registered Nurses leading acute medical services had dementia awareness as part of their mandatory training.
- Consultants and clinicians with practising privileges were not required to complete training via the hospital system but the medical advisory committee checked assurance of their mandatory training. Consultants had to produce confirmation on yearly that all mandatory training for that year has been successfully completed (including, but not limited to, basic life support, safeguarding, mental capacity training, and where relevant, paediatric training to level.
- The resident medical officers (RMOs) received mandatory training via their RMO agency and had access to the hospital's on-line training systems. The RMOs received advanced life support (ALS) training via the RMO agency. The clinical director had oversight of this training to ensure competency was achieved.

Assessing and responding to patient risk

- Staff used the National Early Warning Score (NEWS) to identify patients at risk of deterioration. NEWS scores were recorded in patients' records. During our inspection of this hospital, we reviewed four patient observation charts. We found nursing staff did not always adhere to guidelines for the escalation of the NEWS. We found that where scores were high enough to trigger action staff continued to monitor scores until they dropped to a safe level. There had been no evidence of escalation to an RMO or consultants or a corresponding care plan to reflect the patient's treatment plan in light of the high scores.

- There was no critical care unit at BMI Bishops Wood and patients who became medically unwell were transferred to a nearby NHS hospital or a critical care unit at a nearby BMI hospital by ambulance if required. Consultants followed their patients' progress following the transfer. There were no service level agreements in relation to the transfer of patients to these critical care units.
- Staff checked on patients every two hours as part of assessing patient risk.

Nursing staffing

- BMI Bishops Wood used the BMI nursing and skill mix labour tool to plan the nursing skill mix against predicted nursing activity. The tool was used five days in advance to provide an overview of the staffing required and reviewed daily to confirm staffing requirements for the following 24 hour period, changes were then made to the roster as required. The tool was formulated against NICE guidance to ensure safe staffing levels and appropriate skill mix targets.
- At the time of our inspection BMI Bishops Wood Hospital were piloting another tool that demonstrated patients acuity and staffing levels required with a view to switching to it if it was deemed better than the tool in place at the time of our inspection.
- Nursing staff on the medical ward consisted of the ward manager (working between both the medical and the surgical ward), two ward sisters, seven registered nurses, four registered bank nurses, four healthcare assistants, a clinical nurse specialist (breast care) and two clinical nurse specialist Macmillan nurses employed through a service level agreement (SLA) with a nearby NHS trust.We also found that there were student nurses on the ward.
- Nursing staff met three times a day to discuss patients' treatment and handover to other staff during shift changes.
- Two Macmillan clinical nurse specialist nurses and a breast care nurse worked on the medical ward as part of the palliative care team. This was in recognition of the fact that the majority of medical patients seen at this hospital were oncology patients. The two Macmillan clinical nurse specialists were employed by the hospital through a service level agreement with a NHS trust. The breast care nurse specialist was employed directly by the hospital.
- Staffing levels were displayed on a patient information board at the entrance to the wards. During our inspection, we observed that actual staffing levels were in line with planned levels.
- Ward nursing staff we spoke with told us that additional qualified members of staff were allocated from the bank during busy periods to ensure staffing levels were safe and patient needs could be met.
- At the time of our inspection there was a ward manager vacancy on the medical ward since September 2016. We also found that a senior chemotherapy nurse was due to leave as she had handed in her notice.
- The hospital used both bank and agency staff. Senior nurses told us regular bank staff were used whenever possible as these were staff that were familiar with the ward, hospital policies and the patients. This was supported by the evidence we found during the inspection. Bank staff we spoke with had worked for the hospital as permanent staff before leaving and joining the bank.
- Data received from the hospital prior to the inspection revealed that the use of bank and agency staff nurses on both the surgical and medical wards was similar to the average of other independent acute hospitals for which we had information. There was 11% use of bank and agency staff in September 2015 and 20% in June 2016.
- We also found that the use of bank and agency health care assistants was higher than the average for other independent acute hospitals we held data for in the same period except for in August 2015 when this was lower. In September 2015 there was 18% use of bank and agency healthcare assistants and in June 2016 the figure was 15%. This was for both the medical and surgical wards.
- The ward used both bank and agency staff. However, there was more use of bank than agency staff. Between April and June 2016 there was a 4.3 to 1 ratio for bank to agency staff use of nurses and 18 to 1 ratio for bank to agency health care assistants. Banks staff received the same training as permanent staff.

- Data received prior to the inspection showed that there was no staff turnover for health care assistants or inpatient nursing staff between July 2015 and June 2016.

Medical staffing

- There were 246 consultants who had been granted practising privileges at BMI Bishops Wood Hospital. Practising privilege refers to medical practitioners being granted the right to practice in a hospital after being approved by the medical advisory committee (MAC). All consultants worked at local NHS Trusts. Consultants retained responsibility for the patients they had treated during that patient's entire pathways in the hospital. Between July 2015 and June 2016, 98% of consultants with practicing privileges had carried out an episode of care.
- Consultants had to provide proof of licencing with the general medical council (GMC) and hold a consultant post in the NHS or defence medical services as part of the application process to obtain practising privileges. The medical Advisory Committee (MAC) reviewed all applications and made recommendations as to the suitability of the applicants. Following the review and recommendation by the MAC and approval by the executive director, an induction pack, including BMI policies and terms of employment were sent to the consultant applicants. There was evidence of systems and processes to ensure that consultants were compliant and up to date with documentation according to Practising Privileges Policy (BMI Pol04). For example, failure to provide the necessary documentation could result in suspension of practising privileges. No consultants had had their privileges suspended between July 2015 and June 2016.
- Consultants we spoke with told us that they were easily contactable via telephone as they worked at hospitals close to BMI Bishops Wood hospital. However, nursing staff told us they were not always able to get hold of consultants.
- A Resident Medical Officer (RMO) covered the hospital 24 hours a day, 7 days a week. RMOs were not directly employed by the hospital and were provided by an outside agency. RMOs worked at the hospital for two weeks at a time during which time they provided 24 hour cover. RMOs told us they arrived on the ward at 8am, checked patients and discussed any concerns with nursing staff and consultants.
- The hospital had come up with an RMO log book as a way of ensuring that RMOs had enough rest when on duty. Nursing staff on the night duty would enter non-urgent requests requiring the RMO's attention in a log book to be ready for them when they attended the ward. This minimised any disturbance overnight to urgent patient needs. RMOs told us they had adequate periods of rest.
- The hospital obtained RMO training records from the RMO agency prior to the RMO placement. This allowed the hospital to know what training an RMO had received and inform whether or not they would be placed with the hospital. The RMO's modules included resuscitation, safeguarding adults and children, equality and diversity, blood components and blood transfusion, infection prevention control, mental capacity, medicines management, health and safety, and data protection.
- There were systems, processes and standard operating procedures to support effective handover between the RMO, consultants and other clinical staff.

Are medical care services effective?

Requires improvement

We rated effective as requires improvement.

Evidence-based care and treatment

- Staff had access to a range of corporate guidelines via the intranet. We saw these guidelines were up to date and referenced to current best practice from a combination of national and professional guidance, such as the National Institute of Health and Care Excellence (NICE), Royal Colleges and General Medical Council (GMC).
- We saw staff followed NICE guidelines relating to the assessment and prevention of venous thromboembolisms (VTE).All patients were assessed on admission to identify those who are at increased risk of VTE. We looked at records for four patients and there was evidence the risk of VTE had been assessed.
- The latest NICE guidelines were reported in the Clinical Governance Bulletin issued to staff and discussed at clinical governance meetings. We saw evidence of this in the clinical governance meeting minutes for May 2016.

Medical care

- Endoscopy staff followed National Institute for Health and Care Excellence (NICE) guidance but did not have Joint Advisory Group on gastrointestinal endoscopy (JAG) accreditation. JAG accreditation provides evidence that best practice guidelines are being followed for endoscopy. JAG measures quality and safety indicators, including outcomes. The structure, process and staffing levels and competencies are reviewed, and outcomes audited.
- Medical staff told us they referred to the NICE guidelines on the management of neutropenic sepsis including the prescribing of antibiotic for such patients.
- However, not all staff we spoke with knew what national guidance they referred to in their roles.
- Staff were not working in accordance to the national 'Ambitions for Palliative and End of Life Care' framework, as they were not using an advanced care plan tool or holistic needs assessment tool.
- The service did not achieve the priorities for care of the dying person set out by the NHS England Leadership Alliance for the Care of Dying Persons.

Pain relief

- BMI Bishops Wood Hospital captured patients' pain scores on the national early warning score (NEWS) chart, throughout their stay in hospital. The patients' pain was addressed when the patient indicated they were in pain or when there was an increasing pain score.
- Two patients we spoke with told us staff managed their pain well. They reported staff regularly checking on them and asking if they were in pain.

Nutrition and hydration

- All patients were screened for malnutrition and the risk of malnutrition on admission to the hospital using an adapted Malnutrition Universal Screening Tool (MUST).
- A dietician saw patients referred to her by staff on the medical ward. The dietician was self-employed and worked on the ward between Mondays and Fridays and sometimes worked weekends if there was a patient with increased needs such as a patient being fed via a tube. A colleague based at a nearby hospital provided cover in her absence.
- The dietician gave advice to patients based on individual needs. They prepared a nutrition plan for each patient and a copy was given to the patient, the family and to staff on the ward. During the inspection, we saw evidence of these plans in the patient records. Plans were dated and if a new plan was completed a new date would be entered and the plan would be re distributed to the patient, family and staff. A nutrition note was given on discharge.
- We found that the involvement of the dietician had a positive impact on patients with dysphagia (difficulty swallowing). There were clear plans on what was appropriate for each patient. There was clear information on how to prepare individual smoothies and a nutrition note was given to the patient on discharge.
- Patient-led assessments of the care environment (PLACE) scores for food in the period February 2016 to June 2016 showed that BMI Bishops Wood scored 83%, which was lower than the England average of 91%.

Patient outcomes

- BMI Bishops Wood participated in the BMI hospitals corporate audit programme. This included audits of patient health records, infection prevention and control, resuscitation, controlled drugs, consent, safeguarding, hand hygiene, medicines management and consent. Audit results of concern were discussed in the clinical governance meetings.These were sent corporately for comparison and monitoring against the equivalent results of other BMI hospitals.Areas of concern were placed on the risk register and individual action plans and remedial projects were undertaken to remedy issues,for example, pharmacy refurbishment and improvement in patient discharge.
- The hospital participated in national audits such as Patient-Led Assessments of the Care Environment (PLACE), and the National Confidential Enquiry into Patient Outcome and Death (NCEPOD) anaphylaxis audit. Anaphylaxis is extreme and severe allergic reaction.
- It was not possible for the medical team to effectively measure patient readmission rates due to the nature of the patients and the treatment pathway. Oncology patients returned to the ward for treatment such as chemotherapy multiple times. There was therefore no accurate way of recording these figures as one patient could return to the ward multiple times as a day case patient or as an inpatient.

Requires improvement

Medical care

Competent staff

- Staff were appraised yearly between October and September. Data received from the hospital prior to the inspection indicated that 52 % of inpatient nursing staff and 57% of health care assistants had been appraised at the time of submitting that data (July 2016). These figures were for both the medical and surgical ward.
- Information received from the hospital following the inspection showed that as of October 2016, 92.9% of staff on the medical ward had been appraised .
- There were systems in place to ensure that all consultants' practising privileges were kept up-to-date. This included regular reviews by the medical advisory committee (MAC) and by the executive director.
- Nurses working on Pinner ward were appropriately trained and had completed competencies in the administration of intravenous chemotherapy. Nursing staff attended a yearly BMI organisational updates.
- Teaching services for wound care, communication and breast awareness were provided for ward staff.
- Two clinical nurse specialists and breast care nurse worked on the ward. They had specialist knowledge on working with oncology patients at the end of their life and patients with breast cancer respectively.
- Staff had access to training and development opportunities to advance their professional skills, experience and to aid development of their service.
- New staff completed a BMI corporate induction programme.
- Staff we spoke with told us that they had received training that allowed them to carry out their roles.

Multidisciplinary working

- BMI Bishops Wood Hospital held breast and skin cancer multidisciplinary team (MDT) meetings across both their own hospital and another BMI hospital. This was because of the cross site working of consultants from both hospitals. The MDT consisted of pathologists, consultant surgeons, oncology consultants, and breast care nurses and dermatology consultants. Discussions about BMI Bishops Wood patients discussed at these MDTs were fed back to senior staff at BMI Bishops Wood Hospital.
- Nursing staff told us there was strong MDT working with a daily ward round attended by medical, nursing, and pharmacy staff. However, dieticians did not attend MDTs and relied on informal discussions to pass information to or get information from nursing staff.
- We found there were good working relationship between Pinner staff and pharmacy staff. There were also good working relationships between nursing staff and resident medical officers (RMOs).

Seven-day services

- Consultants were available on call 24 hours a day seven days a week for their patients on the medical ward.
- The medical ward was open 24 hours a day; seven days a week and patients could telephone the ward out of hours if they required advice from home. Patients told us they had been able to call the ward for advice out of hours and had managed to speak to a member of staff.
- The pharmacy department operated between 8am and 5pm Monday to Friday. On call services were provided outside these times. Senior nurses and the on duty RMO had access to the pharmacy out of hours and access to the cupboard where medicines given to a patient on discharge from hospital stay were kept on Pinner ward.
- There was a resident medical officers (RMOs) available 24 hrs per day seven days per week covering the whole hospital including the medical ward.

Access to information

- Information needed to deliver effective care and treatment was available to relevant staff in a timely and accessible way. This included risk assessments, prescription charts and case notes. Information and guidance regarding specific procedures or conditions was available through the organisations intranet. However, we did not find any care plans in patient records.
- Staff had access to electronic and paper copies of hospital policies and guidelines on the ward.
- Nursing staff and consultants communicated with other healthcare professionals involved in patients' care. For example, on discharge consultants wrote to patients' general practitioners (GPs).

Medical care

- Patients received same day discharge information, which included medication use, possible side effects and a telephone contact number in case of a problem.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- We reviewed consent forms for four patients on the medical ward. Forms had been completed fully and were clear and concise and showed consent had been obtained from the patient for planned treatment. Quarterly consent audits were completed as part of the corporate audit programme.
- Consent was part of the mandatory training for all staff in a clinical role and their role included obtaining implied, verbal or written consent. We found that staff were knowledgeable about consent and deprivation of liberty safeguards.
- Staff understood the need to ask for patients' consent prior to completing care tasks, such as taking observations or applying dressings.
- Some ward staff demonstrated an awareness of Deprivation of Liberty Safeguards and requirements under the Mental Capacity Act, but others were unfamiliar with the terms or how they applied to patients on the medical ward.

DNACPR forms

- Consultants made decisions on 'Do Not Attempt Cardiopulmonary Resuscitation' (DNACPR) orders. During our inspection there was no evidence of DNACPRs being in place even though there were five patients on the medical ward who were at the end of their life and who nursing staff felt should have been spoken to about having a DNACPR order in place. On the second day of the inspection staff told us a consultant would be attending the ward in order to complete multiple DNACPR forms all at once. Staff told us that there was reluctance by consultants to discuss and complete these forms.
- There was no audit of DNACPR forms even though we had been told that such an audit was taking place. When we asked for details of this audit we were given a piece of paper which was not an audit but had various staff names on it.Subsequent to our main inspection we were shown an audit of DNACPR forms. We noted that this was undated.The provider also subsequently told us that BMI Bishops Wood Hospital had completed a patient preferred place of care and death audit review, and the documentation audit,as part of the corporate audit review.

Are medical care services caring?

Good

We rated caring as good.

Compassionate care

- The Friends and Family Test is a satisfaction survey that measures patient's satisfaction with the care they have received and asks if they would recommend the service to their friends and family. For June 2016 98.8. % of all patients (NHS and Private) who completed the survey said they would recommend BMI Bishops Wood to their friends or family. In April 2016 99% of patients said they would recommend the hospital to their friends or family.
- We spoke with four patients and two relatives during our inspection. Patients and relatives spoke positively about the staff on the medical ward. Patients told us that they were happy with the care they received during their stay at the hospital. We also spoke with relatives who told us that staff were caring and compassionate. Patients described care as "excellent" and "cannot be faulted". Patients told us staff responded to call bells swiftly.
- Thank you cards from patients were displayed on the medical ward. Some of the messages read "it has been a difficult time but the path has been easier with all your support", and "a huge thank you for all your hard work, care, friendship and cups of tea". There were many other positive messages in the cards which described staff as caring and compassionate.
- Patients were cared for in individual rooms and we saw staff knocking on doors and waiting for a response before entering. Patients we spoke with told us staff were kind and caring and that they had been treated with dignity and respect.
- We saw patient's names were displayed on their individual rooms, but only after consent had been obtained.

Requires improvement

Medical care

- We observed staff supporting oncology patients in a caring and compassionate manner. There was evidence of a good rapport between patients and their nurses and staff demonstrated professionalism and knowledge that provided reassurance and support to their patients during their treatment.
- Patient-led assessments of the care environment (PLACE) scores for the hospital showed that the hospital scored 80% for privacy, dignity and wellbeing. This was below the England average of 83% in the same category between February 2016 and June 2016.
- Staff were aware of confidentiality and we saw them check the environment before discussing or sharing patient information.
- Staff asked patients if they wanted the door closed during chemotherapy.

Understanding and involvement of patients and those close to them

- Patients knew who their named nurses and consultants were.
- All patients we spoke with told us they felt involved in the planning of their care. They told us they had received full information about their treatment and the care and support that would be offered during their treatment and afterwards. Relatives also told us they had been provided with information and when in doubt they telephoned the ward and advice was always given.
- Information given to patients and relatives included information about the signs and symptoms to look out for following chemotherapy, and what they could do to relieve them. They also gave them in and out of hours contact details in case of advice or concerns.
- Patients we spoke with said they were told about any new medicines prescribed and what they were for in a way that they understood; and they continued to get their medicines at home where appropriate.

Emotional support

- Patients had access to counselling services. The hospital had an arrangement with a local NHS hospital trust to provide these services. At the time of our inspection this was on a trial and informal basis with a view to entering into a service level agreement at the end of the trial period if successful.
- There was evidence of an assessment of spiritual needs in all the patient notes we looked at. We also saw that staff assessed social and emotional needs and these were recorded in the patients' records.
- Patients from Pinner Ward had access to a local cancer centre (a charity). The centre provided complimentary therapies to patients diagnosed with cancer. Counselling services were also provided there. There was no formal service level agreement at the time of our inspection. There was an agreement between the cancer centre and consultants working at BMI Bishops Wood that consultants working at a local NHS hospital trust and at BMI Bishops Wood could arrange for their patients to access the cancer centre.

Are medical care services responsive?

Good

We rated responsive as good.

Service planning and delivery to meet the needs of local people

- BMI Bishops Wood reported that out of all inpatients and day case patients seen between July 2015 and June 2016, 76% were non NHS and 24 % were NHS referrals. Following the inspection the provider told us that the hospital does not admit NHS oncology patients and that NHS patients requiring endoscopy go through theatres. If they need to stay in,they go to the surgical ward (Northwood Ward).
- It was a requirement of BMI Healthcare practising privileges policy that consultants remain available or arrange appropriate alternative named cover at all times when they had inpatients in the hospital.
- Relatives were allowed to stay overnight and staff provided a foldable bed for them. Patients we spoke with told us that the ward allowed their relatives to stay overnight if that was required, for example, because of long distance from the hospital. Relatives staying overnight could also use the en suite facilities in the patient room. Staff provided them with refreshments.

Access and flow

- Admissions to the medical ward and for endoscopy were planned. This meant the hospital did not have any waiting lists for endoscopy or chemotherapy treatments. Patients attended outpatients where consultants made the appropriate referrals for treatment.

- Patients were offered treatment according to their availability and the clinical need or urgency for the treatment.
- Between July 2015 and June 2016, above 90% of all patients were admitted for treatment within 18 weeks of referral. This met national waiting times for patients to wait no longer than 18 weeks for treatment after referral.
- Some cancer patients may have had their diagnosis elsewhere such as in the NHS. However, patients whose diagnosis was at BMI Bishops Wood Hospital would start on their treatment pathway within two or a maximum of three weeks from diagnosis, dependant on findings through screening.Patients diagnosed elsewhere received treatment within the same time period from referral to the hospital.
- Patients reported that they sometimes had to wait for chemotherapy treatment if staff required the authority of a consultant to commence treatment, for example, if a reduced dose as required. One patient said there was a "slight wait". However the hospital reported an incident in May 2016 where a patient waited an hour and twenty minutes for chemotherapy as it had not been ordered on time.
- Discharge planning for patients involved coordination with district nurses where patients were receiving palliative care. Discharge summaries were sent to the district nurses. Staff reported that sometimes patients' discharge from the medical ward was delayed because district nurses did not have capacity.
- Data received from the hospital prior to the inspection revealed that between July 2015 and June 2016, the hospital cancelled 11 patient appointments. None of the patients had been offered another appointment within 28 days of the cancelled appointment.
- The nature of the private work at the hospital enabled choice for patients in respect of when they access the care they need.
- Patients' blood tests were sent to an external company. There were arrangements for the collection of bloods by courier at 11am, 3pm and 8pm. Staff reported some delays in receiving bloods and this sometimes caused delays in administering or ordering chemotherapy. The hospital had the capability to carry out some but not all blood tests using machines in the hospital.

Meeting people's individual needs

- Between February 2016 and June 2016, the hospitals patient-led assessment of the care environment (PLACE) scores for dementia were 77%. This was lower than the England average of 80%. The scores for disability were 70% which was lower than the England average of 81%.
- The hospital had few dementia patients. The director of clinical services told us that this was a rare occurrence and the few patients living with dementia received one to one nursing from a dementia trained nurse.
- Patients had access to a psychotherapist, a service provided to the hospital via a service level agreement.
- Relatives and patients told us visiting times were flexible and visitors could arrange to visit at a time outside the normal hours.
- Interpreter services were available to patients at BMI Bishops Wood hospital. However services had to be requested from a nearby BMI hospital.
- There was no critical care service at the BMI Bishops Wood hospital. Patients requiring critical care could be transferred to a nearby BMI hospital which was which had a critical care unit. It was up to the consultants to decide where the patent would go. Staff told us that another option was for consultants to arrange care at the NHS hospitals where they worked.
- Patient information booklets were not readily available in other languages. If another language was required they would have to be ordered. This meant that patients who did not understand English did not have ready access to patient leaflets in their own language.
- Patients whose observations revealed they needed more monitoring were moved to rooms closer to the nursing station so staff could check on them more.
- There were seven chemotherapy rooms on the medical ward and they were part of the 42 beds spread between the surgical and medical wards. The rooms had individual chairs and were also ensuite. All chemotherapy rooms had a mood wall. This was a

television screen with the ability to play music and display visuals. It was meant to give the patient of what music they wanted to hear whilst receiving chemotherapy treatment.

- We found that patient rooms had safes for patients to store valuables during admission or chemotherapy treatment.
- There were a number of service level agreements in place for services to be supported or provided to the hospital. For example, BMI Bishops Wood patients having access to chaplaincy and counselling services at a local NHS acute trust.
- The hospital provided chaperone service in line with their policy on the provision of chaperones during examination, treatment and care.

Learning from complaints and concerns

- The medical service did not report any complaints between 1 July 2015 and 30 June 2016. The hospital reported 35 complaints in the same period but these were not related to medical patients.
- BMI Bishops Wood used the information leaflet "Please tell us" which provided guidance on raising concerns and was available throughout the hospital including at reception. Staff were aware of the complaints process for the hospital.
- Staff were encouraged to identify and address patient/visitor concerns whilst they were still on site and escalate to their line manager for prompt resolution. Ward managers escalated complaints and concerns to the manager on call, the executive director or the director of clinical Services.
- The quality and risk lead led the investigations of and responses to all non-clinical complaints. The director of clinical services oversaw all clinical complaints. The executive director oversaw the management of all complaints within the hospital. Complaints were reviewed at weekly senior management team meetings and at the clinical governance and medical advisory committee meetings.

Are medical care services well-led?

Requires improvement

We rated well-led as requires improvement.

Vision and strategy for this this core service

- The service had a clear corporate vision in place to be achieved by 2020. There were eight strategic priorities which focused on patient outcomes, patient experience and financial viability. The strategy for BMI Bishops Wood reflected the corporate vision. The strategic priorities were effective organisational and governance structures , providing the highest quality of clinical care, being an employer of choice for staff, business growth, maximising efficiency and cost management, improving and updating facilities, improving communications within BMI and with stakeholders and managing effectively. The hospital’s strategic plans were shared with staff through heads of department and senior nurse meetings.
- Staff were aware of the vision and strategy for the service and this was evident in our interviews with them. Staff spoke about the National 6 C’s campaign which helped staff to focus on six key areas; care, compassion, competence, communication, courage and commitment.
- The oncology service on Pinner ward developed its strategy to meet the needs of its patients with The Macmillan Quality Environment Mark (MQEM) a detailed quality framework used for assessing whether cancer care environments meet the standards required by people living with cancer.
- The risk register for the hospital showed 23 rooms in the hospital were to be fitted with vinyl flooring. This figure included three out of the seven inpatient rooms on Pinner ward. The risk register also showed that 29 rooms were to have sinks replaced on both the medical and the surgical wards. Also, there were plans to move pharmacy to a different part of the hospital as it was considered small. The hospital’s risk register stated there was lack of suitable working space in pharmacy, risk of exposure to cytotoxic agents, musculoskeletal injuries and stress.
- The quality and risk lead told us the risk related to use endoscopy equipment being carried through theatres to access the sluice would be addressed as part of the hospital’s ongoing refurbishment plan.
- There were plans to expand the outpatient chemotherapy service in conjunction with the hospital’s consultants.

Medical care

Governance, risk management and quality measurement

- The quality and risk lead was responsible for clinical governance, risk management and the hospital's audit programmes amongst other responsibilities.
- BMI Bishops Wood had a risk register covering all risks relating to the hospital. Risks were discussed at monthly senior management team meetings and we saw risks were weighted depending on severity and actions were taken to mitigate them. The register included a description of the risk, controls in place to mitigate the risk and a summary of actions taken. Senior leads and ward sisters had a good knowledge of the risks contained within this register.However there was no risk register for the end of life care. This meant that there was no framework in which risks that threatened the delivery of the service were being captured.
- The risk register for Pinner ward showed risks relating to carpets, and the replacement of intumescent strips in patient rooms. Intumescent strips are designed to help prevent the spread of fire and smoke into other areas of a building. Risks were reviewed monthly by the risk management committee.
- There was a clear governance and risk management structure with well-defined accountabilities. The executive team used various methods to gain assurances from the ward to the board. There were committees in place, which fed into the integrated governance committee and the Medical Advisory Committee (MAC). Committees included health and safety, heads of department, infection prevention and control, risk management, and patient safety committee. The MAC met every two months. Evidence obtained during inspection indicated that the MAC met in February, April, May, July, and September 2016.The provider confirmed that consultants with practising privileges for all the major specialties including oncology were represented on the MAC.
- Clinical governance and risk management meetings took place monthly. At these meetings, discussions and conclusions from health and safety, and resuscitation and safeguarding meetings were discussed. The resuscitation and safeguarding meetings take place every three months.
- The ward manager for the medical ward attended the monthly clinical governance meetings. Meetings were attended by representatives from various departments and oncology was represented and discussed at these meetings. Agenda items included equipment and environment, infection prevention and control, audits, medicines management, National Institute for Health and Care Excellence (NICE) guidelines and the risk register. The clinical governance bulletin was also discussed in the clinical governance meetings with a focus on lessons learnt from other BMI hospitals. This information was cascaded to staff by senior staff in attendance to these meetings. We found that the clinical governance bulletin was displayed on the notice board in the nurses' office on Pinner ward.
- Ward meetings were expected to take place monthly. However staff told us these meetings did not always take place. Bank staff were not always able to attend staff meetings on the ward but they told us minutes from minutes were displayed in the staff room.
- Senior clinical staff maintained quality measurement and performance dashboards for each service. They discussed outcomes at the clinical governance and head of departments' meetings and made comparisons with other BMI healthcare hospitals. Clinical staff had access to these performance dashboards.
- There were systems and processes in place to ensure that consultants maintained safe practising standards and around the granting of practising privileges.

Leadership and culture of service

- The medical care service was led by the director of clinical services.
- The leadership on the medical ward included the ward manager who managed both the medical and the surgical ward due to a ward manager vacancy on the medical ward at the time of our inspection.
- Staff reported that the director of clinical services attended the ward daily. They also reported the executive director conducted regular walkabouts where he was visible to staff within the hospital. Staff told us they would be comfortable raising concerns directly with the ward manager, the director of clinical services or the executive director.

Medical care

- Resident Medical Officers (RMO) felt supported in their roles and told us they would be comfortable raising concerns with consultants. One Resident Medical Officer said BMI Bishops Wood was “the best out of all the hospitals” they had worked at.
- Staff reported they liked the fact that BMI Bishops Wood Hospital was a small hospital in comparison to other hospitals and they liked this about working there. They spoke positively about how they knew most staff in the hospital and how it felt like a family.
- One of the sixteen staff we spoke with told us they were bullied by their line manager. They told us this had been escalated to the director of clinical services and the executive director of the hospital.
- Staff also reported they did not always get their breaks. Other staff reported that the quality of food provided at the staff canteen could be improved on.
- Bank staff we spoke with told us they felt supported and valued by their colleagues and by their managers.

Public and staff engagement

- Feedback forms were given to patients in order to gather their views about the service. During the inspection we looked at feedback forms relating to patients who had received treatment in various departments of the hospital. We found that feedback had been positive.
- Information received from BMI Bishops Wood prior to the inspection indicated that on call managers visited patients to obtain their feedback on their personal experience in the hospital including nursing and consultant care and whether they would recommend the hospital to others. BMI Bishops Wood also used a Quality Health Questionnaire to obtain feedback on patients’ experiences of using the hospital throughout their patient journey. This included the friend and family test recommendation asking patients if they would recommend the hospital to their friends or family. The results were discussed within management teams and fed back to each department. That information also indicated that BMI Bishops Wood took part in the yearly corporate “BMI Say” survey.
- Staff engaged patients in cancer awareness and fundraising events. For example, the service held a Pink Day event and a Coffee Morning once a year. The coffee morning involved staff and patients bringing cakes which were sold as part of the fundraising. Staff and patients wore a pink item of clothing on Pink Day as part of the fundraising event. During the inspection we saw leaflets informing patients and visitors about the Pink Day.
- Patients had access to a breast care support group “Wonder Women” which was a place where patients could be engaged.
- Staff had been involved in the refurbishment of the medical ward. Staff ideas and input were taken into account in the refurbishment of the chemotherapy rooms. Staff we spoke with told us they had had been consulted about the colour of the chairs and had been involved in the ideas around the mood wall. The mood wall is a television screen with the option of playing different types of music. It also displays visual graphics which patients could find relaxing during chemotherapy.
- Staff also reported they had been involved in the process for adopting a new food menu for the hospital canteen.
- Data received from the hospital indicated that the hospital had a staff recognition and reward scheme which involved staff being encouraged to nominate individuals who had displayed “Above and Beyond” behaviours or actions. Names were collated at the end of each month for staff to vote for the winner.
- Staff were in involved in various campaigns at BMI Bishops Wood, for example, the "Hello… My Name is" campaign to encourage staff to introduce themselves to patients and reflect on their practice to ensure that all patients were treated with dignity and respect at all times.

Innovation, improvement and sustainability

- We saw evidence of nurse led initiatives and innovation such as the patient support group “Wonder Women”.
- A refurbishment of the medical ward took place in 2015 and we saw notable improvements in patient’s rooms. We were able to make comparisons because not all rooms had been refurbished.

Medical care

- The BMI Bishops Wood hospital oncology service had been awarded the Macmillan Quality Environment Mark (MQEM), a detailed quality framework used for assessing whether cancer care environments meet the standards required by people living with cancer in 2015.

Good

Surgery

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

Information about the service

A range of surgical specialties are available at BMI Bishops Wood, for example orthopaedics, ophthalmology, urology, ear nose and throat, general and gynaecology. Patients attend preoperative assessments and are then booked into an appropriate surgical slot. Patients are accommodated in the five-bedded day case unit (for stays of six hours or less) or in individual rooms on the 26-bedded inpatient ward (Northwood). There are two multi-specialty theatres available, both with laminar flow, and there was also a minor procedures theatre. Between July 2015 and June 2016 there were 4135 visits to theatre, including day cases and outpatient procedures.

We visited the surgical service at BMI Bishops Wood for two announced inspection days. During our inspection we inspected the preoperative assessment clinic, theatres, recovery and the inpatient ward, and spoke with 16 members of staff including doctors, nurses, allied health professionals and ancillary staff. We also spoke with the surgical leadership team, 11 patients and five relatives. We reviewed information provided by the hospital, twelve patient records and checked many items of clinical and nonclinical equipment.

Summary of findings

Overall, we rated this service as good. We gave this rating because:

- A range of evidence based practice was observed, such as the use of enhanced recovery programmes, as well as adherence with guidance from organisations like National Institute for Health and Care Excellence (NICE).
- Procedure specific data, mortality rates, unplanned readmissions to hospital and unplanned returns to theatre indicated that patient outcomes were good.
- Staff working throughout the service were competent, and supported to identify their learning and development needs.
- Feedback we received from patients was positive and they told us they received clear information from staff, as well as opportunities to ask questions.
- NHS and private patients could access care in a timely and efficient manner. Information provided by the hospital indicated 92-99% compliance within the 18 week referral to treatment time target for NHS patients between July 2015 and June 2016.
- Children and young people could be accommodated by the service and specific arrangements were in place to ensure the care they received was appropriate.

Good

Surgery

- A focus on quality and safety throughout the surgical service was evident, with appropriate governance structures in place and regular audit programmes including cross-site audit completion.
- Staff feedback about the leadership team was positive and managers were described as approachable and friendly.

However:

- A number of environmental concerns posed infection prevention and control risks to patients.
- The rate of surgical site infections in four key areas was worse than the average performance in other independent acute hospitals.
- Processes for identifying patients without mental capacity were not robust and we observed a consent form signed by a patient who did not appear to have capacity.

Are surgery services safe?

Requires improvement

We rated this service as requires improvement for safe because;

- The rate of surgical site infections in four key areas was worse than the average performance in other independent acute hospitals.
- Root cause analysis did not suitably explore the causes of the surgical site infections. For example, one RCA for a surgical site infection following a total hip revision reviewed the actions taken once the infection had been identified, and did not fully review the potential reasons why the infection occurred.
- During the inspection we noted that majority of clinical staff received level one safeguarding vulnerable adults and children training. This was not sufficient to comply with the recommendations from NHS England which suggest that all clinical staff should have a minimum of level two safeguarding training, therefore the training provision did not meet this recommendation. However following the inspection all clinical staff had completed safeguarding level two training for vulnerable adults with a number that had completed level three safeguarding for children and young people.
- A number of environmental concerns posed infection prevention and control risks to patients:
  - The theatres sluice did not have a handwashing sink for staff therefore they had to use the same sink in which used surgical instruments were rinsed in.
  - Used endoscopy equipment was carried through the theatres (when not in use) to the used equipment storage area.
  - Patient rooms on Northwood did not have designated hand wash sinks, which meant staff washed their hands in patient basins.
  - Carpeted floors in patient rooms were not in line with infection prevention and control guidance due to the

difficulties with sufficiently cleaning this type of flooring.There is an ongoing refurbishment plan which will include replacement of the carpet in inpatient rooms.

However:

- There was full compliance with the WHO Five Steps to Safer Surgery checklist
- A strong incident reporting and feedback culture was evident and staff were able to give examples where learning points from incidents had been disseminated.
- Medicines were stored, administered and prepared correctly. Staff completed medicines competencies before being able to give medicines to patients.
- Patients records, including risk assessments, were stored correctly, fully completed and legible.

Incidents:

- Incidents were reported on paper-based forms which staff passed on to the theatre or ward manager, as appropriate. Incidents were followed up by the relevant manager, who communicated their findings to the quality and risk team. This team then inputted the incident data onto a computer-based system and further reviewed the incident if appropriate.
- Staff throughout the surgical service were able to identify the types of situations which would trigger them to complete an incident form, such as patients arriving for procedures without a preoperative assessment and out of date equipment.
- Senior staff told us any significant incidents were also raised at the Comm Cell meeting held with the senior management team and other area managers daily, and this facilitated immediate awareness of key issues throughout the hospital.
- There were 167 clinical incidents and 45 non clinical incidents reported by the surgical service between July 2015 and June 2016.
- The was one never event in August 2015. This was a wrong site surgery where the incorrect teeth were removed. The never event was fully investigated using root cause analysis and actions were put in place to reduce the risk of the same event occurring again, such as double checks of the consent form against the booking form. We observed these checks taking place during our inspection.
- Learning from incidents was passed onto staff during daily team huddles in theatre, in handovers on the ward and in team meetings. Staff were able to recount learning points from incidents, including those from the never event.
- During the inspection we found no records of formal morbidity and mortality meetings held in the hospital due to the low number of patient deaths. Patient deaths were discussed at hospital-wide clinical governance meetings and debrief meetings were also held with staff involved in the patient’s care if appropriate.However following the inspection, the provider told us that they held monthly mortality and morbidity meetings, including both surgical and medical services.
- Some staff were unaware of the term duty of candour but were familiar with the principles, and described the need to be open and honest with patients when mistakes occur. Staff told us patients would be immediately informed if there were any issues with their care and an ongoing dialogue between the hospital staff and patient regarding the issue would occur.
- Senior staff told us they encouraged transparency throughout the service, which included transparency during communications with patients.

Safety Thermometer:

- The NHS Safety Thermometer is a national tool used for measuring, monitoring and analysing common causes of harm to patients receiving NHS funded care, such as new pressure ulcers, catheter and urinary tract infections (CUTI and UTIs), falls with harm to patients over 70 and venous thromboembolism (VTE) incidence. A single day ‘snapshot’ of all NHS inpatient safety data was submitted to the database on a monthly basis.
- Between October 2015 and September 2016, there were no new pressures ulcers, catheter and urinary tract infections or VTEs reported to the safety thermometer. During this period, one fall with harm was reported.
- Safety thermometer data, or an equivalent for private patients, was not displayed at any point of the surgical

service. A quality and safety board was on display in the stairwell, however this displayed staffing levels, patient satisfaction and "you said, we did" rather than specific safety performance data.

Mandatory Training:

- All staff were required to complete several mandatory training modules including information governance, basic life support and health and safety. Other topics such as aseptic non-touch technique, infection prevention and control and blood transfusion were also covered for those clinical staff requiring these specific skills. Training was completed by e-learning modules or classroom-based teaching.
- The hospital set a 100% target for mandatory training completion. Compliance of theatre staff with this training was 85.6% and senior staff told us any outstanding topics were already booked for most staff members. Compliance with mandatory training for ward staff was 90.3%. Senior staff told us a plan was already in place to improve compliance.

Safeguarding:

- Safeguarding training was provided as part of the mandatory training programme. All staff were received safeguarding vulnerable adults and children training level one. Managers responsible for the inpatient ward and theatres were required to complete safeguarding level two training for vulnerable adults and children. The safeguarding lead had completed level three training. NHS England recommendations suggest that all clinical staff should have a minimum of level two safeguarding training, therefore the training provision did not meet this recommendation.
- Staff were able to identify the types of situations which would trigger a safeguarding referral, however told us it was very rare that this was required. Staff were aware who the hospital's safeguarding lead was and told us they would discuss any concerns with the lead.

Cleanliness, infection control and hygiene:

- Housekeepers were allocated to each area of the service, and worked according to a schedule of work. Reviews of cleanliness were completed by senior staff and the housekeeping supervisor.
- We inspected the storage areas, anaesthetic rooms, operating theatres, recovery area, day case and inpatient ward. All areas of the surgical service were visibly clean, other than some dust on high level areas in theatre storage areas.
- Disposable curtains were used in recovery and on the day case ward, and staff told us they were changed quarterly or sooner if they became soiled.All curtains we inspected were dated and had been changed within the last month.
- All patients were swabbed have their procedure last on the operation list, to allow for a deep clean of the theatre overnight. Patient rooms were also deep cleaned when patients with MRSA had been accommodated within them.
- We observed thorough and efficient theatre preparation and cleaning between cases.
- A service level agreement was in place for an external organisation to complete decontamination of surgical equipment used at the hospital. Staff checked all equipment delivered to the hospital, and again when received in theatre, prior to an anaesthetic being given to the patient.
- The provision of the decontamination service was listed on the hospital risk register, as patient procedures would need to be cancelled if decontamination of equipment could not be completed quickly enough to meet service needs. The risk was fully mitigated at the time of our inspection, through improved communication channels between the decontamination provider and the hospital.
- There were 19 surgical site infections between July 2015 and June 2016:The rate of surgical site infections per 100 surgeries performed for primary knee arthroplasties (four infections in total), other orthopaedic and trauma operations (four infections), gynaecological procedures (three infections) and upper GI and colorectal operations (two infections) were worse than the average performance in other independent acute hospitals.
- The rate of infection for breast procedures (one infection in total) was better than infection rates in other independent acute hospitals.

- There were no surgical site infections resulting from primary hip arthroplasty, revision of knee arthroplasty, spinal or urological procedures.
- We saw evidence that surgical site infections were investigated using root cause analysis (RCA) when they had been identified, however investigations did not suitably explore the causes of the infections. For example, one RCA for a surgical site infection following a total hip revision only reviewed the actions taken once the infection had been identified, and did not fully review the potential reasons why the infection occurred.
- We saw that procedures regarding patient preparation for surgery, including appropriate theatre attire and antibiotic prophylaxis, were compliant with NICE CG74 (surgical site infections; prevention and treatment). Intraoperative and
- Endoscopies were completed in the minor procedures theatre, and equipment used during these procedures was covered with red plastic packaging before being taken to the theatres sluice. This meant staff carried used equipment through theatres (when not in use), which was not appropriate practice and placed patients at risk of cross contamination. Senior staff acknowledged this as a concern during our inspection and told us they were in the process of developing a more appropriate sluice area near to the minor procedures theatre so the endoscopy equipment did not have to be taken through the theatres.
- A number of sinks throughout the surgical service, including in recovery and in Northwood patient rooms, were not compliant with infection prevention and control best practice due to the type of taps in place. Additionally, there were no separate handwashing sinks in patient rooms which meant staff had to wash their hands in patients' basins. This was not in line with hand hygiene protocols. These issues were recorded on the hospital risk register and a programme to change the uncompliant taps had been organised by senior staff. No actions were in place to introduce separate handwashing sinks in the patient rooms.After the inspection the provider subsequently provided a document showing instructions to staff owing to the lack of handwash basins in patient rooms.
- We observed staff cleaning their hands with alcohol gel or soap and water at appropriate intervals throughout our inspection and in all aspects of the surgical service
- Hand hygiene audits were completed regularly in theatres and on Northwood. Results from these audits which showed 100% hand hygiene compliance, including bare below the elbows, on Northwood in January, March and June 2016. These results supported our inspection findings.
- In theatres, we only reviewed results from March 2016, which showed 60% of staff were bare below the elbows and 80% were compliant with hand hygiene. This did not reflect our inspection findings, as we observed all staff were bare below the elbows and cleaned their hands at appropriate intervals.
- Personal protective equipment (PPE), such as gloves and aprons, was available throughout the surgical service. We observed staff wearing and disposing of PPE appropriately.
- The patient rooms on Northwood had carpeted floors, which was not in line with infection prevention and control guidance due to the difficulties with sufficiently cleaning this type of flooring. This issue was listed on the hospital risk register and senior staff told us a flooring replacement programme had been approved and was due to start imminently.This will include replacement of the carpet in inpatient rooms.
- Within Northwood sluice, we saw bags of dirty laundry stored alongside bags of clinical waste on the floor, which was not appropriate storage. Additionally, it was difficult to access some cupboards and the commode as the bags were blocking the way.
- An infection control link nurse was allocated on the ward and in theatres. This staff member was responsible for liaising with the infection prevention and control lead in the hospital, completing relevant audits and assisting staff with any applicable queries.

Environment and equipment:

- The two main operating theatres had laminar airflow systems, which was best practice for ventilation within operating theatres.
- Both of the main operating theatres had access to a shared sluice area. All used surgical equipment was

processed in this sluice prior to being sent for decontamination. There was only one sink in the sluice, which was used for rinsing dirty instruments and for staff handwashing. This was not appropriate and increased the risk of infection to patients. The theatres sluice area was listed on the hospital risk register as “not fit for purpose” because of this.

- Equipment matrixes were held for equipment throughout the surgical service. We reviewed the theatre equipment matrix which showed what items should be located in the department, the serial number of each item and its required service date.
- We inspected many items of equipment throughout the ward and theatres, and saw that the equipment had been safety tested recently. Dates were recorded on each item to highlight when the next test was due.
- All equipment used in theatres was checked once each day by an operating department practitioner, and again by the anaesthetist in charge of the case. This was in line with recommendations from the Association for Perioperative Practice (AfPP).
- New anaesthetic machines had recently been purchased for the theatres department, and senior staff told us there had been some problems with machines breaking down. They told us these issues were always reported as incidents and the department was working alongside the manufacturer to address the issue. This matter was placed on the risk register for further monitoring.
- There were two resuscitation trolleys in recovery; one for paediatric patients and one for adults. Staff told us that the trolley contents were checked daily when theatres were in use, and documentation we reviewed supported this. We also saw evidence that equipment on the resuscitation trolley was calibrated daily, such as the defibrillator.
- We saw evidence of additional emergency equipment within theatres. For example, in the stock room adjacent to theatre one, an emergency tracheostomy kit and a difficult airway kit were available.
- Contents of resuscitation trolleys and emergency kits within theatres were all seen to be in date.
- There was a paediatric resuscitation trolley available in the day case unit on Northwood. Staff told us it had been decorated in cartoons and stickers to ensure staff realised it was a paediatric trolley and did not try to use it for an adult resuscitation. We saw evidence this trolley was snap locked, and checked weekly. There were no gaps in checking documentation and all items were seen to be in date.
- An adult resuscitation trolley was also available on Northwood and we saw evidence the trolley was secured with snap locks, and checked weekly. There were no gaps in checking documentation and all items were seen to be in date.

Medicines:

- Pharmacy support was available from 8am to 5pm Monday to Friday. Outside of these times, an on call pharmacist was available to provide support and advice for the care of patients in the hospital.
- There were two medication incidents attributed to the surgical service between April and July 2016. One related to a patient who was readmitted due to a postoperative deep vein thrombosis (DVT) and one related to a patient who had an allergic reaction to a medicine in theatres.
- On the ward, medicines were stored in a lockable cupboard, located within the ward treatment room. Keys to the cupboard were held by the nurse in charge, and accessed by other authorised staff when needed.
- Medicines were also stored in appropriately secured units in theatres.
- All permanent staff were required to complete medicine competencies for oral and IV medicines prior to being able to give medicines to patients. We saw a number of completed competency documents within a folder stored in the treatment room and staff we spoke with confirmed that they had completed companies prior to giving medicines independently.
- Agency staff completed competencies for giving oral medicines when they started work in the hospital. Agency staff were not authorised to administer IV medicines.
- The medicines cupboard was organised alphabetically to assist staff in finding items quickly, and medicines we checked were seen to be in date.

- The controlled drugs (CDs) were stored within the lockable medicines cupboard, with a separate lock on the CD storage. The CD stock book and signatory list were also stored within the medicines cupboard. We reviewed the stock levels of three randomly selected CDs against the stock book and saw that the record was accurate.
- We observed staff preparing and administering oral and IV medicines, as well as CDs and noted that they followed appropriate procedures, including having two staff present when needed and correctly documenting what CDs had been used in the stock book.
- Quarterly medicines management audits were completed in theatres and on the inpatient wards. Staff told us the target for these audits were 100% compliance. Results for theatres from February and May 2016 were 93% and 95% respectively. Results for the inpatient ward from February and May 2016 were 88% and 97%.
- Quarterly controlled drugs audits were completed in theatres and on Northwood. Staff told us the target for these audits were 100% compliance. Results for theatres in March and June 2016 were 100% each month. Results for Northwood from March and June 2016 were also 100% each month.

Records:

- Patient records were paper-based throughout the surgical service and files contained entries from medical staff, including outpatient consultations, operation notes and inpatient reviews. Nursing notes, including surgical care pathways and patient observations, were stored in a separate nursing notes file.
- On the ward, patient notes were stored in a padlock secured storage unit. We saw this unit was locked at all times when not in use.
- We reviewed medical and nursing records, and found records were fully completed in a legible and sufficiently detailed manner. Patient risk assessments were fully completed in the surgical care pathways, however none of the records we reviewed triggered initiation of a specific care plan (for example in response to a raised risk of pressure ulcers), therefore we were unable to see evidence of escalation of care in response to these assessments.
- Senior staff completed monthly patient health records audit. Results from these audits showed patient documentation was consistently completed to a high standard, although some aspects, such as patient unique identification on each page, was variable (100% in April and May 2016, 70% in June 2016).
- We saw secured confidential waste bins were available throughout the surgical service.

Assessing and responding to patient risk:

- The World Health Organisation (WHO) Five Steps to Safer Surgery checklist was in use within theatres and audit results showed consistently 100% compliance with the checklist in January, February and June 2016. Two other months scored over the 90% target; March (95.1%) and May (92.8%). Results from April were marginally below the target, at 89.6%.
- Patient health records audits from April to June 2016 showed that documentation relating to the WHO Five Steps to Safer Surgery checklist was correctly completed in 90% of patient records (April and June 2016) and 100% of records in May 2016. These results were an improvement from previous months, where correct completion was 80% in February and March, and 50% in January 2016.
- During our inspection, we observed theatres staff consistently completing the WHO Five Steps to Safer Surgery checklist correctly during the procedures we observed.
- A theatres audit was completed in May 2016 which assessed a range of patient safety and risk parameters, for example assessments of skin integrity and manual handling. The audits showed 92.9% full compliance with the set parameters, 6.1% partial compliance and 1% non-compliance.
- The hospital risk register listed theatre staff competence in procedures for the retrieval of blood in emergency situations. In response to this, senior theatres staff put additional staff training in place and 71% of theatres staff had completed the training by June 2016.
- Assessments completed as part of the preoperative assessment were reviewed by the medical team on patients' admission to hospital. More specific investigations, such as echocardiograms (ECGs), were reviewed by the anaesthetist who would be responsible

for the patient during their procedure. If no anaesthetist was identified on the patient's booking form, an anaesthetist was identified by the Medical Advisory Committee to review investigations as needed.

- All patients attending the hospital for a surgical procedure were assessed for their VTE risk as part of the surgical care pathway. We saw evidence these were fully completed in the records we reviewed. Patients were prescribed anticoagulant (blood thinning) medicines or mechanical VTE prophylaxis (such as massage boots) as required. We also saw that most patients were provided with pressure stockings.
- VTE assessment completion audits showed 100% of patients in July, August and September 2016 had their VTE risk assessed at appropriate intervals throughout their admission.
- If a patient had a history of poor mobility or there were concerns about their walking while admitted, a falls risk assessment was completed by staff. This could trigger a referral to the physiotherapy team for further review if needed. None of the surgical patients admitted during our inspection had needed a falls risk assessment, therefore we were unable to inspect this in practice.
- A pressure ulcer risk assessment was completed on admission for all surgical patients. Patients with a high risk of pressure ulcers could access pressure relieving equipment, such as air mattresses or chair cushions, if indicated by the results of this assessment. Staff told us it was very rare for surgical patients to have this kind of clinical need but it was always assessed. We saw fully completed pressure ulcer risk assessments in the records we reviewed.
- Staff told us patients exhibited confusion or delirium following their procedure would receive one to one nursing care to reduce the risk of the patient injuring themselves, for example trying to stand up on their own.

Nurse Staffing:

- Two tools for workforce planning were used to review ward activity and determine the staffing requirement for the following week. Nurses were generally allocated to care for six to eight patients at any one time, with support from health care assistants. Our observations of patient acuity and care delivered, as well as feedback from staff and patients, indicated that staffing was appropriate for the patients accommodated on the ward.
- Senior staff indicated that there was a cohort of regular Bank staff who were rostered to work shifts in the same way as permanent staff. They felt this was a helpful resource to make use of, as it allowed flexibility of staffing according to patient need.
- Some nurses were dual trained and could therefore care for both adults and children. The booking and paediatric teams liaised with the ward to ensure a paediatric nurse was available to work on the days that children and young people were booked in. Staff told us paediatric nurses could also accessed through nursing agency if required.
- Staffing within theatres was arranged according to the planned lists for the following week. We observed that staffing within theatres was compliant with recommendations from the Association for Perioperative Practice (AfPP).
- Staff told us vacancies, annual leave and unplanned absence were covered through Bank and agency staff; however there had been no use of agency staff to fill daytime shifts in the previous 12 months. Data provided by the hospital showed there were no unfilled shifts in theatres or on the inpatient ward between April and June 2016.
- Agency and Bank staff who commenced work at the hospital received a full induction to the local working area, including orientation to the ward and key procedures. We saw documented evidence that these inductions were completed.
- There was a theatre team available on call 24 hours a day, in case patients required an emergency return to theatre outside of normal working hours.

Medical Staffing:

- Consultants and anaesthetists who operated at the hospital were required to maintain current practicing privileges in line with the BMI practicing privileges policy to be eligible to work on site. At the time of our inspection, there were 246 consultants with practicing privileges at the hospital.

- Surgeons operated with a theatre team provided by the hospital and an assistant, who was either a surgical trainee from their primary hospital or a member of hospital theatre staff.
- Surgeons were clinically responsible for the patients admitted under their care, and were required to review their patients once per day as a minimum. This was achieved with support from the registered medical officer (RMO) who completed additional reviews as needed.
- RMOs were provided to the hospital by an external organisation. There was one RMO deployed to cover the inpatient wards for seven days to complete ward tasks such as assessing patients, inserting cannulas and writing drug charts.
- Appraisal rates for registered nursing staff and health care assistants on Northwood were low in July 2016 (52% and 57% respectively).

Are surgery services effective?

Good

We rated this service as good for effective because:

- A range of evidence based practice was observed, such as the use of enhanced recovery programmes, as well as adherence with guidance from organisations like National Institute for Health and Care Excellence (NICE).
- Procedure specific data, mortality rates, unplanned readmissions to hospital and unplanned returns to theatre indicated that patient outcomes were good.
- A comprehensive audit schedule ensured key topics were reviewed at regular intervals, allowing senior staff the opportunity to monitor performance.
- Staff working throughout the service were competent, and supported to identify their learning and development needs.

However:

- Processes for identifying patients without mental capacity were not robust and we observed a consent form signed by a patient who did not appear to have capacity. A review of the patient's medical notes identified a past medical history of dementia; however no documentation indicated capacity had been assessed or that a best interests decision had been made.

Evidence-based care and treatment:

- A clinical audit schedule was in place, outlining what needed to be audited in each department each month. For example, patient health records audits and VTE assessments. We saw evidence of actions in response to audit findings and staff told us they received feedback following audit completion.
- Specific surgical care plans were in use and were commenced depending upon what procedures patients were having, for example there was a separate care pathway for patients undergoing hip arthroplasty and hysteroscopy. This was because their post procedure care needs were different and the care plans reflected this. Care plans were based on best practice guidance and relevant national recommendations.
- Staff told us evidence-based enhanced recovery programmes were used following certain procedures in line with relevant best practice guidance, for example following hip arthroplasty surgery. We saw evidence of postoperative care leaflets which were based on best practice guidance.
- Staff working within preoperative assessment told us the investigations that were requested for each patient adhered to NICE NG45 (Routine preoperative tests for elective surgery). We saw evidence of staff referring to this guideline during our inspection and that tests which had been requested adhered to the guideline.
- The 'American Society of Anaesthesiologists' (ASA) physical status classification was used to establish the physical status of patients prior to undergoing anaesthesia and followed best practice guidance.
- Nursing staff on the inpatient ward assessed and recorded patient visual infusion phlebitis (VIP) score in line with the '

Nutrition and hydration:

- Meals and nutrition included options for those with specific nutritional or religious needs. Options included hot and cold meals, as well as healthy options.

- Patients were provided with water jugs and glasses, and we saw these were left within patient reach. Hot drinks were also offered to patients frequently.
- Staff used the Malnutrition Universal Screening Tool (MUST) to assess if patients were undernourished or at risk of becoming undernourished. We saw these assessments were completed in the surgical care plans we reviewed, however none of the patients triggered additional support therefore we were unable to inspect if staff responded appropriately to raised MUST scores.
- Staff told us it was rare that any patients requiring fluid monitoring or fluid restriction, and we did not see any patients having this information recorded at the time of our inspection. Staff were able to identify which forms would be used for this and explain how to calculate fluid balances when asked.

Pain relief:

- Patients received pain relief through IV medicines, oral medicines or patient controlled analgesia (PCA) devices, which allowed patients to administer a controlled amount of pain relief when they wished.
- Patients told us staff asked about their levels of pain whenever they were having observations taken and also during other interactions. They told us their pain was well controlled and staff brought analgesia quickly when requested.
- The patient feedback questionnaire from April to June 2016 showed that 92.3% of patients reported good or better pain management.
- Pain audits were completed monthly for surgical patients. We reviewed audit results from April and May 2016, which showed patients were prescribed pain relief however still had pain scores documented as seven or more out of a possible ten in some cases. It was unclear what the audits were monitoring or what actions were taken as a result of the audit findings.

Patient outcomes:

- There were no patient deaths within 30 days of surgery between September 2015 and September 2016.
- Between July 2015 and June 2016, there were four cases where patients had unplanned returns to theatre
- Between April 2015 and March 2016, there were six unplanned transfers of inpatients to other hospitals, either within the BMI hospital group or to an NHS provider if BMI was unable to provide the necessary treatments. The rate of unplanned transfers was not high when compared to other independent acute hospitals which submitted performance data to CQC.
- Between July 2015 and June 2016, there were six cases where patients had unplanned readmissions to hospital within 28 days of discharge. The rate of unplanned readmissions was not high when compared to other independent acute hospitals which submitted performance data to CQC.
- Between July 2015 and June 2016, there were 56 cases where patients had unplanned conversions from day case procedures to being admitted as inpatients. All of these patients were admitted as inpatients due to clinical complications post procedure, such as pain or vomiting.
- There was insufficient patient reported outcome measures (PROMs) data for primary knee replacement (for NHS funded patients) to calculate a result which could be compared with other centres. This was because of low numbers of eligible procedures. However, out of 20 modelled patient records, 100% reported improvement on the Oxford Knee Score. Additionally, out of 18 modelled patient records, the EQ-5D Index indicated 77.8% of patients reported improvement.The EQ-VAS (Visual Analogue Scale component of the EQ-5D) showed 33.3% were reported as improved out of 15 modelled patient records, and 33.3% were worse.
- There was insufficient patient reported outcome measures (PROMs) data for primary hip replacement (for NHS funded patients) to calculate a result which could be compared with other centres. This was because of low numbers of eligible procedures. However, out of 20 modelled patient records, 95% reported improvement on the Oxford Hip Score. Additionally, out of 16 modelled patient records, the EQ-5D Index indicated 93.8% of patients reported improvement.The EQ-VAS showed 53.3% were reported as improved and 13.3% as worsened out of 15 modelled patient records.
- There was insufficient patient reported outcome measures (PROMs) data for groin hernia treatment (for

NHS funded patients) to calculate a result which could be compared with other centres. This was because of low numbers of eligible procedures. However, out of 17 modelled patient records, the EQ-5D Index indicated 58.8% of patients reported improvement and 29.4% reported worse symptoms.The EQ-VAS showed 43.8% were reported as improved out of 16 modelled patient records and 25% were worsened.

Competent staff:

Nursing:

- All staff new to the hospital were required to complete the generic hospital induction. After this, staff were allocated a two week period of supernumerary practice on the ward or in theatres, to familiarise them to their new working area and working methods.
- New staff were allocated a mentor on the ward and shifts during the new starters' supernumerary period were completed alongside their mentor where possible.
- Senior staff told us new starters were encouraged to shadow different services throughout the hospital to develop an appreciation of how services interact and depend on one another.
- Student nurses received a thorough induction to the ward and were allocated a mentor, who worked alongside the student and helped them achieve their learning goals. Students told us they worked every shift with their mentor and had copious learning opportunities while at work.
- Staff working in preoperative assessment were registered with the Preoperative Association.
- Staff working in theatres rotated assumed different roles for different cases; for example we observed an ophthalmology list where three different staff members assisted the consultant. Staff told us this was beneficial because it meant everyone got the opportunity to do interesting cases and prevented complacency within the team.
- In theatres some specific competencies for different specialties and equipment were in use at the time of our inspection, such as competencies for patient warming equipment. Senior staff were working on competencies for other areas. In the meantime, senior staff told us they had self-assessment documents for staff to identify any learning needs.
- Staff received annual appraisals to identify any learning needs and to create a personal development plan for the upcoming year. Staff throughout the surgical service were positive about the appraisal process and told us it helped to identify their strengths as well as areas for improvement. The hospital set a 100% target completion rate for staff appraisals.
- In July 2016, 88% of registered nursing staff and 83% of ODP registered and health care assistant staff working in theatres had completed an up to date appraisal.
- In July 2016, 52% of registered nursing staff, 57% of health care assistants and 100% of other care staff working on the inpatient ward had completed an up to date appraisal.
- Staff received training through supervised working and also in formal training sessions. For example, theatres staff described receiving training on specific items of equipment from medical reps.
- Staff told us their development was well supported by the hospital. For example, one nurse described enrolling on a master's degree programme with assistance and support from the senior team.

Medical:

- Surgeons operated with an operating assistant, who was sometimes a surgical trainee from the consultants' usual place of work. Any operating assistants who were not employees of BMI Bishops Wood had to be booked into the theatre diary in advance and the staff member in charge of theatres on the day of the procedure was responsible for checking the assistant's relevant paperwork, such as General Medical Council (GMC) registration and occupational health clearance.
- RMOs were provided by an external organisation that completed relevant employment checks, such as DBS and General Medical Council registration. CVs were sent to the hospital for approval before new RMOs were sent to work there, and the hospital reviewed documentation to ensure relevant training and registration was up to date. Mandatory training was organised and overseen by the agency, not the hospital.

- New consultants and RMOs were inducted to the hospital by the director of clinical services and the relevant departmental managers.

Multidisciplinary working:

- Multidisciplinary meetings were held to discuss patient care options prior to them being admitted. Meetings were usually held on other hospital sites but involved discussion with a multidisciplinary team to determine the most appropriate treatment options for each individual patient.
- We observed several examples where different members if the team liaised throughout the surgical service, for example nurses and physiotherapists liaised closely on Northwood, discussing patient mobility and discharge plans. We also saw preoperative assessment staff discussing specific cases with consultants and anaesthetists as necessary.
- Ward staff were aware that patients were under the care of their admitting consultant throughout the course of their admission. Support could be obtained from the RMO and could be escalated to seek assistance from the consultant at any time required.
- Staff told us they felt comfortable contacting consultants out of hours to seek urgent clarification or support if needed.

Seven day services:

- There were two theatres available from Monday to Friday from 8am to 8:30pm and 7:30am to 5pm on Saturdays. Both theatres were set up for multiple specialities and could accommodate unplanned returns to theatre if needed.
- The minor procedures theatre was available Monday to Friday from 8am to 8:30pm, and could accommodate local or minor procedures only.
- Surgical patients could access imaging during department opening hours, however an on-call radiologist was available out of hours, when the imaging department was closed. This meant patients requiring urgent investigations could access this service, for example after a fall on the ward.
- Physiotherapy services were available seven days per week to assist with patient rehabilitation and mobility. An on-call physiotherapy service was available out of hours to treat patients with specific respiratory difficulties and those requiring additional mobility support.
- Pharmacy support was available from 8am to 5pm Monday to Friday. Outside of these times, an on call pharmacist was available to provide support and advice for the care of patients in the hospital.

Access to information:

- Patient information was compiled in medical notes or in the care plan documentation. These records followed the patient through their admission; from initial consultant and preoperative assessment to follow up outpatient appointments. Staff told us missing notes were rarely an issue.
- Upon patients' discharge from hospital a discharge summary, containing information about the patient's admission and operation details, was sent to the patient's GP to ensure continuity of care in the community. A copy of the discharge summary was also given to the patient for their reference.
- Where patients were funded by private health insurance, copies of relevant documentation were also sent to the insurers, along with any invoices.
- Certain investigations could be completed on site, such as some blood tests and imaging, which allowed staff quick access to results. Staff told us that other results, such as group and save blood tests, had to be sent off site for testing which meant a slightly longer wait for results. Staff told us urgent results could be obtained in three to four hours, although the wait for standard tests was usually a maximum of two to three days.However the provider subsequently told us that the turn around time was 24 hours for non urgent blood tests,and for urgent blood tests this would be within two to three hours as per the service level agreement (SLA).

Consent, Mental Capacity Act and DoLS:

- Patients were consented and marked for their procedure in their individual room on the ward. We reviewed results from a consent audit completed in March 2016. The audit showed 100% compliance with consent procedures, such as completion of relevant documentation by both surgeon and patient. Patient health records audits also showed completed corporate consent forms were found in 100% of audited records between January and June 2016.

- Staff throughout the surgical service told us patients without capacity would be identified by the consultant, at the point of booking or during the preoperative assessment. We were concerned that this process was not robust because we observed a consent form signed by a patient who did not appear to have capacity. A review of the patient's medical notes identified a past medical history of dementia; however no documentation indicated capacity had been assessed or that a best interests decision had been made.
- Ward staff were clear that they needed to ask for patients' consent prior to completing any care tasks, such as taking observations or changing dressings. Staff told us they would do these tasks in patients' best interests if the patient was unable to consent. Some staff told us they would ask patients' family members for consent in this circumstance, which is not appropriate as family members cannot consent on behalf of a patient unless they are identified legally as the patients' advocate.
- Senior staff were aware of deprivation of liberty safeguards (DoLS) and identified that policies and risk assessments were in place, however they were unclear what type of situations the hospital's DoLS policy should be instigated.
- Some ward staff demonstrated an awareness of DoLS, however others confused this with Duty of Candour and were not able to describe DoLS when prompted.

Are surgery services caring?

Good

We rated this service as good for caring because:

- Results from the inpatient feedback questionnaire indicated patients were happy with the care they received and were treated with dignity and respect.
- Cards on display demonstrated patient gratitude for the standard of care they received.
- Feedback we received from patients was positive and they told us they received clear information from staff, as well as opportunities to ask questions.
- Relatives were trusted staff would take care of their loved one and praised the care provided throughout the surgical service.

Compassionate care:

- The patient feedback questionnaire from April to June 2016 showed that 96.2% of inpatients reported that the care they received met or exceeded their expectations.
- We saw numerous cards and thank you letters from previous patients, praising the care they had received. Cards thanked staff for the "care and attention" and the "great care" they provided.
- Patients told us staff were "kind and friendly", and that "nothing [was] ever too much trouble". They told us staff chatted to them as they worked and made an effort to make them feel comfortable.
- Relatives were positive about the care provided by staff throughout the surgical service and told us they were "confident that [all staff] do their best".
- We observed that patient call bells were answered quickly and patients told us they did not have to wait very long for a member of staff to come to them.
- Patients told us staff treated them with dignity and respect. They described how staff ensured patients remained suitable covered, even when they were on the operating trolley prior to their procedure and afterwards when getting in or out of bed.
- The patient feedback questionnaire from April to June 2016 showed that 99% of patients reported being treated with respect and dignity throughout their admission. The patient questionnaire also showed that 100% of patients reported that they were given privacy when discussing their procedure with staff.

Understanding and involvement of patients and those close to them:

- Patients told us they receive full and understandable explanations about their procedure prior to the admission, and again when signing the consent documents. They told us they were offered the opportunity to ask questions and answers provided were clear and explicit.

- Relatives told us they were involved in discussions about the patient care and were also asked if they had any questions. One relative told us they “had been apprehensive about [the patient’s] procedure but the surgeon was reassuring and [the relative] trusted their opinion”.
- The patient questionnaire from April to June 2016 showed 99% of patients reported feeling suitably involved in decisions made about their care.
- Patients and their relatives told us most staff introduced themselves when they first met and that they knew who was looking after them.

Emotional support:

- Staff told us they provided emotional support to patients and the patient questionnaire from April to June 2016 showed 100% of inpatients reported feeling able to speak to hospital staff about their worries or fears during their admission.
- Theatre staff acknowledged that having medical procedures was an anxiety provoking time for patients and told us it was important that patients felt supported at all times. We observed staff offer to hold a patient’s hand during the procedure when the patient voiced feeling nervous.
- We observed surgeons chatting to patients as they completed procedures, asking the patients about their friends and family to put them at ease.
- One relative told us they felt very upset when the patient was taken for their procedure and described how a member of staff spent time with them until they felt less upset.

Are surgery services responsive?

Good

We rated this service as good for responsive because:

- NHS and private patients could access care in a timely and efficient manner. Information provided by the hospital indicated 92-99% compliance within the 18 week referral to treatment time target for NHS patients between July 2015 and June 2016.
- Flow through the surgical service was unimpeded and patients transitioned throughout different aspects of the service without delay.
- Children and young people could be accommodated by the service and specific arrangements were in place to ensure the care they received was appropriate.
- Patients could access preoperative assessment appointments outside of normal working hours, which facilitated access for working patients.
- Staff in the service strived to meet patients’ individual needs and used a holistic approach to plan patient admissions.

However:

- No specific support mechanisms for patients with a learning disability or those living with dementia were identified.

Service planning and delivery to meet the needs of local people:

- Procedures completed at the hospital were elective and patients’ length of stay was usually predictable, which made planning admissions and discharges more straight forward. It also meant theatre times were relatively consistent and therefore service activity could be anticipated.
- Staff told us they could accommodate patients who needed to return to theatre or a slightly longer inpatient admission without affecting other planned activities because the planned services had sufficient leeway to absorb this.
- Hospital data indicated there were 11 procedures cancelled for nonclinical reasons between July 2015 and June 2016. Staff told us this was usually due to patients eating before their procedure, despite having been told to be nil by mouth. We observed staff in the preoperative assessment clinic advising patients how long they needed to be nil by mouth before their procedure.

- Services were delivered according to what individual consultants wished to provide for both NHS and privately funded patients. However, when specific surgical services were commissioned at the hospital, the hospital worked with their consultant-base to ensure the terms of the commissioning contract could be met.
- Surgical inpatients were accommodated in individual rooms on the inpatient ward. Each room had en suite bathroom facilities. Patient rooms had their own air conditioning control which meant patients were able to set the temperature for their own comfort.
- Day case patients were accommodated in the day unit, located near the nursing station on the surgical ward. If day case patients were expected to on the ward for more than six hours, staff tried to accommodate them in an individual room instead.

Meeting people's individual needs:

- The hospital accepted referrals for children and young people to undergo surgical procedures. Staff told us these were usually completed as day case procedures, although there were some occasions when overnight stays were required. In this instance, parents were able to be accommodated in the patient's room.
- All bookings for paediatric patients were reviewed by the hospital paediatric team, who liaised with the ward to ensure that they could accommodate a child on the booked day.
- Staff told us they assumed a holistic approach when planning patients' procedures. For example, staff told us a patient had recently been asked to reconsider their hip arthroplasty because there would be no one at the patient's home to help their recovery. Staff felt this placed the patient at risk, and the patient's procedure was delayed until family support could be organised.
- There were no specific support mechanisms in place for patients with a learning disability or those living with dementia, and staff told us there were no link nurses identified. Staff told us advice would be sought from the patients' family members or own carers, to guide and support the patients' admission.
- Information leaflets were available throughout the service and we saw these staff providing these to patients.
- Translators were available over the telephone or to attend the hospital for face to face meetings if needed. We also saw a list of voluntary translators, comprised of bilingual hospital staff members.

Access and flow:

- NHS patients could access surgical services at the hospital via the 'choose and book' system, where services had been commissioned by local clinical commissioning groups (CCGs). Surgical services could also be accessed by NHS patients where specific contracts had been agreed with other local providers. For example, a local hospital could sub-commission procedures to BMI Bishops Wood.
- Patients who were self-funding their care or with private health insurance accessed surgical services at the hospital via GP referrals direct to specific consultants.
- Surgical bookings were made at a convenient time for the patient and surgeon involved. A designated team within the hospital was responsible for ensuring NHS patients accessing elective consultant-led care and treatment at the hospital did not wait more than 18 weeks from referral to treatment. Hospital data indicated that waiting times were dependent on consultant and patient availability rather than access to theatres or ward beds, which could be made available within five days. Hospital data showed that between 92-99% of patients received treatment within 18 weeks in the period July 2015 and June 2016.
- A rolling five week rota was used to allocate theatre slots to surgeons using the hospital. This was an ongoing rota, which allowed surgeons and patients flexibility for booking procedures as they could book a long time in advance if they wished.
- Any ad hoc availability of theatre slots was communicated to consultants via email, to maximise theatre utilisation. The theatre management team told us ad hoc booking were thoroughly reviewed before being approved to ensure that all relevant departments in the hospital could support the patient's procedure, for example imaging and the inpatient ward.
- Surgical procedures had to be booked a minimum of five days in advance to ensure suitable theatres staff and

equipment were available. This rule also ensured that results from preoperative investigations, such as blood tests and MRSA swabs, were back before the patient was admitted for their procedure.

- Preoperative assessments were completed for all patients undergoing significant procedures at the hospital and all NHS patients. Face to face assessments were completed for most patients, but always for patients over 50 years of age, those requiring blood tests or MRSA swabs.
- Preoperative assessment clinic was available until 8pm two evening per week and every other Saturday. Staff told us the evening and weekend appointments were popular for working patients who would otherwise have to take time off to attend.
- Patients attending for their procedure without having attended a preoperative assessment would have their assessment completed on the ward instead. Staff told us this was only possible for patient undergoing certain minor procedures, as larger operations such as joint arthroplasties, required the patient to have undergone certain tests prior to being completed.
- In order to improve theatre utilisation, the theatres leadership team told us they were in the process of reviewing surgeon's lists and removing those who were not using their slots.
- There was a four bedded recovery bay where patients remained postoperatively for an average of twenty minutes before being transferred back to the ward. If patients remained drowsy, had high levels of pain or high oxygen requirements, they remained within the recovery area for longer periods of time.
- Patients had a designated room on Northwood which was reserved for them from the time they were admitted. This meant there were no delays in discharging patients from the recovery area back to the ward.

Learning from complaints and concerns:

- There were seven complaints about the surgical service, including Northwood and theatres, between July 2015 and June 2016.
- Informal complaints were managed at ward level by senior staff and escalated to the ward manager if needed. Staff also told us that the on call manager would speak to patients on the ward to discuss any issues or to follow up on a complaint.
- Formal complaints were investigated by a member of the senior management team and an official response was sent from the executive director. We saw example complaint responses which showed key issues from complaints were reviewed and apologies made where appropriate.
- Staff told us they received anonymised feedback about complaints during daily huddles, handover or in staff meetings, and that learning points were identified.

Are surgery services well-led?

Good

We rated this service as good for well led because:

- There were appropriate governance structures in place and evidence to demonstrate staff received feedback from hospital-wide meetings.
- The risk register listed issues we identified during our inspection and was reviewed regularly at governance meetings.
- A focus on quality throughout the surgical service was evident, with regular audit programmes including cross-site audit completion.
- There was evidence of innovative practice, including intraoperative radiotherapy and healing-promoting joint injections.
- Staff feedback about the leadership team was positive and managers were described as approachable and friendly.

However:

- Senior staff did identify shortcomings in safeguarding training as a concern or an issue to be addressed.

Leadership of service:

- Leadership on Northwood was provided by the ward manager, with support from two senior sisters. The ward manager's office was located on the ward and staff told us the manager was readily available if needed.
- Leadership in theatres was provided by the theatre manager, with support from the deputy theatre manager. The managers were located in the theatres corridor and also did some clinical shifts. Staff told us they were approachable, helpful and supportive.
- Consultants using theatres told us they worked at several different independent hospitals but that BMI Bishops Wood provided the best theatre service. The consultants we spoke we attributed this to the leadership team, who "[ran]a tight ship" and "make sure their staff [were] competent and efficient".
- The Medical Advisory Committee provided medical leadership throughout the service. Representatives from a range of specialties, including orthopaedics, general surgery and ophthalmology, reviewed consultants applying for practicing privileges and reviewed consultant performance, in the event of any concerns or complaints being raised.
- Staff were complimentary about the hospital senior leadership team. Staff told us they were visible throughout the hospital and were willing to help out when needed, for example the director of clinical services was identified as helping with patient care on a particularly busy day on the ward. Staff valued their presence and input.

Vision and strategy for this service:

- Senior staff in theatres were clear that they were aiming to optimise the use of theatres as much as possible. They told us they were working to upgrade the air handling unit in the minor procedures theatre so that specialities, such as ophthalmology, could make use of this space. This would therefore free up additional theatre time in the laminar flow theatres and enable more cases to be completed.
- Staff in theatres were unaware of the potential upcoming changes to the minor procedures theatre, however were clear that efficiency and utilisation in theatres were the key aims for the department.
- Senior ward staff were unable to identify a specific vision for the surgical service, beyond increasing activity in a range of specialties. Ward staff told us they were aiming to provide a safe and caring service, but were not aware of any developments to the surgical service.

Governance, risk management and quality measure:

- A "Comm Cell" meeting was daily and attended by all head of departments and the senior management team. During this meeting hospital activity levels, incidents, complaints and staffing were discussed, which ensured the senior staff within the hospital had an up to date oversight of any issues within the hospital.
- Hospital-wide clinical governance meetings were held monthly and attended by senior representatives from all areas of the hospital, including theatres and Northwood. Discussion including incidents, risks, patient satisfaction and complaints, and quality improvement.
- Theatres and ward meetings took place quarterly. We reviewed minutes from the theatres meetings, which showed attendance from a range of staff and coverage of various topics, including clinical incidents, audits and human resource issues, such as sickness.
- The Medical Advisory Committee met bimonthly to review governance around a range of issues, from incident investigation to reviewing applications for new services in the hospital. We reviewed minutes from these meetings and saw that discussions were held alongside the hospital senior management team.
- Risks within the surgical service were recorded on a departmental and centrally based risk registers, which could be accessed by senior staff for reviews and updates. We reviewed the risk registers which reflected environmental issues identified in theatres and on Northwood. The risk register accurately reflected our inspection findings and demonstrated risk mitigation actions which had been implemented. For example, additional training was made available for staff in response to concerns about theatre staff competence in procedures for the retrieval of blood in emergency situations.
- A Theatre User Group, including consultants and the hospital and theatres senior management team, met quarterly to discuss the performance and development

of theatres within the hospital. Senior staff told us it was a very productive group, as it facilitated communication about what worked well for consultants using theatres and what could be improved.

- Surgery outcomes were reviewed by the Medical Advisory Committee (MAC), alongside the senior management team, and if there were concerns about the performance of a specific consultant, a review of their practicing privileges took place.
- Safeguarding vulnerable adults and children training provided for staff within the service was not adequate to protect these patient groups from harm. Senior staff did not acknowledge the shortfall in safeguarding training.

Culture within service:

- Staff throughout the surgical service told us there was an open and honest culture throughout the hospital. They told us their line managers and senior management in the hospital encouraged staff to come forward with ideas and to raise concerns.
- Staff told us they were encouraged to report incidents and were supported with this if needed. They described a no blame or 'finger pointing' culture, but a culture of learning and improving.
- Ward staff told us there was a positive atmosphere on the ward and one staff member described how "staff lift each other up". They told us staff work together to complete tasks and provide patient care, and get on well.

Public and staff engagement:

- A Patient Satisfaction Focus Group was held quarterly and staff told us this was attended by a representative from each department, as well as patients. This forum provided patients with an opportunity to voice any concerns or suggestions for improvement they might have, as well as providing feedback for processes which worked well.
- The quality and safety board used "you said, we did" to demonstrate responses to patient feedback, however the information displayed was relevant to the hospital generally, rather than to the service offered on Northwood specifically.
- Staff had the opportunity to engage with the senior management team within the hospital through open staff forums, where the management team provided feedback about developments and changes within the hospital. Staff had the opportunity to voice any concerns and ask questions during these forums.
- Staff also provided feedback through the 'BMI Say' survey which was completed annually. Staff on the ward told us they had confidence any concerns they had would be addressed by the senior management team.

Innovation, improvement and sustainability:

- An innovative technique to promote healing was being offered at the hospital. The technique involved putting a patient's blood through a centrifuge until a specific type of protein-rich fluid could be extracted, then injected into the patient's joint. Outcome data was being gathered during our inspection.
- Two cases of intraoperative radiotherapy had been completed at the hospital and plans were in place to develop this service further. Both cases had been completed with the support of a medical rep, due to the complexity of the procedure.
- Where new techniques or services were suggested by a consultant, a business case including details of anticipated service demand and sustainability, was put forward to the senior management team to evidence that it would be worthwhile training staff for the new service. The MAC would also be involved in advising the senior management team regarding the impact of any new services.

Good

Outpatients and diagnostic imaging

Safe	Good
Effective	
Caring	Good
Responsive	Good
Well-led	Good

Information about the service

The outpatients and diagnostic imaging service provides a wide range of specialty appointments for adults and children over the age of three years.These include cancer services, orthopedics, physiotherapy and rapid diagnosis.Diagnostic imaging includes MRI scanning, radiography, ultrasound, fluoroscopy screening, X-ray and digital mammography.

The outpatients department consists of 8 Consulting rooms; one Ophthalmology consulting room, one Ear, nose and throat (ENT) consulting room, and one Treatment room.The Imaging Department consists of; two X-ray Rooms, one Ultrasound Room, one Digital Mammography suite, one Mobile MRI Unit, and one Image Intensifier.

The outpatient department operates from 8am until 9pm Monday to Friday and 8.30am until 1pm on Saturday mornings when required. The radiology department operates from 8am- 8pm Monday to Friday. Physiotherapy provides a seven-day service for both inpatients and outpatients. Evening and weekend appointments are offered to allow patients who work 9am-5pm Monday to Friday access to healthcare.

Summary of findings

Overall we rated this service as good. We gave this rating because:

- Medicines were stored securely and well managed.
- Staff had a good understanding of how to report incidents and learning from incidents was shared at departmental level.
- Staff undertook appropriate mandatory training for their role. Staff received good support for continuing professional development (CPD).
- Patients were protected from the risk of abuse and avoidable harm.
- Hospital infection prevention and control practices were followed and these were regularly monitored.
- Equipment was well-maintained and inspected in accordance with manufacturers' guidelines.
- Staffing levels and skill mix were appropriate for both outpatients department and diagnostic imaging services.
- Staff provided good caring and emotional support to patients both in person and over the telephone.

Good

Outpatients and diagnostic imaging

Are outpatients and diagnostic imaging services safe?

Good

Incidents

Incidents

Over the last 12 months there were no reported never events for the outpatient or diagnostic imaging department. Never events are serious incidents that are wholly preventable and have the potential to cause serious patient harm or death.

- All staff we spoke to knew who to report incidents to.
- There was an electronic incident reporting system.
- During the inspection staff told us that only managers could make entries onto electronic reporting systems after a verbal or written report from a member of staff.The provider subsequently told us that all staff can access and report incidents on the electronic system.
- Staff were aware of the type of incidents they needed to report and what type of incident was needed to be escalated to more senior staff.
- The outpatients department staff had monthly meetings where incidents are discussed.
- There were 6 clinical incidents reported between September 2015 and August 2016 in the outpatients and diagnostic imaging service. The rate of clinical incidents was lower than the rate of other independent acute hospitals we hold this type of data for in the same reporting period.
- There were eight non-clinical incidents within outpatients and diagnostic imaging services in the reporting period of September 2015 and August 2016. The rate of clinical incidents was lower than the rate of other independent acute hospitals we hold this type of data for in the same reporting period.
- As there were only a few incidents reported it was not possible to detect a trend or any themes, an example of the type of incident reported was fainting/collapsing.
- Duty of Candour legislation provides a legal duty on the hospital to inform and apologise to patients if there have been mistakes in their care that have led to significant harm.
- Regulation 20 of the Health and Social Care Act 2008 (regulated Activities) Regulations 2014 I requires the organisation to notify the relevant person that an incident has occurred, provide reasonable support to the relevant person in relation to the incident and offer an apology.
- Senior staff were aware of a Duty of Candour (DoC) and understood the terminology. However, we spoke to two of the health care assistant's (HCA's) in outpatients who had heard of the terminology but could not explain what it was at the time of their interview. The hospital had a DoC policy.

Cleanliness, infection control and hygiene

- The housekeeping staff were responsible for cleaning rooms up to the level of the couch and very high surfaces. HCA staff were responsible for cleaning the top of the couch, the trolley, worktops, lamps and all clinical equipment. We saw evidence of cleaning rotas and checklists. We saw schedules for both nursing and housekeeping staff that were signed and dated daily.
- The consultation rooms were clean. However, when we asked staff to point out 'I am clean stickers' on any of the equipment they could not do this. We did not observe any 'I am clean stickers' on any equipment.
- All of the sharps disposal bins that we observed were labelled correctly with the correct temporary closure used.
- In every room, there was personal protective equipment (PPE) available not including aprons, which were only available in the treatment room, as they were not required in consultation rooms. The gloves were stacked near the sinks or placed on treatment trolleys rather than through a designated dispenser. In radiology, there was a lack of wall space to have a designated dispenser for gloves, but gloves were available if required.
- There were hand sanitisers on the walls of the department, which were all full, in good working condition and conveniently located around the outpatients and radiology department. We saw hand

hygiene audit results from September 2015 to August 2016 that scored 96% compliance by staff. This showed that staff were good at minimising the risk of cross contamination within their environment.

- The patient toilets in outpatients were found to be not completely satisfactory in terms of cleanliness. We saw wet floors, and tissue on the floor on more than one occasion which could have caused a slip or trip. There was a separate toilet for disabled users. The flooring and sinks inside this toilet were Hospital Building Note (HBN) approved. The sink did not have 'hand washing technique' posters displayed, although there were instructions printed on the soap dispenser.
- During our inspection, we observed staff adhering to the 'bare below the elbows' policy.

Environment and equipment

- The paintwork in outpatients and radiology was in good condition. However, in consulting rooms, there was carpet on the floor, which is contrary to the (HBN) 00/10 Part A 2.4. This clearly states 'carpets should be avoided in clinical areas'. Many of the consulting rooms were in use at the time of inspection but we did see a sink with an overflow hole in one of the rooms, which is not compatible with HBN 00/09 infection control. This was already logged onto the risk register, and a plan of action was in place to correct this.
- A member of staff told us and we saw that the staff changing rooms were in poor condition. There were no windows, the paintwork needed renewing, the wall plaster was poor, and toilet facilities were inadequate in terms of dignity.
- The examination couches observed within the consultant and treatment rooms were wipe-able and covered with white disposable tissue. There was plenty of white disposable tissue stocked in the room. All staff were responsible for replenishing stock. The meant that the couch could be easily cleaned between patients. The curtains in use within the consulting and treatment rooms were disposable and were in date. They were clean and neatly presented. Radiographers had set lists for cleaning equipment at the start of each day and this was recorded.
- The Electricity at Work Regulations 1989 requires that any electrical equipment that has the potential to cause injury is maintained in a safe condition. Green Portable Appliance Testing (PAT) stickers were pointed out by staff when asked. However, on observation not all-electrical equipment had a sticker. We asked for a copy of their PAT testing log. All equipment had been tested; apart from two extension leads in the X-ray department where access was not permitted.
- There were light boxes outside the radiology treatment rooms to indicate that radiation was being delivered. We did not see this in use at the time of the inspection but normally these would prevent staff or service users from entering the room when potential harmful radiation equipment were in use.
- There was an appointed radiation protection supervisor (RPS) in the hospital and the radiation protection advisor (RPA) was situated at the adjacent NHS Mount Vernon Hospital, in accordance with the Ionising Radiation (Medical Exposure) Regulations 2000 (IRMER) regulations. This meant that the hospital had an independent annual audit of the imaging services. The RPA audit carried out in September 2016 showed 100% compliance for mandatory training. The RPA and the RPS also carry out QA and set dose reference levels.
- The hospital's Patient Led Assessment of the Care Environment (PLACE) audit was thorough and actions to be taken were clear. All actions were completed, with no outstanding actions required. For example, an issue was 'there is no sign or pictorial sign on the door to the stairs to Pinner (ward) to indicate it is stairs'. The action to be taken was to 'obtain sign with a pictorial staircase'. This was completed on 10 October 2016.

Medicines

- Medicines that required refrigeration in outpatients were stored in a locked fridge in the treatment room. Keys were held by the senior nurses and temperatures were checked and recorded daily. In radiology, only contrast agents were stored in a locked cupboard in the fluoroscopy room. This was mainly because pharmacy was situated next door. All the boxes of contrast were in date and were routinely checked by the radiographers and pharmacy. There was a record of this in the sheet above the cupboard; items near their expiry date were flagged.

- Prescription pads were kept in a locked cabinet in the nurse's station and locked away in the treatment room. The senior sisters had the keys for these cabinets. We did not see prescription pads left unattended in any of the consultation rooms that we were able to view.

Records

- Patient's medical records were available 100% of the time when seen in the outpatients and diagnostic department. The hospital had stated that people's medical notes were never taken off site but were stored safely, overnight and locked. We found that some consultants brought their patients notes, or an electronic patient record with them to their clinic and took them away again at the end of each clinic.The provider confirmed that all consultants were registered as a data controller with the Information Commissioner under the Data Protection Act 1988 in order to do this.
- A copy of every clinical letter was sent from the consultant's medical secretory and filed in the medical records department at the hospital. These letters were also scanned into an electronic archive.
- If notes were required from medical records for clinics, they were collected first thing in the morning and returned at the end of the day. The notes were kept in a locked filing cabinet in the nurse's station when not in use throughout the day. Patients were not seen without their notes.

Safeguarding

- Hundred per cent of staff who were involved in the care of people under the age of 18 were trained to Safeguarding level two.
- Sixty-seven per cent of staff who were involved in the care of people under the age of 18 were trained to Safeguarding level three.
- There was always a practitioner with a Safeguarding level three qualification on site. We spoke to a paediatric senior sister who told us at the time of inspection there were 15 consultants, four ward staff, four patient service staff, five ward nurses, one night sister, six leads, and two managers who all had safeguarding training to level two. There was a goal to have all registered nurses and above to be trained for level three safeguarding. We were told that HCA's were not involved with the care of children.
- Staff told us that contact details were readily available on wards if they needed safeguarding advice, and there was a flowchart on the wall to see who needed to look after each age group. There were no reported safeguarding incidents in the last year.
- Staff had introduced a new policy whereby young patients' medical letters were sent directly to their GP, rather than relying on parents to drop these letters to their child's GP. This meant that the child's GP was informed directly of any medical procedures or examinations undertaken at the hospital.

Mandatory training

- Mandatory training was undertaken either online or in-house, for example infection control. Other training could be booked online and could be done at any BMI clinic/hospital in the BMI group. This allowed staff to have more flexibility on where and when they completed their training. Staff received emails reminding them when the training was near expiry or needed to be renewed.
- There was 100% completion of mandatory training for all staff including bank staff. Nursing and HCA staff were all trained in phlebotomy through a mandatory annual module.; this meant that patients did not have to wait long for a blood test.

Assessing and responding to patient risk

- We checked the paediatric and adult resuscitation trolley in outpatients and the adult resuscitation trolley in radiology. We saw the daily log books were completed in full and the oxygen cylinder was full.
- The maintenance dates for the defribillator, suction maintenance and suction catheters were all within their expiry date. The resuscitation trolleys were easily accessible when required in an emergency.
- We were also told that the first floor had their own paediatric resuscitation trolley. This meant that in the event of an emergency or patient collapse, staff would not need to bring the emergency equipment up the stairs or in the lift, therefore treatment could be delivered in a timely manner.

Nursing and radiology staffing

- We spoke to the senior sister who informed us that a registered nurse had already been appointed to start in November 2016 in outpatients. At the time of inspection, there were two senior nurses and three health care assistants (HCA) in total. Therefore at the time of inspection they were short of one senior nurse, as three senior nurses were required.

- In outpatients, we saw the HCA competency folder, which was comprehensive, and all up to date. It was easy to locate and staff were proud of it.
- In radiology, the clinical service lead position was being covered two days a week by a member of staff from BMI Syon Clinic hospital. Recruitment to this post was at the shortlisting stage.
- In radiology, there were two radiographers, and one receptionist; there were also two regular bank staff. At the time of inspection they were fully staffed. For the work load in diagnostics the number of staff was adequate.
- There were no agency staff working at the time of inspection

Medical staffing

- Staff told us there were approximately 150 consultants that held outpatient clinics at the hospital.
- Electrocardiograms (ECGs) were generally done by consultant staff, some were done by nurses
- The cardiologists reviewed the ECG's
- Only consultant staff operated the lung spirometry machine
- There were 10 radiologists with practicing privileges (practicing privileges is a term used when doctors have been granted the right to practice in an independent hospital).
- There was a Resident Medical Officer (RMO) on site for 24 hours 7 days per week to support the clinical team in the event of an emergency or with patients requiring medical support.

Major incident awareness and training

- Three members of the outpatient department had immediate life support training. This meant that these members of staff could be called upon in the event of a patient collapse or emergency situation with a patient relative or member of staff. Three members of the outpatient department had adult basic life support training and basic paediatric life support training.
- We observed the nurse's station door being propped open continuously throughout the time of inspection, even though this was a fire door. This was unsafe practice and against fire safety regulations.
- There were patient emergency cords in place, which would alert the reception staff in case of an incident. All toilets had emergency cords/call buttons, which were also located in examination rooms and radiology viewings areas. Staff knew the procedures to call for the crash team, and how to acquire assistance in an emergency.
- We observed fire extinguishers suitable for extinguishing electrical fires and liquid fires in outpatients, which were tagged and dated. This was also observed in radiology where the fire extinguishers are in a location for easy access.
- As there were only a few incidents reported it was not possible to detect a trend or any theme, an example of the type of incident reported was fainting or collapsing.
- All staff we spoke to knew who to report incidents to. There was an electronic incident reporting system. Managers made entries onto this system after a verbal or written report from a member of staff.
- Staff were aware of the type of incidents they needed to report and what type of incident was needed to be escalated to more senior staff.
- The outpatient department staff have monthly meetings where incidents are discussed.

As there were only a few incidents reported it was not possible to detect a trend or any themes[TR1], an example of the type of incident reported was fainting/ collapsing.[TR1]Put in here the main incidents or if not possible put in examples of the incidents reported.All staff we spoke to knew who to report incidents to.There was an electronic incident reporting system called SentinelOnly managers made entries onto Sentinel afer a verbal or written report from a member of staff.Staff were aware of the type of incidents they needed to report and what type of incident was needed to be escalated to more senior staff.The outpatient department staff have monthly meetings where incidents are discu

Good

Outpatients and diagnostic imaging

Are outpatients and diagnostic imaging services effective?

Evidence-based care and treatment

- The imaging lead for the whole of the BMI group cascaded any relevant changes in NICE (the National Institute of Clinical Excellence) guidelines or polices relating to diagnostic imagery to the hospital imaging managers. The radiology team had monthly staff meetings where these were discussed.
- Staff in radiology and outpatients told us that all policies were available on the intranet. Staff adhered to all relevant legislation and were updated from the BMI lead for clinical imaging on a corporate level if any new guidelines or polices were brought in.
- Staff in the outpatient department knew where to look on the intranet for access to national and local guidelines and policies. There were also hard copies in the nurse's station.

Pain relief

- None of the patients we spoke with required pain relief at the time of our inspection. Staff told us that they would escalate any concerns around pain relief to their seniors and then to the RMO if required.

Patient outcomes

- We were told by staff that investigation results were batch printed twice a day and checked by both the RMO and by nursing staff. Abnormal results may also be telephoned through to the hospital from the clinical laboratories. Consultants were alerted of abnormal results by telephone. Consultants received routine results from fax or could collect them from their pigeonhole at the hospital. The staff had the contact details for all the consultants; if the consultant was not available, the consultant's secretary would then be contacted.
- The minutes from the clinical governance meeting stated that audits on the following were yet to be completed; medicine management, WHO (world health organisation), consent, controlled drugs, and part of the infection prevention control. As a result the hospital did not know its performance rate in these areas. When the hospital was asked if they were currently participating in any national audits one national audit was mentioned which was the NCEPOD– Anaphylaxis (National Confidential Enquiry into Patient Outcome and Death), but results from this audit were not yet available.
- The provider subsequently told us that the clinical governance meetings held monthly, highlighted reports that were to be still completed in accordance with the audit programme that is set corporately and reviewed at monthly clinical governance meetings. However the deadline had not yet passed therefore the data was not available at the time of inspection.

Competent staff

- Hundred per cent of staff in the outpatient department had completed their annual appraisals, for the year running from September 2015 to September 2016.
- Staff in radiology told us they had received good support for continual professional development (CPD). As long as courses could be related to the service staff were supported financially. We spoke to the senior sisters in outpatients and they told us they were encouraged to go on courses and felt they received a great deal of support when wanting to do so.
- Staff told us that once a year the service manager requested that the radiographers (including bank staff) provide their health care professional council (HCPC) certificates. They were photocopied and put into a folder; they were also scanned into the individuals training records. The small number of staff meant that it was easy to assure that everyone complies with this requirement.
- The clinical services manager for physiotherapy and outpatients told us that physiotherapy staff maintained their competencies, and these had review dates on them. The competencies were set by BMI to minimise differences between other BMI hospitals and clinics. Staff told us they used a drop box to help share information in the physiotherapy team. This meant that staff could call upon this as proof for their CPD.
- There was 100% validation of professional registration for nurses working in the outpatient departments. The hospital conducted annual checks to make sure all the nurses were registered with the Nursing and Midwifery Council (NMC).

Multidisciplinary working

Good

Outpatients and diagnostic imaging

- We spoke to a senior member of staff who informed us that there was no regular MDT meetings but that staff were brought together to discuss individual patients when necessary.
- However we spoke to a consultant breast surgeon who informed us that there was a regular and well attended pre-operative breast MDT meeting where every patient was discussed.

Seven-day services

- We spoke to the clinical services manager who told us that physiotherapy provided a seven day service, with the weekend service primarily for inpatients. There was no requirement for on call cover; Patients whose condition deteriorated were taken to an appropriate NHS hospital and "blue lighted" by emergency ambulance if necessary depending on who their condition.
- Various outpatient clinics were operating between 9am-8.30pm Monday to Friday with some clinics scheduled on Saturday mornings, which enabled patients to attend the hospital at a time that suited them.
- Radiology services were available 9am to 5pm Monday to Friday, with later appointments available. Some appointments were scheduled on a Saturday morning.

Access to Information

- Hospital staff received medical information regarding NHS patients from their GP as part of their referral process via the ‘choose and book’ system. Choose and book is a national electronic referral service, which gives patients a choice of place, date and time for their first outpatient appointment in a hospital or clinic.
- Some consultants brought their own patients' notes or an electronic patient record with them to their clinic and took them away again at the end of the clinic. All consultants were registered with the Information Commissioners Office to allow them to take patient information out of the hospital. A copy of every clinical letter was sent from the consultant’s medical secretory and filed in the patient’s record in the medical records department at the hospital. These letters were also scanned into an electronic archive.
- Staff were happy with the systems in place. If notes were required from medical records for clinics, these were collected first thing in the morning and returned at the end of the day. The notes were kept in a locked filing cabinet in the nurse’s station when not in use throughout the day. Patients are not seen without their notes.
- Staff told us when a patient was referred to radiology the patient arrived with a signed request form. This was then scanned into the system and this was then linked with the patient’s notes and images. This meant that consultants were able to call up diagnostic results on the hospitals electronic system. Radiologists were called from Mount Vernon hospital when an urgent report was required. This was a reciprocal but informal arrangement.

Consent, Mental Capacity Act and deprivation of Liberty Safeguards

- Staff in radiology told us that the Deprivation of Liberty Safeguards (DoLS) training was not completely applicable to radiography but most of the staff had undertaken the on-line training that was available. However, when we spoke to staff in outpatients they could not remember what DoLS stood for..
- There was a hospital policy on the Mental Capacity Act (MCA), but it was unclear if there was any additional training or support given to the staff in the outpatient department. We requested a list of all the mandatory training staff received in outpatients and MCA was not listed.

Are outpatients and diagnostic imaging services caring?

Good

Compassionate care

- We observed examples of compassionate care. All patients were greeted in a very friendly manner by staff and signposted to where they needed to go.
- Staff introduced themselves with the ‘my name is’ approach to new patients and it was clear to see that they had built a good rapport with the people who had used this service for a number of years.

Good

Outpatients and diagnostic imaging

- We spoke to a patient's relative who told us that staff constantly came out to the waiting area to reassure them that their relative was safe and was ok. We then observed this patient being walked back to the waiting area to their relative with a nurse.
- The outpatients and diagnostic department had feedback surveys at reception. There was a ballot style box for returns. The survey asked patients how likely they would recommend the service to friends and family if they needed similar care or treatment. There were 10 easy to answer questions; all bar one was a simple tick exercise. The radiology and outpatient department used the same feedback survey as this is the BMI in house survey. The response rate to these questionnaires varied throughout the year, we requested the results of these questionnaires but did not receive them.
- In the radiology department, we saw two small curtained changing cubicles. Gowns were given on request, and the curtains promoted dignity. One out of the two cubicles was out of use as the entrance was blocked by the resuscitation trolley. However the department was not busy and it was rare that both cubicles would be required at the same time.
- We observed chaperone posters in visible areas around the outpatient department and inside the consultation rooms. For example, there were posters on the wall in the consultation rooms and on the reception desk at radiology. Staff also informed us that this service was always verbally offered to patients. There was a written log detailing when a chaperone was used.
- Consultation rooms were private and spacious and were used to speak to patients away from the waiting area when required.
- We saw two cubicles that had curtains in physiotherapy that also promoted patient dignity. There was also a closed cubicle. We noticed that when all three cubicles were in use you could hear patients could be heard in the other rooms meaning that privacy was compromised.

Understanding and involvement of patients and those close to them

- We observed examples of compassionate care. All patients were greeted in a very friendly manner by staff and signposted to where they needed to go.
- Staff introduced themselves with the 'my name is' approach to new patients and it was clear to see that they had built a good rapport with the people who had used this service for a number of years.
- We spoke to a patient's relative who told us that staff constantly came out to the waiting area to reassure them that their relative was safe and was ok. We then observed this patient being walked back to the waiting area to their relative with a nurse.
- We saw one consultant walk to their patient and formally greet the patient when calling them in for their appointment. However, we saw another consultant standing at one end of the waiting room and shouted out a patients name several times before being heard. The consultant turned to walk back into the consultation room before the patient had walked the length of the waiting room to the consultant. This was observed on a number of occasions.

Emotional support

- Throughout our visit, we observed staff giving reassurance to patients both over the phone and in person. Staff took their time with patients and did not rush. We observed nurses in outpatients on more than one occasion speaking with a service users and their relatives asking questions on their well being.

Are outpatients and diagnostic imaging services responsive?

Good

Service planning and delivery to meet the needs of local people

- The outpatients department operated from 8am until 9pm Monday to Friday and 8.30am until 1pm on Saturday mornings when required. The radiology department operated from 8am- 8pm Monday to Friday. When staff were needed for the mobile MRI scanner they came into the department on a Saturday. Staff told us appointment times could be flexible to suit the needs of patients. Physiotherapy offered a seven-day service for both inpatients and outpatients. Evening and weekend appointments allowed patients who worked 9am-5pm Monday to Friday access to healthcare that suited their circumstances.

- We spoke to a consultant ophthalmologist who said there was limited practice at the hospital because there were no optical lasers or optical CT scanning facilities, so when these tests were required they needed to be done elsewhere.
- The hospital could refer patients to BMI Syon Clinic, which is 40 minutes away, and to BMI The Clementine Churchill Hospital, which is 15 minutes away if they required extra capacity in radiology.

Access and flow

- The hospital had achieved 100% of the national target for non-admitted patients Referral to Treatment (RTT) waiting times between July 2015–June 2016.
- There was no patient waiting for 6 weeks or longer for a Magnetic Resonance Imaging (MRI) scan in the reporting period from July 2015- June 2016. There was a slight change however in August 2015; where there was 50% of Patients waiting for a MRI scan, which was greater than the England average of 8.9%.
- There was no patient waiting for six weeks or longer for a non-obstetric ultrasound scan in the reporting period from July 2015- June 2016. There was a slight change however in March 2016; where there was 14.3% of patients waiting for a scan, which was greater than the England average of 7.5%.
- There was no patient waiting for six weeks or longer for a Computerised Tomography (CT) scan in the reporting period from July 2015- June 2016. However, in July 2015 and November 2015 there was 14.3% and 20% of patients waiting for a CT, which was greater than the England average of 1.1%.
- NHS patients were referred by their GP's through the choose-and-book system and private patients were either self-referred or referred by their GP's. There was a strict referral criteria for NHS patients under agreed contractual conditions; this ensured that the patients' needs could be met by the hospitals services.
- On arrival patients reported to the main reception where they would be directed to the outpatients, physiotherapy or radiology. The nurse's station door, which was a fire door, was wedged opened to keep an eye on the number of patients that were waiting in outpatients. There was a separate waiting area for radiology but not for physiotherapy.
- When speaking to a patient in the late afternoon on the second day of inspection they said they had been waiting 45 minutes and no one had informed them of the delay so the patient went to the main desk to make an enquiry themselves.
- We spoke to a patient in radiology who had just been referred from outpatients, the patient told us that there was hardly any time to sit down before being called in for their examination, and the patient stated she was very pleased with the service.
- Staff in physiotherapy told us that DNA (did not attend) rates were low, and there was a text reminder service available for appointments. Staff told us that NHS patients who did not attend two appointments were referred back to their GP by the hospital's booking team. There were a total of 6384 physiotherapy appointments between September 2015 and August 2016, and a total of 107 DNA appointments in physiotherapy which was fairly low compared with other BMI hospitals.

Meeting peoples individual needs

- Private patients were directed to the BMI National Enquiry System (NES) if they had any queries about charges. The hospital had a fixed price system for procedures, and set package costs. Arrangements could be made for an interest free payment over a stated period of time, usually 12 months.
- There was a leaflet stand in the waiting area, located next to the nursing station and the hot and cold drinks machine.
- The hospital was not equipped to look after bariatric patients with a body mass index (BMI) greater than 40 so patients above this BMI were not accepted at this hospital. We were told that , very occasionally, a private patient with a BMI over 40 might be seen in the outpatient clinic. However, there were no chairs or equipment specifically for bariatric patients.
- There was sufficient space in the outpatient and radiology with enough chairs, which all had variable back heights and armrests that allowed good posture. The chairs supported the independence of patients who may find it difficult to go from a seated position to standing unaided.
- All radiographers had dementia training, although there had not been a case where they had needed to call upon this training, as there had not been a patient with

dementia in the department. Staff stated they were adequately trained to recognise a patient suffering with dementia. There was no dementia lead or dementia champion in the hospital.

- Staff told us that they used a telephone translation line if necessary for patients who did not speak English as their first language. Staff told us the need for translation services was rare but there was also a list of staff members on display that are able to speak a different language in the hospital displayed in various locations. We were told that patients often came with their own interpreter.
- We observed sufficient wheelchair access. There was plenty of space for wheelchairs to pass through in an emergency, both in outpatients, and in radiology and the corridors were spacious and free from clutter. The outpatients department was all on one floor, which meant there was easy accessibility for those patients requiring a wheelchair. There was one oncology outpatient clinic on the first floor, with easy access via a lift. Physiotherapy was cramped but a single wheelchair could pass through in an emergency. In radiology the access to the toilet was not wheelchair friendly as the large reception desk narrowed the entry. The nearest disabled toilet was not too far and was located just pass the main reception desk.
- In radiology, there was no dedicated waiting area for paediatric patients. However, in the outpatients department we saw a dedicated area for children with a play mat, toys and books, staff in radiology said they were able to utilise this area when required, and were happy to leave the child in outpatients and call them when needed.
- There was a free water and a hot drinks machine in outpatients. Some patients were not offered a drink on arrival but knew they were welcome to use the drinks dispenser. Another patient stated that they were regularly offered refreshments by staff. In radiology, there was also a drinks dispenser.
- Although parking at the hospital was limited, parking was free. Service users were given a one-day paper pass on arrival, which they did not need to return before leaving. There were a number of disabled parking bays.
- Patients were able to access free Wi Fi in outpatients.

Learning from complaints and concerns

- A senior member of staff for outpatients and physiotherapy was named to be the person who took the overall responsibility for responding to written complaints. We observed no patterns or themes to identify in complaints, as they were not common. When talking to junior staff it was not clear if there was a method in place in which complaints were fed back to all staff. There was a total of 15 complaints received between September 2015 and August 2016.
- Staff in radiology told us that complaints were dealt with at a local level. The paper based system was soon to be replaced by a new electronic system.

Are outpatients and diagnostic imaging services well-led?

Good

Leadership/culture of service

- The leader of this service was the director of clinical services.
- The low staff turnover (two members of staff in outpatients between September 2015 andAugust 2016) reflected the positive regard in which staff held the service and their colleagues.
- Staff reported that their direct manager was helpful and always visible and approachable; they were also supported greatly and spoke very highly of the director of clinical services. They described an open friendly culture with an emphasis on delivering the best care possible. The staff felt comfortable in the work environment and described an open culture. Radiology staff told us that management was very visible and approachable. Imaging managers had their own email group within BMI, which made it very easy for information to be shared. Staff in physiotherapy told us that management were approachable and were very responsive to comments.
- Staff told us they were supported by the general manager who was visible and approachable. We were told by staff ‘this is a good place to work, like a family’ and the executives all have an open door policy.

Vision and strategy for this core service

- There was a clear values vision statement with a clear vision statement poster displayed. However when we asked seven members of staff what the vision statement for the hospital was, it was clear the vision statement was not known. However all staff worked well in their team and showed evidence of the seven points listed in the values.

Governance, risk management and quality measurement for this core service

- We saw the minutes from the last clinical governance meeting, which was held on the 29th September 2016, (the last meeting was on 28th July 2016). This included progress on previous action points.
- The meeting's minutes were in detail and discussed incidents, infection prevention control and clinical performance/compliance. Each department was discussed and relevant governance issues were raised. There was a list of policies that were approved at the meeting, and actions added in bold for the next meeting.
- The risk register for the outpatients department was also discussed. The risk register showed risks relating to non compliant sinks and the use of carpets. There was a new checklist which had been devised to monitor this and new taps had also been purchased as an action plan for these risks.
- There was a morning 'huddle' meeting conducted on a daily basis by the executive director and director of clinical services. This was an informal meeting held at the start of each working day where the Heads of Department came together to discuss potential issues for the day.

Public and staff engagement

- We were told that all staff were happy to be working for the hospital, which was evident through the number of years that they had all worked for the hospital. All the staff got on well with each other and they all had a good rapport with each other. They spoke kindly of one another and showed a great deal of respect for their co-workers.
- The hospital had an anonymous staff survey for the outpatient department with multiple questions with five potential answers, ranging from 'agree strongly' to 'disagree strongly'. We were given a sample of 10 questions with the most positive results. The response rate varied per question. Question 15 had a response rate from 79% of staff. The question was 'I am committed to doing my very best for BMI healthcare'. Fifty-eight per cent of staff answered 'strongly agree', 'agree' or remained neutral and answered 'neither'. This meant that there was a 0.3% increase from the previous results last year. Question three had a response rate from 78% of staff. The question was 'I find my job interesting and fulfilling'. thirty-one per cent of staff answered 'agree strongly' or 'agree' this meant that there was a 2.1% increase from the previous results last year.

Innovation, improvement and sustainability

- We were told of plans to extend outpatients and provide a greater number of consultation rooms, and move managerial offices off site. We were also told of plans to extend the radiology department to make room for a new MRI. The patient liaison officer also told us of plans to improve the booking service and have a remote access to the booking system.

Outstanding practice and areas for improvement

Outstanding practice

We found areas of good practice including the following:

- Staff understood and fulfilled their responsibilities to raise concerns, report incidents and near misses.
- We saw that the environment was clean and well maintained and we saw that equipment worked well and was clean.
- Staff had a good understanding of what was meant by safeguarding and their responsibilities to protect vulnerable patients.
- Staff undertook appropriate mandatory training for their role. Staff received good support for continuing professional development (CPD).
- Care and treatment was mainly planned and delivered to patients in line with current evidence based guidance, standards and legislation.
- There was good multi-disciplinary working in most areas of the hospital. and good relationships with local acute trusts.
- A range of evidence based practice was observed, such as the use of enhanced recovery programmes.
- Staff positively interacted with patients and treated them with kindness and compassion.
- The service met national waiting times for patients to wait no longer than 18 weeks for treatment after referral.
- Patients were involved and encouraged to be active partners in their care and in making decisions.
- BMI Bishops Wood had largely a clear vision for the organisation and a clear strategy for achieving this vision.

However we found areas of poor practice including the following:

- The prescribing and administering of chemotherapy at BMI Bishops Wood required improvement. Staff were not always acting in compliance with prescribing guidelines.We wrote to the provider with our concerns prior to report publication. The provider has given us an action plan much of which is to be completed in the future and we will return to check on this.
- Despite dedicated Macmillan nurses, leadership in End of Life Care was inadequate with no vision and strategy, poor clinical governance, no risk management in place, lack of multi-disciplinary working , lack of performance measures and audit in place, and lack of patient assessment and care planning.
- Not all rooms on the medical ward were compliant with Health Building Note (HBN) 00-09 as they had carpet in them.
- Not all rooms on the medical ward had a designated hand washing basin for staff and this was not compliant with hand hygiene protocols.
- In surgery a number of environmental concerns posed infection prevention and control risks to patients:
- The theatres sluice did not have a hand washing sink for staff therefore they had to use the same sink in which used surgical instruments were rinsed in.
- Used endoscopy equipment was carried through the theatres (when not in use) to the used equipment storage area.
  - The rate of surgical site infections in four key areas was worse than the average performance in other independent acute hospitals.
  - Patient rooms on Northwood did not have designated hand wash sinks, which meant staff washed their hands in patient basins.

Areas for improvement

Action the provider MUST take to improve

- The provider must ensure that prescribing and administering of chemotherapy at BMI Bishops Wood

Outstanding practice and areas for improvement

follows best practice guidelines. This includes ensuring that all clinicians with practicing privileges and all staff who have independent prescribing status as well as all staff without that status adhere strictly to those guidelines.
- The provider must improve its governance arrangements for end of life care to ensure clinical governance, risk management, patient assessment and care planning processes, multi- disciplinary working and adequate performance measurement and audit are in place.

Action the provider SHOULD take to improve

- The provider should ensure that rooms in the medical ward are compliant with Health Building Note (HBN) 00-09.
- The provider should ensure that all patient rooms on all wards have designated hand washing basins for staff to ensure compliance with hand hygiene protocols.
- The provider should ensure that the theatres sluice has a separate hand washing sink for staff to prevent them having to use the same sink in which used surgical instruments are rinsed in.
- The provider should prevent used endoscopy equipment being carried through the theatres (when not in use) to the used equipment storage area.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment • Regulation 12, Safe care and treatment, of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (1) (2) (g) the proper and safe management of medicines.? • Patients' blood was tested on the day of treatment to ensure their chemotherapy prescription was appropriate and within safe guidelines to receive. If a patient's prescription was identified as being outside of the safe levels the prescribing consultant was required to alter the patient's prescription. • We were told by nursing staff that the prescribing consultant was often off site or unavailable and therefore the resident medical officer (RMO), who is a generalist doctor, altered paper prescriptions on the verbal authority of the consultant. The Oncology Pharmacist confirmed this practice and told us that the amended prescription should be countersigned by the prescribing consultant retrospectively but this was not always done. • The pharmacist prescribes on the electronic prescription system. We identified one prescription where a dose reduction was made by the pharmacist on ichemo (pt. S.P 27/10/16). This arose when, because CQC inspectors did not know how to use the electronic prescribing system, they asked the pharmacist to produce on the electronic prescribing system an example of a prescription where a patient had received a dose reduction. The pharmacist told us they could not remember why they had done this as opposed to the consultant but it was probably because the consultant was too busy. In the electronic notes the pharmacist had documented "20% dose reduction as per consultant". The pharmacist was not qualified an independent prescriber.

Requirement notices

- This contravenes prescribing guidelines which state 'prescribing of second or subsequent cycles may be delegated to Specialist registrars in training (ST3 or above), non-medical independent or supplementary prescribers'.
- Chemotherapy in the ward area was stored in a general use medicines refrigerator rather than in a separate fridge. There is therefore a risk of contaminating other medicines with chemotherapy medication and a risk of mistakenly giving chemotherapy to a patient not on chemotherapy.? Where patients were identified though blood tests as requiring lower doses of chemotherapy, part of their pre-prepared bag was administered. We identified a prescription where 500mg dose of carboplatin was given to a patient from a 700mg bag. Staff told us that bags were part used three times a month on average. Your protocol 'Risk Assessments for PHpol14 (Safe management of chemotherapy)' states that this practice should only be used in exceptional circumstances. Staff told us that parts of bags were used on average three times per month. We are unable to find evidence of how often this practice took place apart from the anecdotal comments from staff. We are not assured that this practice is only used in exceptional circumstances and that staff are aware of what an exceptional circumstance is.
- We were not assured by conversations with staff, by observing practice or through records that the 'Risk Assessments for PHpol14 (Safe management of chemotherapy)' protocol was adhered to by all staff. This protocol describes what to do in the exceptional circumstance that a patient requires a lower dose than has been compounded on the day of their treatment and the required does cannot be obtained within the required time frame.

All of the above is a breach of Regulation 12, Safe care and treatment, of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (1) (2) (g) the proper and safe management of medicines.

Regulated activity	Regulation

Requirement notices

Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance **Regulation 17, (1) (2 (b) (c), Good governance, of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.** • At the time of inspection there was no written guidance or procedure for the changing of chemotherapy prescriptions and this was not being documented as being done in patients notes. Both the chemotherapy nurse and pharmacist confirmed this point to us. • We found no audits or checks in relation to this practice. Subsequently and following a further request for information, you provided CQC with a document entitled “Working Instruction PHW105 Guidance to support Oncology Clinical Pharmacy Services”. This document related to pharmacists only and did not appear to apply to nursing or other clinical staff. • During our inspection we found that there were no risk assessments or processes to mitigate any risks that may arise from chemotherapy being prescribed by anyone other than the patient’s prescribing consultant; or in relation to patients being administered part-bags of the preparation already prescribed where blood tests indicate a lower dose. • We saw that the provider had a new electronic prescribing system (iChemo). 60% of your chemotherapy prescriptions were on paper of which 90% were on a blank pro-forma. Guidance stipulates that where paper prescribing is used the paper prescriptions should be pre-filled to prevent error.Best practice guidelines state that where electronic prescribing systems are not normally currently available, chemotherapy should ideally be prescribed by using appropriate prescription pro-formas’. • There was a lack of record keeping with regard to the specific individual such as a consultant under whose authority chemotherapy has been prescribed. There were no patient or other records in connection with this practice other than the paper prescribing forms.? We looked at several paper prescriptions where chemotherapy had been prescribed by consultants. Without route/volume/dilution a prescription is incomplete. In some cases this was filled in by the pharmacist but in some cases was blank with no route, volume or dilution indicated .These should be

Requirement notices

completed by a prescriber and then checked for accuracy by a pharmacist. If the prescriber leaves the above information blank it introduces a risk, for example of chemotherapy being given by more than one route if not specified.

- Staff were not able to state clearly the exact circumstances of when a part bag would be considered and there was no mention of exceptional circumstances when this would be undertaken. No record was made when a part bag was administered.

All of the above is a breach of Regulation 17, (1) (2 (b) (c), Good governance, of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

This section is primarily information for the provider

Enforcement actions

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.