BMI Healthcare Limited

BMI The Cavell Hospital

Quality Report

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Date of inspection visit: 21 - 23 June 2016
Date of publication: 03/11/2016

This report describes our judgement of the quality of care at this hospital. It is based on a combination of what we found when we inspected, information from our 'Intelligent Monitoring' system, and information given to us from patients, the public and other organisations.

Ratings

Overall rating for this hospital	Requires improvement
Medical care (including older people's care)	**Requires improvement**
Surgery	**Good**
Outpatients and diagnostic imaging	**Good**

Summary of findings

Letter from the Chief Inspector of Hospitals

BMI The Cavell Hospital is an acute independent hospital in Enfield that provides outpatient, day care and inpatient services. It has 27 registered beds. The hospital is owned and managed by BMI Healthcare Limited.

The hospital comprises two main buildings; the original hospital (Cavell building) dates from 1976 and accommodates the consulting rooms, physiotherapy department and endoscopy suite. The newer main building (Trent building) dates from 1994 and houses the imaging suite, ward and theatres.

The hospital provides a range of services including surgical procedures, outpatient consultations and diagnostic imaging services. Services are provided to both insured and self-pay private patients and to NHS patients.

We inspected the hospital on 21-23 June 2016 as part of our independent hospital inspection programme. The inspection was conducted using the CQC's comprehensive inspection methodology. It was a routine planned inspection. We inspected the following three core services at the hospital: medicine, surgery and outpatients and diagnostic imaging.

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

Facts and Data

The hospital had 27 beds which were used for inpatients and day-case patients. All rooms had en suite facilities. Twenty-six percent of the patients seen at the hospital in 2015 were NHS funded, and the remaining 74% were insured and self-pay patients.

BMI The Cavell provided an outpatient service for various specialties. This included, but was not limited to, gynaecology, cardiology, dermatology, oncology, ophthalmology and orthopaedics. Outpatient services were provided from 13 consulting rooms, in addition to a nurse treatment room, an imaging suite and a physiotherapy department which also provided post-operative treatments and rehabilitation. There were over 27,500 first (46%) and follow-up (54%) outpatient appointments booked at the hospital from January to December 2015.

The hospital had two operating theatres, one with laminar flow. There were 5,070 visits to the theatre between January 2015 and December 2015. The five most common surgical procedures performed were:

- Hysteroscopy including biopsy, dilatation, curettage and polypectomy (495)
- Image-guided injection(s) into joint(s) (311)
- Phacoemulsification of lens with implant -unilateral (212)
- Therapeutic endoscopic operations on uterus (208)
- Multiple arthroscopic op on knee (inc meniscectomy) (179).

Medical care included chemotherapy and endoscopy. The chemotherapy service was situated on the Trent Ward, in four designated single accommodation rooms. The endoscopy services included gastroscopy, colonoscopy, oesophageal dilatation and flexible cystoscopy. The dedicated endoscopy unit was situated in the Cavell building separate to the main theatre located within the Trent building.

There were 153 doctors with practising privileges at the hospital and 79.6 whole time equivalent employed staff.

Summary of findings

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

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

BMI The Cavell Hospital was last inspected by the CQC in February 2014.

We inspected and reported on the following three core services:

• Medical care

• Surgery

• Outpatients and diagnostic imaging

We rated the hospital as Requires Improvement overall.

Our key findings were as follows:

Are services safe at this hospital?

We rated safe as requires improvement for all three core services because:

The environment did not always comply with national guidelines relating to infection prevention and control. Rooms used for chemotherapy were used by other patients on occasions increasing the risk of immuno-compromised patients getting an infection. There was a known issue with the temperature control system for theatres, however, the hospital had plans to resolve this. Funding was approved for replacement of the DX units, and temporary chiller units were being installed in the interim to ensure the temperature of the theatre environment was controlled, as there was a minimum 12 week order time for the replacement units.

Patient records were not always complete. For example, some outpatient records did not include care plans. Staff were unable to access records for chemotherapy patients outside of daytime hospital hours. Some records had poor legibility.

There were systems for reporting incidents, however, these were not always implemented.

The hospital pharmacy did not hold an up to date list of authorised signatories for staff working in theatres and on the ward.

There was no formal anaesthetic on-call rota, the hospital relied on an informal agreement that anaesthetists in charge of the list were responsible for patient up to 48 hours post-operatively.

However,

Patients were appropriately monitored for signs of deterioration and patient records we reviewed had evidence of National Early Warning Scores (NEWS) being completed. Staff knew what actions to take if NEWS was elevated.

The hospital monitored and reported hospital acquired infections. In the year prior to inspection there had been no incidents reported of hospital acquired infections such as MRSA or C Difficile and the rate of surgical site infection was within the expected range.

Staffing levels and skill mix were planned using an acuity tool and there were enough staff on duty on every shift to ensure patients received safe care.

Medicines were managed safely and stored appropriately. Clinical waste including medicines, sharps objects and chemotherapy waste, was disposed of safely.

Summary of findings

Staff demonstrated an understanding of their responsibilities in relation to safeguarding and knew how to raise concerns.

Are services effective at this hospital?

We rated effective as requires improvement overall because:

For medical care, there was limited evidence of how practice was audited against current evidence-based guidance, standards and best practice. There was no regular physician representative on the medical advisory committee (MAC) or at the clinical governance committee. The hospital did not audit use of National Institutes for Care Excellence (NICE) guidelines and other evidence based practice in the outpatient department. However, the hospital participated in national audits in endoscopy, which showed good outcomes within an expected range.

Staff appraisal rates did not meet the hospital target for some staff groups. There were gaps in clinical supervision of the Resident Medical Officers (RMO).

There were limited opportunities for multidisciplinary team (MDT) working in the outpatient department and there were no formal arrangements to ensure MDT discussion of medical patients except oncology patients.

Staff in outpatients did not always have the complete information they needed before providing care and treatment. Systems to manage and share care records were uncoordinated.

Documentation around 'do not attempt resuscitation' (DNACPR) was not in line with the organisation's policy and discussions with family members were not always recorded.

However,

The MAC chair worked closely with the senior management team and the clinical governance committee to ensure that the hospital was completing and acting on audits.

Surgical care and treatment was provided in line with national guidelines and most outcomes for patients were within the expected range.

We found evidence of good MDT working in surgery, and for oncology patients.

There was evidence of good pain management. Consent to care and treatment was obtained in line with legislation and guidance. Staff showed a good understanding of the consent process including assessing capacity for consent.

Staff were competent and had the necessary skills and knowledge to provide safe care and treatment.

Are services caring at this hospital?

We rated caring as good for all three core services because:

Nursing, medical and other healthcare professionals were caring and patients were positive about their care and experiences.

Patients were treated with dignity and respect. They were kept informed about their care and treatment and felt supported by staff.

Staff encouraged patients to complete the NHS Friends and Family Test (FFT) and we saw the FFT scores for the period of July to December 2015 were consistently between 98% and 100% which was better than the national average.

Are services responsive at this hospital?

We rated responsive as good overall because:

Summary of findings

The hospital consistently performed better than the England average for independent acute hospitals for referral to treatment (RTT) pathways in 2015.

The hospital had an admission policy to ensure only patients whose needs could be met were admitted. Senior nurses worked closely with consultants to ensure the policy was being adhered to.

Staff completed dementia awareness training and ensured patients who lived with dementia or who had learning disability were seen quickly to minimise the possibility of distress to them.

Complaints were acknowledged, investigated and responded to in a timely manner, and were discussed at the complaints review forum.

However,

The hospital did not monitor diagnostic imaging and procedures waiting times.

Information on how to make a complaint was not always clearly displayed.

Are services well led at this hospital?

We rated well led as requires improvement overall because:

Within the year prior to inspection there had been senior management vacancies which meant managers had not been able to effectively implement the arrangements for governance and performance management. For example, there had been no permanent Head of Clinical Services for 16 months.

There was a lack of effective medical leadership and medical care was not regularly represented at the MAC.

Although there was an audit calendar in place, some audits were not regularly completed.

However,

Staff were aware of the vision and strategy of the hospital. For example, they told us of plans for a new high dependency unit.

There was a team of suitably qualified heads of department with managerial responsibilities.

The MAC reviewed all new consultants before practising privileges were approved; this included their scope of practice. The hospital had an effective system in place to ensure that practising privileges were updated with the relevant information.

Staff told us the senior management team were visible, approachable and supportive. We observed that staff worked well as a team.

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

Importantly, the provider must:

Review the governance arrangements to ensure structures, processes and systems of accountability for the medical service are clearly set out, understood and effective.

Ensure the chemotherapy service is complying with national guidance for monitoring and reporting neutropenic sepsis and other patient outcomes.

Keep an up to date list of authorised signatories of staff that can order medicines in the hospital pharmacy, so that staff who undertake this responsibility can be identified.

Ensure that when risks are identified that they are recorded, reviewed regularly and timely action is taken to mitigate them.

Summary of findings

Ensure patient records are complete and up to date, including care plans, nursing assessments and do not attempt cardiopulmonary resuscitation orders.

Ensure all consultants who are transporting and storing medical records are registered with the Information Commissioners Office.

Improve staff attendance at mandatory training.

Ensure all relevant staff can access records in the chemotherapy service out of hours.

Ensure all staff have an annual appraisal.

In addition the provider should:

Ensure the medical service benchmarks its performance so it can monitor and improve its service. This includes ensuring the audit schedule and calendar are followed.

Review the multidisciplinary arrangements for all medical patients and ensure they meet national requirements.

Establish a formal service level agreement for the emergency transfer of unwell patients for treatment in local NHS facilities.

Ensure all staff comply with infection prevention and control practices such as being bare below the elbow and decontaminating hands between patient contacts.

Ensure all clinical areas comply with the requirements of Health Building Notice (HBN) 00-09: Infection control in the built environment.

Ensure patients have access to information on how to make a complaint as well as information on how to access external support.

Ensure all staff involved in care and treatment have access to full information related to patients' treatment to support decision-making.

Audit the use of National Institutes for Care Excellence (NICE) guidelines to ensure these are followed when providing treatment.

Enable multidisciplinary involvement in outpatients to ensure treatment options are considered in full and knowledge is shared.

Monitor key performance indicators, such as whether patients with suspected cancer were seen promptly, diagnostic imaging and procedures waiting times, and the time it took to issue an appointment letter from receipt of referral, to ensure quality monitoring and continuous improvement.

Professor Sir Mike Richards
Chief Inspector of Hospitals

BMI The Cavell Hospital

Detailed findings

Services we looked at
Surgery; Medical care (including older people's care); and Outpatients and diagnostic imaging.

Detailed findings

Contents

Background to BMI The Cavell Hospital

BMI The Cavell Hospital is a 27 bed private hospital in Enfield and was acquired from Nuffield Health in 2008. The hospital comprises two main buildings; the original hospital (Cavell building) dates from 1976 and accommodates the consulting rooms, physiotherapy department and endoscopy suite whilst the main building (Trent building) dates from 1994 and houses the imaging suite, ward and theatres.

The hospital provides a range of services including surgical procedures, out-patient consultations and diagnostic imaging. Services are provided to both insured, self-pay private patients and to NHS patients through both GP referral and contract systems.

The hospital has two operating theatres, one with laminar flow, a Walk in Walk out unit, in addition to a dedicated endoscopy unit. CT & MRI facilities are also available in a joint venture with Alliance Medical.

Outpatient services are provided from 13 consulting rooms, in addition to a nurse treatment room, an imaging suite and a physiotherapy department which also provides post-operative treatments & rehabilitation.

Our inspection team

Our Inspection team was led by ; Inspection Manager David Harris

The team included a CQC Inspection Manager and five inspectors supported by specialist professional advisors including, a consultant surgeon, an infection control nurse, a radiographer, and an outpatients manager.

How we carried out this inspection

To get to the heart of the patients' experiences of care, we always ask the following five questions of every service and provider:

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive to people's needs?
- Is it well-led?

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

Detailed findings

We carried out this announced comprehensive inspection between 21 and 23 June 2016, as part of inspections of independent health services. The inspection was conducted using the Care Quality Commission's new methodology.

We spoke with members of staff, including nurses, doctors, allied health professionals, managers and support staff. We reviewed patients notes, observed treatment and care, examined facilities and equipment. We also spoke with patients and their families and carers.

Our ratings for this hospital

Our ratings for this hospital 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	Requires improvement	Not rated	Good	Good	Good	Good
Overall	Requires improvement	Requires improvement	Good	Good	Requires improvement	Requires improvement

Medical care (including older people's care)

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

Information about the service

Medical services at The BMI Cavell Hospital include inpatient, endoscopy, and chemotherapy treatment and care. There were a total of 1,908 endoscopy and 485 oncology patient attendances between January 2015 and December 2015. Between June 2015 and April 2016 there were 24 general inpatient medical care patient attendances. The hospital provides care to a small number of patients who proceed to end of life.

The inpatient medical service is situated in the 27 bedded Trent ward for patients with medical conditions such as urinary sepsis, chest infection, and pain or rheumatism. The inpatient medical service is provided by medical consultants, a resident medical officer (RMO), nurses, including specialist nurses, health care assistants, a pharmacist, allied health professionals and administrative assistants.

The endoscopy service is provided in a dedicated unit which comprises a waiting area, four patient bedrooms, a treatment room (theatre), clean utility room, decontamination area, and recovery area. The service is provided by consultants, a pharmacist, and specialist nurses, who are supported by administrative assistants. Procedures undertaken include upper gastrointestinal (UGI) endoscopy, colonoscopy, sigmoidoscopy, bronchial endoscopy, enteroscopy and flexible cystoscopy. The endoscopy service is normally open between 8am and 8pm Monday to Friday.

The chemotherapy service is provided for adults with any cancer. The service is provided by five oncology consultants, an RMO, three chemotherapy specialist nurses, a breast care nurse, pharmacists and pharmacy technicians, and other allied health professionals. Treatments include simple and complex cytotoxic drug treatments and targeted therapies. The chemotherapy service is situated in one location on the Trent Ward, in five designated single accommodation rooms, where patients are provided with a bed, chair and en-suite bathroom facilities. It is an evolving service with plans to move to another area within the hospital as part of its improvement plan. The chemotherapy service is normally open Monday to Friday between 9am and 5pm.

There are arrangements to care for, or transfer patients to either the inpatient ward or other facilities, if they became unwell as a result of their treatment. However there is no formal transfer arrangement when patients need to be moved to NHS facilities.

During our inspection we spoke with 24 members of staff: senior managers, nursing staff (including lead nurses and specialist nurses), consultant physicians, resident medical officer, a pharmacist, housekeepers, catering staff, health care assistants (HCAs), and a ward clerk administrator. We also spoke with a number of patients and relatives on Trent ward, of which two were medical care patients. We observed interactions between patients and staff. In addition, we considered the environment and looked at records, including 21 patient records. Before and during our inspection we also reviewed performance information about the service.

Medical care (including older people's care)

Summary of findings

Overall we rated medical care services at BMI Cavell as requires improvement because:

- Five to seven rooms on the ward were usually used for medical care patients. However, staff told us the rooms were not solely dedicated to medical care and patients were only admitted if there was space, as surgical patients always took priority.
- Medicines errors and incomplete record keeping had occurred and had not been reported.
- Rooms used for chemotherapy services were used by other patients on occasions increasing the risk of infection. We saw fabric chairs in the rooms used for chemotherapy were not cleaned in accordance with national specifications for infection prevention and control.
- There were gaps in clinical supervision of the Resident Medical Officers (RMO).
- There was no evidence that rapid treatment for patients who were suspected of having neutropenic sepsis was audited.
- A list of authorised signatories of staff ordering medicines was not fully completed or up to date.
- There was no clear audit trail for the request and receipt of medicines stock.
- Staff were unable to access patient records in the chemotherapy service out of hours.
- Staff appraisal rates were below the hospital's target.
- There was limited evidence of audits against current evidence-based guidance, standards and best practice.
- There was no physician representation on the Medical Advisory Committee (MAC) or at the clinical governance committee.
- Do not attempt cardiopulmonary resuscitation (DNACPR) orders were not completed in accordance with local or national guidance.
- Staff used family members to translate when English was not the patient's first language rather than using a recognised interpreter service. Information leaflets were only available in English language.
- There was no visible information on the ward or hospital to explain to patients or relative how to raise concerns or complaints, or how to access bereavement, financial, psychological or emotional support.
- There was no system in place to record information about patients with additional needs such as patients with a learning disability and dementia.
- There was no specific forum to formally review governance and performance of the medical care service.
- Although the provider had worked on improving its auditing programme, we found there were gaps in the auditing process.
- There was a limited approach to obtaining the views of people who used the services in order to drive improvement.

However, we also found that:

- Patients were treated with respect and compassion.
- Patients were kept informed about their care and treatment and felt supported by the staff.
- There was sufficient equipment to deliver safe and effective care. All equipment including electrical equipment was regularly tested and safe for use.
- In the last year, there were no reported health acquired infections for Meticillin Resistant Staphylococcus Aureus (MRSA), Meticillin Sensitive Staphylococcus Aureus (MSSA) and Clostridium Difficile (C. Diff).
- Patients were reviewed by a consultant at least once every 24 hours.
- There was good multidisciplinary (MDT) working for breast cancer patients. Patients' chemotherapy treatment was discussed at the local NHS MDT meetings.
- Nurses and health care assistants had a personal competency and mandatory training folder where

Medical care (including older people's care)

they stored their certificates and recorded evidence of learning and development. The programme ensured staff had knowledge and skills to care for both surgical and medical patients.

Are medical care services safe?

Requires improvement

By safe we mean that people are protected from abuse and avoidable harm.

We rated safe as requires improvement because:

- There were systems in place to report, investigate and act upon safety incidents. However, they were not always effectively implemented. For example, we saw where medicines errors and incomplete record keeping had occurred and were not reported, which meant there was no evidence of any learning or corrective action to resolve them.
- There was a Resident Medical Officer (RMO) on site 24 hours a day, seven days a week. They had a range of general skills; however they did not have specific qualifications to care for patients undergoing chemotherapy.
- There was a process in place to obtain rapid treatment for patients who were suspected of having neutropenic sepsis. However, there was no evidence that an audit had been undertaken to monitor this and the data was unavailable.
- Rooms used for chemotherapy were used by other patients on occasions increasing the risk of immuno-compromised patients getting an infection.
- Staff were unable to access patient records in the chemotherapy service out of hours.
- We saw incomplete patient records in the inpatients and chemotherapy services.
- Mandatory training included a range of patient safety topics. The overall compliance rate with mandatory training in the hospital was 89.1 %. The medical service fell just below the target of 90% in all areas: medical inpatient service was 88%, chemotherapy service 85% and endoscopy 88%.

However;

- Patients who deteriorated were appropriately monitored. There was a system in place to recognise and manage a deteriorating patient. Appropriate triggers were in place to ensure patients, who had

deteriorated were treated according to their clinical needs. All patient records we reviewed had evidence of NEWS being completed and staff knew what actions to take if NEWS was elevated.

- The hospital gathered patient information about hospital acquired infections and reviewed these through its clinical governance processes. In the last year, there were no reported hospital acquired infections for Meticillin Resistant Staphylococcus Aureus (MRSA).
- Clinical waste was disposed of safely. This included disposal of medicines, sharp objects and chemotherapy waste.
- There were systems in place for managing medicines, to keep people safe. Chemotherapy drugs were manufactured off site, on a named patient basis, aseptically, (in a germ free environment) by an external provider. Medicines were stored safely and administered only when prescribed by a doctor.
- There was sufficient equipment to maintain safe and effective care. Safety checks were carried out to ensure equipment remained ready for use.
- There were systems in place to make safeguarding referrals if staff had concerns about a vulnerable adult. There had been no safeguarding concerns reported within the previous year.

Incidents

- There were 225 clinical incidents reported across the hospital between January 2015 and December 2015. None of them were classed as serious incidents (SIs).
- There were no never events between January 2015 and December 2015. Never events are serious, preventable patient safety incidents that should not occur if the available preventative measures have been implemented.
- An incident policy (including serious incidents) was available on the hospital intranet site and staff knew how to access it. Although some staff members we spoke with could not recall the last time they reported an incident, they told us what the process was and gave us examples of incidents that were discussed during team meetings. Staff used a paper form to record incidents which was then entered onto the electronic system to allow the monitoring of trends.
- Staff and managers told us there had been no medicines errors reported between January and December 2015. Those we spoke with told us they found this unusual and did not feel confident to state no errors had occurred. During our inspection we looked at 21 patient medicines administration records (MARs). The majority were completed in line with national and local standards. However, we saw an example of a medicines error where one patient was prescribed and administered six medicines without a doctor's signature. This had not been reported as a medicines error or safety incident.
- Clinical and non-clinical incidents were reviewed and discussed at a range of meetings including a bi weekly incident review meeting and the monthly hospital clinical governance committee meeting. There was monthly feedback to all staff of learnings and outcomes.
- Analysis of all incidents reported between May 2015 and May 2016 showed that the most prevalent type of incidents related to delayed admission of day care patients to the ward, cancelled operations, staff accidents and unplanned patient transfers.
- Expected and unexpected deaths were discussed at the weekly incident review meetings and monthly clinical governance meetings. There were no unexpected deaths reported between January 2015 and December 2015.

Duty of Candour

- The Duty of Candour (DoC) 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 had an understanding of the DoC. They gave us examples of when they applied the principle of the duty of candour by apologising and being open and transparent with patients. The examples related to delays in treatment however we did no see written evidence.

Safety thermometer or equivalent

- There was incomplete information displayed in the hospital to show recent overall patient satisfaction rates and actions taken in response to concerns raised.

Medical care (including older people's care)

- Details of required staffing and actual staffing levels should have been displayed on a notice board in the main ward corridor for relatives and visitors to see. However this was incomplete.
- Safety thermometer data provided by the hospital showed that between June 2015 and May 2016 the VTE (venous thromboembolism) screening was completed on all patients apart from November 2015 when VTE assessments were not completed on four patients. There were no incidents of hospital acquired VTE or PE (Pulmonary Embolism) in the reporting period.

Cleanliness, infection control and hygiene

- There was an infection prevention and control programme in place, led by an infection prevention and control nurse and supported by a consultant microbiologist. National specifications for cleanliness were adhered to which meant that patients were kept safe from the risk of infection. However, rooms used for chemotherapy were used by other patients on occasions increasing the risk of immuno-compromised patients getting an infection.
- National specifications for cleanliness were not always adhered to. For example, we saw fabric chairs in the rooms used for chemotherapy were wiped with a cloth and not steam cleaned as recommended.
- The hospital reported that there had been no incidents of neutropenic sepsis during 2015.
- Between January and December 2015 there were no reported health acquired infections or Meticillin Resistant Staphylococcus Aureus (MRSA), Meticillin Sensitive Staphylococcus Aureus (MSSA) and Clostridium Difficile (C. Diff).
- Staff applied the national colour coding scheme for cleaning materials and equipment to avoid cross contamination.
- There were sufficient hand washing facilities and instructions for hand washing in all the areas we visited and we saw they were used in accordance with national and local policy.
- Personal protective equipment (PPE), such as gloves and aprons, was provided throughout the clinical areas of the department and we saw that it was used according to national and local policy.
- Bare below the elbow guidance published by the National Institute for Health and Care Excellence (NICE) states that hands need to be decontaminated after contact with a patient's surroundings as well as after every episode of direct contact with patients. During our inspection we saw all staff were bare below the elbow.
- The ward had two isolation rooms with anterooms which could be used in the event of a patient needing such precautions.
- Disposable curtains with an antibacterial covering were used in all treatment areas we visited and were clearly labelled with the date of when they were last changed.
- Spillage kits for the safe disposal of body fluids were provided, and were within date. Staff knew where to locate them, and correctly described the procedure for managing this situation in accordance with the local policy.

Environment and equipment

- The inpatient service was provided in single accommodation rooms with ensuite bathroom facilities.
- The chemotherapy treatment rooms had recently been refurbished and were spacious with ensuite bathroom facilities.
- The endoscopy service was provided in facilities that were purpose built in 2013. There was clear segregation of clean and dirty equipment and procedures, and a separate admission and recovery area.
- Resuscitation equipment for use in an emergency was readily available, clean and ready for use. Staff provided evidence that they were trained in its use as part of the hospital's mandatory training programme. The equipment was stored securely in designated trollies, checked daily and documented as complete. We saw all drawers and shelves were fully stocked with consumables and medicines that were in date.
- All electrical equipment we saw was marked as having undergone a portable appliance test, giving assurance that it was safe for use. There was a central register of equipment held within the hospital.
- 24 hour maintenance support was provided, which staff knew how to access.

- There was sufficient equipment, such as intravenous pumps and subcutaneous syringe drivers, to maintain safe and effective care. Staff told us that they were also able to borrow equipment from the neighbouring BMI hospital should it be necessary.
- Emergency call bells and fire alarms were available in all areas we visited, and we saw regular testing took place.
- Oxygen was stored correctly with clear signs to indicate its location. Oxygen, patient call bells, and suction were checked daily to ensure they were fit for purpose. Each room had a signed checklist to evidence this happened.

Medicines

- Staff were clear about the arrangements in place for safely managing medicines, including cytotoxic medicines and controlled drugs (CDs). This included policies and processes for ordering, recording, storing, dispensing, administering and disposing of medicines.
- An on-site pharmacy service was provided for inpatients and outpatients between 8am and 5pm Monday to Friday by a team of three whole time equivalent pharmacists, and 2.6 whole time equivalent pharmacy technicians who worked across two BMI hospital sites in Enfield. There were specified arrangements for staff to gain emergency access to the pharmacy out of hours, with the resident medical officer (RMO) and senior nurse holding separate keys.
- The pharmacy manager had access to specialist advice from the chief pharmacists within the BMI organisation, including a subject specialist in oncology (for chemotherapy). Staff we spoke with were consistently positive about the pharmacy information and service provided.
- Patients had access to medicines when they needed them. Medicines were supplied to the hospital pharmacy through a centrally managed contract with the BMI procurement department. There was a top-up service for replenishing medicines stock items and for other medicines issued on an individual basis. However, there was no clear audit trail for the request and receipt of medicines stock, and no formal audit to monitor medicines management against policy. We were told work was in progress towards this.
- The medicines administration record did not allow for documentation of medicines reconciliation on an individual basis and therefore this was not completed.
- Individual prescriptions were monitored by pharmacists on a regular basis, who recorded their observations in patient records, and advised staff in the safe administration of medicines.
- All medicines including medical gases were administered only where prescribed by a doctor. Prescriptions were mostly paper held, with the exception of a new electronic prescribing system for chemotherapy, introduced in May 2016. Prescription stationery was stored and issued safely using a prescription identifier number for security purposes.
- A list of authorised signatories of staff that can order medicines in each department of the hospital should be kept in the hospital pharmacy, so that staff who undertook this responsibility could be identified. We looked at all the lists held in the pharmacy department. With the exception of the list for the endoscopy unit, these were incomplete and out of date, which meant not all authorised staff were identifiable. Staff and managers were unable to tell us when the lists were last reviewed or how they were updated. We brought this to the attention of the senior management team who told us corrective action would be taken.
- Emergency medicines used for the treatment of anaphylaxis or cardiopulmonary resuscitation were clearly labelled, available for use, and regularly checked.
- There was an up to date antibiotic protocol which included first and second choice medicines to use, the dosage, and duration of treatment. However, the planned audit to monitor antimicrobial stewardship had not taken place in March 2016.
- Allergies were recorded in patient records and the medicines administration records.
- There was a policy and procedure in place for handling cytotoxic substances (chemotherapy), which staff were clear about. This included the process for dealing with cytotoxic spillages. Spillage kits were readily available and within date, which meant they were ready for use.
- We looked at a random sample of medicine stock in the pharmacy department and treatment areas, and related records, and saw that these had been reconciled correctly.
- All areas used to store medicines were secure, with access restricted by named staff using a keypad and a

key. There were specific procedures for staff to gain emergency access to the pharmacy out of hours, with the resident medical officer (RMO) and senior nurse holding separate keys.

- Where medicines required cool storage, refrigerator temperature checks were carried out and recorded, and were all within the required range. Staff were aware of the process to follow if the temperature should fall out of the safe range.
- Controlled drugs (CDs) were stored in lockable wall units and were checked on at least a daily basis by registered nurses or pharmacists. The CD registers and order books were completed in line with local procedures. Managers told us that BMI required an audit of the controlled drugs should be carried out every three months. We asked to see evidence of controlled drugs audits within the last year, and were told that these had not taken place due to management changes. However, in June 2016 the hospital had successfully renewed its home office licence to supply and possess controlled drugs. The application process involved an announced inspection visit from the home office with one outstanding action.
- Chemotherapy medicines were manufactured, aseptically (under sterile conditions), by an external provider and supplied on a named patient basis. It was checked by pharmacists and pharmacy technicians with specific training in this area before being transferred to the ward area. If chemotherapy was not given, the reason for this was recorded on the patient's medicines administration record.
- For patients being discharged, tablets to take away (TTA) were delivered to the patient. If patients were given medicines as a TTA, they were given specific advice on how the medicines should be stored and handled.
- Staff received and acted on safety alerts relating to medicinal products and medical devices in a timely manner, and provided us with examples of where this happened.

Records

- The hospital used a paper based system for recording patient care and treatment. A complete set of records for all aspects of patient care and treatment were kept on site including a record of the initial consultation and treatment provided by the admitting consultant.
- Patient records contained information of the patient's journey through the service including pre assessment, investigations, test results and treatment and care provided.
- Out of hours, staff could not access records of patients who used the chemotherapy service. This meant that if patients telephoned for advice information about them was not available.
- The recorded care pathways included risk assessments such as risk of falls and mobility, which were correctly completed and reviewed as required.
- Some patient records were kept at the patient's bedside, such as care plans and fluid balance charts . These were completed and up to date.
- We reviewed 21 sets of patient records: 12 of which were inpatients .These were found to be formatted in a standard layout to allow ease of access to relevant information. There was inconsistency with the completion of records. For example, only three out of ten patients had a record of a multidisciplinary team assessment, 16 out of 21 patients had a VTE assessment, and records of intentional rounding were incomplete.
- Patients who had an endoscopy had a record of the safety checks undertaken against the World Health Organisation (WHO) 'Five Steps to Safer Surgery' checklist. However, although this was recorded on the white board in theatre and theatre register there was no permanent record within the patient notes.
- Once records were no longer required after the patient had been discharged, they were stored on site in a secure records office prior to being archived. Prior to filing, records were checked for completeness and to ensure all records within the file were secure.
- A clerk was employed to ensure patient records were available as required, for example to ensure files were available on site for clinic appointments or following a patient re admission. A tracking system was used which required records to be signed in and out of the store, and was consistently and correctly adhered to.

Safeguarding

- There were no safeguarding concerns at the time of our inspection.
- There were arrangements in place that reflected both relevant legislation and local requirements . Staff understood their responsibilities to protect people from harm. There were systems in place to make safeguarding referrals if staff had concerns about a vulnerable adult. The staff we spoke with talked confidently about the types of concerns they would look for and what action they would take.
- There were two individual staff members who were the named location leads for adult safeguarding and child safeguarding respectively. Staff we spoke with correctly identified the safeguarding leads by name, and correctly described how they would work with them to raise and escalate any safeguarding concerns.
- Data provided by the hospital showed that all but two staff members completed adult safeguarding training at level 1 and all required staff completed adult safeguarding training at level 2 and level 3.

Mandatory training

- There were systems in place that required staff to attend mandatory training. Heads of department were responsible for encouraging staff to complete the training and ensure compliance with attendance. The BMI mandatory training target was 90% compliance. The overall compliance rate for the hospital was 89 % in the reporting period. The inpatient service had reached 88%, chemotherapy 85% and Endoscopy 88%. However, staff were working towards meeting the targets and all spoke positively about the arrangements in place.
- Training attendance was monitored and reviewed at clinical governance meetings.

Assessing and responding to patient risk

- There was an admission policy setting out agreed criteria for admission to the hospital. All patients were admitted to the medical service under the care of a named consultant.
- The practicing privileges agreement for each doctor ensured there was 24 hour clinical support from the named consultant when they had patients in the hospital. This included making alternative arrangements for a named consultant to attend to patients in an emergency if they were not available. There was always a resident medical officer (RMO) on site who had completed advanced life support training, who was able to provide first line emergency treatment. Two nurses in the endoscopy service had also recently successfully completed advanced life support training.
- There was a process in place to obtain rapid treatment for patients having chemotherapy if there was suspicion of neutropenic sepsis: a potentially life threatening complication of chemotherapy. Staff we spoke with were able to recognise the signs and initiate appropriate assessment and treatment for this. Patients were provided with information so that they could self-monitor at home. However, we looked at patient records when they had telephoned for advice from home and saw these were not fully completed as the patient's body temperature was not recorded despite this section being a recognised key indicator .
- Out of hours patients would phone the inpatient ward nurses for advice. The nurses working on the inpatient ward had not completed specialist training to support oncology patients.
- Proactive patient rounds, known as 'intentional rounds' were in place to provide in patients with regular contact with a member of the nursing team and allow hourly checks on welfare and any change in the patient's clinical condition..
- Staff we spoke with were clear of the processes to follow if a patient deteriorated. The inpatient medical services assessed patients by using the national Early Warning Score (NEWS). If patients in the chemotherapy or endoscopy service developed complications they would be transferred to the hospital inpatient facility. Staff and managers told us if the complications were more serious, patients were moved out of the hospital to a neighbouring NHS facility by emergency ambulance. However, there was no formal service level agreement with the local NHS trusts to support this, since the urgent care facilities had been reconfigured. The hospital had tried to get a service level agreement but had been unable to. However, they said this did not impact on the safe and prompt transfer of patients. There were nine transfers of patients from the hospital to the NHS in the reporting period, of which four were patients who used the medical service.
- Extravasation is a recognised complication of chemotherapy, where toxic medicines escape into the tissues rather than being confined to the vein. This can cause anything from a minor skin reaction to severe

tissue injuries. The more serious reactions require rapid assessment by a plastic surgeon, which is best practice. Staff were aware of the policy to follow should extravasation occur. Patients who had a mild reaction would be treated locally according to the hospital's extravasation policy. There were kits available, which staff were aware of, to deal with any extravasation. However, if further treatment was required, the patients would be transferred to an NHS acute hospital.

- During the opening hours for the chemotherapy service, named nursing staff who had completed specialist training provided a telephone triage service for patients following transfer to their home, using the United Kingdom Oncology Nurses Society (UKONS) triage rapid assessment and decision tool kit. This is designed to promote quality and consistency for patients seeking telephone advice. We looked at five records and saw that this happened. However, the records we looked at were incomplete, as none of them had a record of the patient's temperature, and there were missing signatures, and incomplete action plans. We brought this to the attention of the nurse in charge.

Nursing staffing

- A senior nurse was in charge as a contact point for staff, consultants and patients 24 hours a day, seven days a week.
- Nursing staffing was planned using an acuity tool to calculate staffing based on patient nursing dependency levels and skill mix. Nursing staffing was at a ratio of one nurse to 6 patients, with additional support from health care assistants. Staff worked flexibly across two hospital sites. We looked at duty rotas which confirmed this happened and there was also a twilight shift in place to facilitate discharge of patients. The nursing dependency within the acuity tool had clearly defined levels in accordance with NICE safer staffing guidelines. The tool was designed to ensure the right staff were on duty at the right time with the right skills to ensure excellent patient care.
- Staffing levels were monitored daily and staffing allocated no more than a minimum of five working days ahead. There was a minimum staffing level of two registered nurses within the hospital at all times. Between January and December 2015 the hospital occasionally used agency nursing staff (on average 1%). No agency health care assistants were employed in the same period.

Medical staffing

- All patients were admitted under the care of a named consultant. The consultants reviewed patients prior to commencement of each treatment and provided a 24 hour on call service as and when required.
- A requirement for all consultants within the BMI practising privileges policy was that they remained available (both by phone and, if required, in person), or arranged appropriate named cover at all times when they have inpatients in the hospital. Part of the consultant's practicing privileges agreement was that they should be located within 30 minutes travel time of the hospital.
- The day to day medical service was provided by a resident medical officer (RMO) who dealt with any routine and also emergency situations in consultation with the relevant consultant. Out of hours, consultants provided either telephone advice or attended in person.
- The RMOs provided a 24 hour 7 day a week service on a rotational basis. All RMOs were selected specifically to enable them to manage a varied patient caseload and particular requirements. The management of the RMOs was through liaison with the agency and the director of clinical services.
- There was no formal rota for anaesthetists to provide care and support for medical patients.
- There was an on call rota operated by radiology and engineering if support was required out of hours, as well as an on call emergency theatre.
- Patients told us they saw their consultant at each appointment and felt confident that there was clear communication between the medical staff, nursing staff and other therapists.

Major incident awareness and training

- The hospital had a service contingency plan in place for staff to use in the event of interruption to essential services. Staff were aware of the escalation process if there was an incident requiring a major response. However, staff were unable to recall any specific training in this area.
- Managers provided an example of a recent power cut which meant contingency plans were put in place. There was no negative impact on patient care.

Medical care (including older people's care)

- Members of the senior management team were briefed each morning at the daily 'Comms Cell' hospital meeting to ensure that there were clear lines of accountability and responsibility in managing emergencies.

Are medical care services effective?

Requires improvement

By effective, we mean that people's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence.

We rated effective as requires improvement because:

- There was limited evidence of how practice was audited against current evidence-based guidance, standards and best practice. The provider told us they were unable to retrieve data for some patient outcomes and audits within the last year.
- Patient chemotherapy treatment plans were discussed at the local NHS multidisciplinary (MDT) meetings attended by oncology consultants. However, there were no formal arrangements to ensure MDT discussion of other medical patients and we found no evidence that this happened.
- The medical advisory committee (MAC) worked closely with the senior management team and the clinical governance committee to ensure that the hospital was completing and acting on audits. However, this did not happen in the medical service, there was no representation of physicians on the MAC or at the clinical governance committee.
- It was unclear who was responsible for clinical supervision of the resident medical officers (RMOs).
- Staff appraisal completion rates did not meet the hospital's target. Staff did not have regular one-to-one meetings and where they happened they were reactive and corrective in nature.

However, we also saw good practice

- The MAC reviewed all new consultants before practising privileges were approved; this included their scope of practice. The hospital had an effective system in place to ensure that practising privileges were updated with the relevant information, for example appraisal, General Medical Council (GMC) registration, and Medical Defence Union membership.
- There was participation in national audits in endoscopy, which showed good outcomes within an expected range. The hospital was actively working towards obtaining the joint advisory group on gastrointestinal endoscopy (JAG) accreditation.
- There was good multidisciplinary working for breast cancer patients where BMI Cavell staff attended weekly meetings at the neighbouring hospital to discuss care and treatment of their patients.
- All nurses and health care assistants completed a competency based training programme which ensured staff had the necessary knowledge and skills to care for people needing medical care or treatment.
- All staff were aware of their responsibilities with regard to gaining valid consent from adults who lacked capacity.

Evidence-based care and treatment

- Clinical policies and procedures were available on the hospital intranet and staff demonstrated how to access them. These were based on professional guidance produced by the National Institute for Care and Health Excellence (NICE) and the Royal Colleges, for example.
- Staff were informed about updates to national and professional guidelines through the monthly clinical governance and quality and risk bulletin. The bulletin summarised what the guidance covered and provided a hyperlink to relevant documents.
- The hospital told us their consultants were affiliated with a London cancer network. The hospital told us they were represented by a trust board member who relayed the relevant information to the clinical board at local level. Yearly clinical events were attended by all clinical personnel from all the included trusts within each network. Cancer networks help clinicians to deliver safe and effective care and improve cancer clinical outcomes.
- During our inspection, we saw two examples when staff did not adhere to the policies and there was no effective monitoring arrangement in place to ensure compliance. The hospital had guidance on the prevention, identification and treatment of neutropenic

sepsis in patients having chemotherapy. Staff used a form for the initial clinical assessment of neutropenic sepsis. We found all five forms we reviewed were not fully completed and the patient's body temperature was not recorded despite this section being a recognised key indicator. The second example was that we found two patient records had a photocopy rather than the original 'Do Not Attempt Cardio Pulmonary Resuscitation' (DNACPR) template which was contrary to the policy, and that details of those involved in the decision making were incomplete. We asked managers, doctors and nurses how the DNACPRs were monitored and no staff were able to provide us with such evidence.

- There was a limited clinical auditing programme to support and monitor implementation of NICE guidance. For example, the hospital did not have a system in place to audit neutropenic patients receiving antibiotics in line with national guidelines, peripherally inserted intravenous catheter (PICC) lines, or early warning score system to identify deteriorating patients.

Pain relief

- There was no specialist pain team at the hospital; however staff told us they would alert the resident medical officer or consultant if a patient required pain management who could assess the patient and prescribe pain relieving medicines where necessary. Patients could also be referred to a specialist in pain management on an individual basis, but staff could not recall when this had been needed.
- Palliative pain specialists were available to support oncology patients where needed, however there had been no such referrals required in the past 12 months.
- Patients' perception of pain was measured using a recognised pain assessment tool.
- All patients we spoke with told us the staff regularly assessed their pain and they received pain relieving medicines in a timely manner. We saw this happened and was recorded in patients' notes.
- During our inspection we reviewed 21 patient notes and saw that all patients had their pain assessed and acted upon.
- The hospital carried out a pain management audit in February 2016 which scored 89% against 100% target. However, the data did not show where the gaps were.

Nutrition and hydration

- We saw the patients' nutrition and hydration needs were assessed and met. We observed patients always had drinks available within reach.
- Patients were offered the choice of cooked or cold meals three times a day, seven days per week.
- Call bells had a designated function for patients to alert catering staff should they need a drink or food between 7am and 8pm. Outside of these hours patients called a nurse or health care assistant (HCA) to assist with meeting their nutritional needs.
- Catering staff and HCAs informed nurses if a patient did not eat their meal or if their food and drink intake was low.
- Staff told us if they identified a patient with swallowing problems, or patient had percutaneous endoscopic gastrostomy (PEG) feeding tube they would request a dietician. The dietician provided a service to the hospital on a practising privileges basis and was booked by administration staff once agreed by the consultant. Staff told us last time they recalled using a dietician was approximately six months before our visit and that they were satisfied with the service.

Patient outcomes

- The hospital informed us patient outcomes were audited in a variety of ways, utilising local, national, BMI and external data. However, we saw little evidence the medical care service carried out regular and systematic local and national patient outcomes audits related to the effectiveness of treatment for example, cancer related audits, adult diabetes, lung cancer, or national dementia audit.
- Staff informed us the hospital produced a monthly BMI quality dashboard to capture patient outcomes and compare standards with other BMI hospitals. The quality indicators included clinical and non-clinical incidents, transfers out, returns to theatres, infections, average length of patient stay, day case conversion rates, re-admission rates and cancellations.
- The hospital reported on various mandatory quality indicators. Between June 2015 and May 2016 there was one unplanned re-admission of medical in patient within 28 days. Between January and December 2015 there were 88 day care patients who converted to an overnight stay which were 2% of all day care patients. The outcome had improved form 3% in 2014. The data did not differentiate between medical care and other

specialities. Between June 2015 and May 2016 there were three transfers to acute NHS hospitals of medical care patients. Between January and December 2015 there were six deaths reported to the CQC. All mortalities within the medical service were expected.

- We asked to see the most recent audit of patients who displayed signs and symptoms of neutropenic sepsis and were told that no data was available, because there had been no patients with neutropenic sepsis. However, there was no audit tool in place. This meant that the service could not be assured that patients who had displayed symptoms of a possible infection received antibiotic treatment and blood tests within an hour of arrival, which is best practice.
- At the time of our inspection the endoscopy unit was working toward JAG (joint advisory group) on gastrointestinal endoscopy accreditation as part of the BMI corporate project. The JAG accreditation is the formal recognition that an endoscopy service has demonstrated that it has the competence to deliver against the measures in the endoscopy global rating scale (GRS) standards. The hospital had set up a working group including to support the achievement of the accreditation.

Competent staff

- Data from December 2015 provided by the hospital showed the completion of staff appraisals did not meet the hospital's 100% target. We saw completion rates of 40% for allied health professions (AHPs), 61% administrative staff, 75% for health care assistants (HCAs) and 80% for nurses. Managers acknowledged that appraisals had not been undertaken on a consistent basis. Plans were in place to ensure all staff had an annual appraisal, and this had been identified as a priority with the heads of departments.
- Medical services were provided by consultants who had been granted practicing privileges by the organisation. The medical advisory committee (MAC) carried out checks before granting new consultants practising privileges. This included checks on their scope of practice, with regards to management of patients undergoing treatment for cancer, to ensure they were acting within their competence.
- The RMO was up to date with mandatory training for advanced life support (ALS); however, they were no specialist chemotherapy doctors working at this level.
- Nursing staff told us they felt well supported by the consultants, whilst they were on site and if they needed to be telephoned out of hours.
- Staff did not have regular one-to-one meetings scheduled with their line managers. When they did happen they were usually reactive in response to an incident or drop in performance.
- Staff gave us examples of when they managed variable staff performance by supporting improvement of their skills.
- All staff we spoke with completed the BMI corporate and hospital induction programme. This included shadowing experienced staff members and being allocated a mentor. Senior staff told us the hospital tended to employ trained and experienced nurses rather than those newly qualified. They also recruited nurses who had trained overseas, who at the time of the inspection, were working as health care assistants and were working towards professional registration with the Nursing and Midwifery Council (NMC).
- Agency nurses underwent hospital orientation and induction. The use of agency staff was minimal and between January and December 2015 was 1%. Senior staff told us they always tried to book the same agency staff that were familiar with the hospital.
- The hospital had a competency based training programme for nurses and HCAs. We saw each staff member had a personal competency and mandatory training folder where they stored their certificates and recorded evidence of learning and development. This was also used as evidence towards revalidation.
- Staff on Trent ward provided care and treatment to surgical and medical patients. The hospital competency programme ensured staff had knowledge and skills to care for both types of patients. Examples of competencies for registered nurses included: patient controlled analgesia (PCA), oxygen therapy, administration of intravenous (IV) medicines, blood transfusion, point of care testing, and mentorship. Competencies for HCAs included : chaperoning, acute illness management (AIM), admitting patients, taking observations, nutrition and feeding, and hydration.
- Chemotherapy nurses completed and maintained specialist training and skills. For example, through successful attendance at recognised chemotherapy courses and annual chemotherapy updates delivered by

Macmillan. Other examples we were given included breast cancer care and intravenous medication administration. The specialist nurses also attended UK Oncology Nursing Society (UKONS) annual conferences.

- Endoscopy staff completed specific training in the care and maintenance of flexible endoscopes, and decontamination training, and participated in national specialist networks within the BMI organisation.
- Staff could search for and book additional training through their personal e-learning accounts. Staff showed us their e-learning profile and demonstrated where they applied for additional competency courses such as ECGs and cannulation.
- Staff told us they were encouraged and given opportunities to develop their skills. They spoke positively about the choice of additional training although most said it was had not been easy to find time to attend additional courses.
- The Medical Advisory Committee (MAC) chair communicated with NHS Trust medical directors to ensure a coordinated approach to engagement with consultants with practising privileges.
- For a consultant to maintain their practising privileges at BMI The Cavell hospital they had to comply with the minimum data requirements such as registration with the General Medical Council (GMC), evidence of insurance/indemnity and a current performance appraisal and revalidation certificate. It was the consultant's responsibility to keep their information up-to-date.
- The senior management team would discuss concerns regarding a consultant with the MAC chair, and if considered serious, with the group medical director at BMI Healthcare. Concerns related to standards of practice, quality or patient safety were also shared with the consultant's responsible officer for revalidation.
- Staff spoke positively about the resident medical officers (RMOs) and their support in delivering care and treatment to patients. However, it was unclear who was responsible for clinically supervising RMOs to ensure they had sufficient training to meet the requirements of the patients they were treating. We were told the director of clinical services would liaise with the agency that employed the RMOs to provide feedback on general performance issues. We found no evidence their work was formally audited or they received regular clinical supervision or support.

Multidisciplinary working (in relation to this core service)

- Staff caring for patients with breast cancer attended weekly MDT meetings at the neighbouring hospital. Specialist nurses, oncologists, histopathologist, radiologist, radiographers and breast surgeons attended the meeting. The group discussed the care and treatment of their current cancer patients.
- The endoscopy lead nurse attended bi-monthly national BMI endoscopy meeting for leads where the group discussed different topics usually related to JAG accreditation.
- Staff told us for general medicine and oncology patients (other than breast cancer) there were no regular or structured MDT meetings. Consultants were expected to contact specialists, for example physiotherapist, speech and language therapist, occupational therapist, local social services or dieticians on an individual basis. The ward administrator usually booked them on consultant's request.
- We observed staff including nurses, HCAs, pharmacists and the RMO working as a cohesive team in delivering care and treatment to patients.
- There was a daily multidisciplinary meeting within the hospital known as 'the Comm Cell' designed to discuss and review safety issues. For example, equipment, staffing levels and any newly identified risks. We saw this happened and was well attended by a range of professionals.

Seven-day services

- The arrangements to provide medical and clinical care 24 hours a day, seven days per week was a combination of on-site and on-call arrangements. Three RMOs provided cover on a rotational basis. All RMOs had Advanced Life Support training and access to named consultants.
- The hospital had a policy which required all consultants to remain available (both by phone and, if required, in person), and formally arrange appropriate named cover if they were unavailable, at all times when they had inpatients in the hospital. We saw this happened.

Medical care (including older people's care)

- The hospital had an on call rota for pharmacy and radiology if support was required out of hours, as well as an on call emergency operating department team.
- Senior managers had an on call rota where for a week at a time they covered BMI Cavell along with another BMI hospital located 0.5 miles away.
- A senior nurse in charge was available as a contact point for staff, consultants and patients and was available via bleep or telephone.
- Specialist nurses supported patients who received chemotherapy Monday to Friday between 9am and 5pm. If a patient needed to be admitted overnight the specialist nurses handed over their care to the inpatient services.
- Patients were advised to contact the ward staff if they had any concerns out of hours.
- There was a dedicated endoscopy unit in the operating theatre department. The unit was open Monday to Friday 8am until 8pm. There was no endoscopy service available over the weekend.

Access to information

- Daily 'Comm Cell' meetings took place where relevant information on matters such as staff numbers, overnight stays, exceptions, and health and safety were communicated with ward staff and senior managers. The meeting lasted 15 minutes and we found it to have a well-structured agenda and was efficiently run. Staff spoke positively about its purpose and outcomes.
- During our inspection the ward staff and managers were unable to access oncology patients' notes when oncology nurses were not on duty. Staff and senior managers told us this was because the code to the oncology office was recently changed. However, this occurred over a month before.
- Staff showed us how to access key policies and standard operating procedures on the hospital's intranet, for example VTE assessment, neutropenic sepsis or chronic kidney failure.
- Following patients' discharge their medical notes stayed on the ward until post discharge checks were completed. Once completed, records were archived on-site. If clinical staff needed to access medical records administrative staff could retrieve them.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- We saw evidence that patient consent to care and treatment was obtained in line with legislation and guidance.
- Before an endoscopy procedure nurses reconfirmed the consent with a patient and each patient signed a consent form.
- 'Do Not Attempt Cardio Pulmonary Resuscitation' (DNACPR) decision making was set out by a corporate resuscitation policy. Decisions about DNACPR were clearly communicated during staff handover. However, we found examples of two DNACPR orders that were not completed in accordance with national or local policy. The details of 'relevant other' (relatives or friends who were consulted) were not recorded on the form and the correct template was not in use. Additional information regarding the final decision made by the healthcare professionals was also not documented in patient records. We brought this to the attention of the lead nurse.
- We looked at 21 patient records and saw consent forms were completed, signed and dated by the consultant and patient. Audits of ten consent forms carried out in March 2016 and June 2016 showed 100% compliance.
- When necessary, consultants assessed patient's mental capacity. They could request a mental capacity assessment from a psychiatrist if they needed further assistance. Information about patient's mental capacity was usually captured during pre-assessment.

Are medical care services caring?

Good

By caring we mean that staff involve and treat people with compassion, kindness, dignity and respect

We rated caring as good because:

- We saw that patients and those close to them were treated with kindness, compassion, dignity and respect. Those we spoke with were positive and happy about the care and treatment they received and described staff as 'excellent' and 'brilliant'. We observed that staff were also caring and respectful to each other. Staff addressed patients and relatives by their preferred name and always introduced themselves.

Medical care (including older people's care)

- Patients were given appropriate and timely information about their care, and emotional support to cope with their treatment and condition. There was a psychologist and a psychiatrist working under practising privileges at the hospital who provided support to patients when needed.
- All patients said they were kept informed about their care in a way they could understand.
- Staff promptly managed patients worries and anxieties.

Compassionate care

- Hospital wide friends and family test scores were high. Between July and December 2015 the results were 98-100%. The results included patients undergoing endoscopy procedures as there were no other NHS patients using the medical services.
- During our inspection, patients and relatives on Trent ward told us they were treated with kindness, and we saw that staff were always polite and introduced themselves. Every patient we spoke with was complimentary about the care they received. People felt supported and described staff described as 'excellent', 'caring', 'helpful', and 'great'. Patients described their care and treatment as : 'everything done well', 'excellent care', 'staff always helpful', 'courteous' and 'respectful of privacy and dignity'.
- Throughout our inspection, patients and those close to them spoke positively about the treatment and care they received from all hospital staff including clinical and non-clinical staff such as receptionists, housekeepers, porters and catering staff.
- There was a positive relationship between staff and patients; we observed that people were treated with dignity, respect and kindness during all interactions. Patients' privacy was maintained by ensuring the doors and windows were locked and covered during personal care or when visitors were in attendance.
- Patients informed us staff were accessible, approachable and reassuring. We saw call bells were promptly answered. Patients felt they could speak to staff about any concerns or queries.
- Some patients had been attending the hospital for some time and described the good rapport they had established with staff.
- Patients knew who their doctor, allocated nurse and health care assistant were. The name of the allocated nurse and health care assistant were written on the board in each patient room.
- Relatives reported feeling confident in the provider and said they felt patients were in 'good hands' and received 'excellent care'.
- We saw a number of thank you cards in the inpatient ward, endoscopy department and chemotherapy service office. One patient wrote 'thank you for all the kindness you have shown'. Another patient wrote '…I want to say thank you for the professional work you do, which has put me back on the road to recovery'.

Understanding and involvement of patients and those close to them

- Patients on Trent ward told us they felt involved and encouraged to make decisions about their care from admission to discharge. Patients told us they felt supported and were given appropriate and timely information. They gave several examples where they were involved in the decision making about their treatment, pain relief, food choice and care plan.
- Patients were asked about their preferences for sharing information with family members and their wishes were upheld.
- Patients we spoke with knew what to do if they felt unwell during admission and when discharged home. During the inspection, we observed that nurses, a physiotherapist, health care assistant, catering staff and consultants were attentive, friendly and asked how the patients and relatives were doing.

Emotional support

- Staff displayed good understanding of the impact of the patient's care, treatment or condition on their wellbeing and on the impact on those close to them.
- We observed staff communicating in a sensitive and calm manner, offering reassurance to concerned patients and their relatives. Patients gave examples where staff sat down with them to offer reassurance and speak about their anxieties.
- Psychological and emotional support was available to patients following diagnosis of long term condition. The service provided emotional support to both patients

and their families. This service extended to offering counselling and one-to-one consultations with a psychologist, psychiatrist, specialist nurse or consultant. Psychological and emotional support was available to patients following diagnosis of long term conditions.

- Patients told us staff were 'supportive, brilliant, helpful, reassuring' and gave them and those close to them 'the reassurance to ease their anxiety, fears or worries'.

Are medical care services responsive?

Good

By responsive we mean that services are organised so that they meet people's needs.

We rated responsive as good because:

- At the time of the inspection the hospital did not have a high dependency unit (HDU) however there was system in place to ensure right categories of patients were admitted to the ward.
- Relatives could stay overnight if they wished to and staff organised a guest bed for them.
- All NHS referral to treatment times (RTT) met the target rate of 95% of above.
- Referral to treatment times for endoscopy met the 95% target.
- The hospital offered good breast cancer support.
- Staff were knowledgeable about caring for patients living with dementia and how to access specialist advice.
- Patient's dietary requirements were addressed and there was a separate 'religious, ethnic and vegan' menu provided to meet people's individual needs.

However;

- The service did not monitor 30 and 90 day mortality rates after anticancer treatment.
- Staff had limited knowledge about caring for people with a learning disability.
- There was no system in place to record information about patients with additional needs (learning disability and dementia) on the hospital system.
- Although staff told us patients were seen promptly for treatment, this was not formally monitored.
- The hospital generally used patient's family members to translate when English was not their first language, rather than a recognised interpreter service. All leaflets we saw were in English language.
- There was no visible information in the department or hospital to explain to patients or relative how to raise concerns or complaints, or how to access bereavement, financial, psychological or emotional support.

Service planning and delivery to meet the needs of local people

- Five to seven rooms on the ward were usually used for medical care patients. However, staff told us the rooms were not solely dedicated to medical care and patients were only admitted if there was space, as surgical patients took priority. We saw no evidence this had an impact on delivery of care and treatment to medical care patients.
- The ward had four specific rooms which were used for patients receiving chemotherapy although these were not always ring-fenced and when needed the rooms would be shared with the surgical service.
- There were no restricted visiting times for patients. Visitors were able to stay overnight if they wished to, with a guest bed brought to the patient's room. Relatives were also offered refreshments.

Access and flow

- In 2015 there were 448 oncology day cases and 37 oncology inpatients. The majority of the inpatients (26) stayed two to three days with the longest stay being nine days (one patient).
- In 2015 there were 1,908 endoscopy procedures. Most patients (1,017) underwent upper gastrointestinal (UGI) endoscopy and colonoscopy (684).
- The hospital provided care for some NHS patients undergoing endoscopy. They were referred through NHS e-referral service. Patients referred by their GP could book a convenient date and time for their appointment through NHS 'choose and book' electronic booking system.
- All NHS referral to treatment times (RTT) met the target rate of 95% of above. There were no reported delays with patients receiving anticancer treatment.
- We saw no evidence the service monitored 30 and 90 day mortality rates after anticancer treatment.

Medical care (including older people's care)

- Staff did not record and monitor how long patients waited for treatment on the day of their appointment, therefore were unable to establish the extent to which services ran on time.
- The ward manager planned bed capacity on a weekly basis. They communicated with the hospital admissions team and chemotherapy specialist nurses on a daily basis to manage unscheduled overnight stays.
- The hospital had an admissions eligibility policy which ensured suitable patients were admitted to the ward. Since the hospital did not have a high dependency unit (HDU) staff could not accept critically ill patients. The decision to admit patients was carefully assessed by a consultant and ward manager. Senior staff gave us an example of when a consultant assessed a patient in their care home, to ensure the hospital was the most suitable place for them.
- Consultants admitted medical patients by completing a booking form and referring them through the administration team to the appropriate service.
- A nurse or HCA with relevant competencies undertook patient admission risk assessments to ensure suitable patients were admitted to the ward. The risk assessment was documented in the patients' notes and checked and countersigned by a nurse.
- If a patient became unwell during endoscopy procedure or chemotherapy they were admitted to the ward until they recovered. We saw evidence of that and staff told us this happened very rarely. A discharge letter with details of the procedure or treatment, medicines and date of the next appointment was given to the patient, and a copy sent to their GP within 24-48 hours.
- Patients told us the continuity of care was good. They saw the same team of medical, nursing and physiotherapy staff at each appointment. Patients informed us they saw their consultant at least daily, and the nursing staff were always in attendance to check on their condition.

Meeting people's individual needs

- Patients were accommodated in single rooms that provided privacy and comfort of en-suite facilities.
- The provider did not audit patient call bell response times; however, during our visit we saw that call bells were answered immediately. Patients and relatives told us that 'as soon as you ring the bell, [staff] knock on your door to check on you,. Patients told us staff encouraged them to use the call bell when they needed support.
- The hospital outsourced its catering service and since a recent change in contract patient satisfaction results had decreased regarding the choice of food. However, staff told us they were regularly meeting with the catering company to change the menu and introduce more choice to improve the service.
- The hospital did not provide a distinct end of life service however there were occasions when patients chose to die at the hospital. Staff told us they had links to local hospices and palliative care in the community where they could refer patients. The oncology team worked with a local hospice although they did not receive formal support from them. Staff told us previously the hospital had a nurse who was sponsored by the Macmillan charity but not at the time of the inspection.
- Staff told us they could help arrange a funeral and chaplain, although families usually arranged this.
- The hospital held monthly breast support group meetings for patients. Each month they covered a different topic such as diet, exercise and motivation, life coaching, or hair and makeup.
- The inpatient service had a quiet room for breaking bad news to patients and those close to them.
- Information booklets and resource packs such as breast reconstruction, diet and breast cancer, or breast cancer care were provided.
- During our inspection we did not see leaflets in the department or hospital to inform patients or relatives about how to access bereavement, financial, psychological or emotional support. Patients we spoke to were not aware there was a psychologist and psychiatrist on site.
- If needed, staff could arrange for a minister to support patients' spiritual needs. The ward had a sitting room for patients or relatives should they wish to relax outside of the patient's room. We found the room to be uninviting, with bare walls and three magazines issued in 2015.
- Dementia training was mandatory for clinical staff. Information provided by the hospital showed 95.38% of assigned staff completed the training. Staff we spoke with demonstrated knowledge of caring for patients living with dementia. For example, they talked about why different coloured food trays were used, and how

environmental obstacles such as carpets with patterns had been removed. Staff we spoke with knew about and showed us the dementia box that was used for creating dementia friendly environment which included items such as clock and phone with a large display, red jug and drinking glasses, 'this is me' form, and a vintage china tea cup and saucer. However, there was no system in place to record and identify patients living with dementia on the hospital patient record system.

- Staff had limited knowledge about caring for people with a learning disability. There was no specific training provided in this area or formal links with a specialist learning disability nurse. Staff told us it was rare for a person with a learning disability to use the service however the hospital was unable to tell us how many patients with a learning disability they saw in the last year. Staff told us they always tried to contact the patient's family or carer to establish patient's needs and find out how to keep them safe.
- Staff told us they encouraged family members or carers to stay with a patient overnight if this was beneficial to their care and wellbeing.
- Patients' special dietary requirements were noted on a notice board in the kitchen and included in the handover notes. A separate 'religious, ethnic and vegan' menu with variety of food choices included halal, kosher, vegan, Caribbean and Asian cuisines, amongst others. A light meal option was also available.
- A telephone language translation service was available for people who did not speak English as their first language. However, staff told us they did not use it often and when required translation they used a family member to translate. This is against best practice. Family members should not interpret for the patient as there is no assurance that the information has been translated accurately or in confidence.
- Information leaflets were not available in different languages.
- Discharge planning started from the patient's admission. Staff identified if a patient needed input from social services and whether they had appropriate support at home. The patients' discharge plans were discussed during handover and recorded in patient notes.

Learning from complaints and concerns

- Data provided by the hospital showed that between January and December 2015 there were 21 complaints across all services (the data did not specify the speciality). The main complaint themes were poor staff attitude and appointment delays or cancellation. The complaints were investigated, responded to and had learning outcomes and when appropriate, an assigned action holder.
- The complaint process was not displayed throughout the hospital. Most of the patients we spoke with did not know how to complain or raise a concern. However, staff informed us patients were provided with written information prior to admission with details on how to make a complaint.
- All formal and informal complaints were directed to the hospital executive director. A complaint could be raised by telephone, in person, or in writing.
- Patients and relatives could speak to the nurse in charge or a member of the management team if they were concerned about any aspect of care. Staff told us they always tried to resolve complaints informally in the first instance and directed patients or visitors to a manager if they were unable to do so.
- The director of clinical services reviewed formal complaints including those with a clinical element.
- Complaints were recorded on an electronic on-site complaints data base to allow the senior management team and clinical governance committee to monitor compliance with the BMI complaints policy. The system also allowed identification of trends, actions and learning.
- We saw evidence that the patient complaint data was reviewed and discussed at the complaints review forum, clinical governance and daily 'Comm Cell' meetings. Feedback detailing learning outcomes from complaints and concerns was communicated to staff during monthly ward meetings. As a result of learning from complaints the ward introduced hourly nursing rounds to provide patients with regular contact with a member of staff throughout their stay.

Medical care (including older people's care)

Are medical care services well-led?

Requires improvement

By well-led, we mean that the leadership, management and governance of the organisation assures the delivery of high-quality person-centred care, supports learning and innovation, and promotes an open and fair culture.

We rated well led as requires improvement because:

- The leadership arrangements in inpatients and chemotherapy did not always support the delivery of high quality person centred care.
- Although the provider had worked on improving its auditing programme, we found there were still gaps in the auditing process that remained unresolved.
- There was a clinical director with sole responsibility for cancer; however there was no principal cancer strategy.
- There was a team of suitably qualified heads of department with managerial responsibilities. However, within the reporting period there had been vacancies which meant managers had not been able to effectively implement the arrangements for governance and performance management.
- There was a limited approach to obtaining the views of people who used the services. This meant that there was not always sufficient information on which to base decisions to improve services.
- The governance of medical services was predominantly nurse led with no physician representative on clinical governance committee

However;

- Senior staff were engaged and knowledgeable of the challenges the medical service was facing.
- We found effective management and leadership in the endoscopy unit.
- Although there was no separate meeting to discuss performance of the medical care, the service was discussed at a range of meetings which we found were well attended and had structured agendas.
- The executive team visited all clinical areas regularly where they engaged with staff and patients to ask about their care and experiences. We saw feedback was acted on.

Vision and strategy for this this core service

- Staff understood the vision for the medical service it was to open a high dependency unit (HDU), and develop a dedicated medical inpatient unit with an integrated cancer centre. Business plans to open the HDU and medical unit were already in place. The integrated cancer centre was a longer term vision.
- The 'six Cs' initiative which encourage staff to embrace the values of compassion, competence, care, communication, courage, and commitment in nursing, was displayed throughout the hospital. During the inspection, we saw an example where a staff member was thanked for displaying courage and received a certificate in recognition.

Governance, risk management and quality measurement for this core service

- There were systems in place to monitor compliance with local and national policies and processes, including a schedule of audits. In 2015 the hospital reported low rates of compliance in completing audits, reviewing and identifying any actions. In particular, there was no evidence of any pharmacy or medicines management audits or controlled drugs audits between January and December 2015, with the exception of one controlled drugs audit in the endoscopy service. Other gaps were evident in infection prevention and control, record keeping, chemotherapy service audits and consent audits. The executive management team, senior management team and staff all acknowledged that clinical governance and audits had not been effective for at least 18 months, due to interim management arrangements within the nursing, pharmacy, and physiotherapy teams in particular.
- We saw evidence in the three months prior to our visit that improvements of completion of audits had been helped by introducing an audit calendar to remind staff when audits were due, and we also saw the introduction of improved audit tools. However, there were still gaps in the process and we saw little evidence that actions were identified, or that results were discussed and documented in ward meeting minutes.
- The audit calendar did not include a schedule for audit of peripherally inserted intravenous catheter (PICC) lines, audit of neutropenic sepsis pathways for patients having chemotherapy, or any audit of national early warning score (NEWS) systems to identify deteriorating

patients. This meant that compliance with evidence based practice and patient outcomes in these areas were not measured and that such information was not available to improve practice and outcomes.

- There was no specific forum to formally review governance and performance of the medical care service. Staff discussed medical care with other services, at a range of meetings such as heads of department meetings, monthly ward meeting, daily 'comm cell', and the hospital wide clinical governance committee.
- There was no representation or regular attendance of medical doctors at the clinical governance committee or meetings. However, nursing leaders attended the meetings and fed back to all staff.
- Information from heads of department meetings and sub committees fed to the clinical governance committee meeting.
- Hospital governance sub-committees included : blood transfusion, resuscitation, and medicines management committees. The group focused on patients safety and managing risks.
- Ward and departmental meetings were held regularly to discuss unit specific issues such as new policies and procedures, safeguarding, complaints, incidents, training, infection prevention control and any other business.
- The ward manager(s) shared minutes of ward meetings with relevant staff. Staff who could not attend signed a sheet to confirm they had read the minutes. Staff told us the ward manager asked them about the content of the minutes to ensure they read them.
- In 2016 the hospital's senior management team started work to improved risk management process to ensure robust governance. We saw evidence that local risks were regularly reviewed and discussed by clinical governance committee and during heads of department meetings. Also, local risks were a standing agenda of the daily 'comm cell' meeting. All staff we spoke with were aware of the main local risks.
- The endoscopy team attended endoscopy best practice meetings with colleagues from other BMI hospitals where review of policies and practice was a standing agenda. For example, the team had discussed diabetes guidelines, anticoagulation guidelines, and feedback from JAG assessments.

Leadership of service

- The leadership team, known as the senior management team, had been through a period of reorganisation for 18 months prior to our visit. For 16 months there had been no permanent Head of Clinical Services and a succession of interim managers including staff who had been seconded from other posts within the hospital. A permanent Head of Clinical Services came into post five weeks prior to our inspection. There had also been a newly appointed head of pharmacy and head of physiotherapy services.
- Staff and managers described the period of reorganisation as being unsettled and one of 'fire fighting' with a reactive rather than proactive style of leadership. Staff and managers considered this had affected completion of audits, review of policies, and commented that meetings such as the medical advisory committee had been cancelled on three occasions, for example. However, staff spoke positively about the recent change in leadership and felt optimistic about the current and future direction of the service.
- Senior staff were engaged and knowledgeable of the challenges the medical service was facing.
- Staff told us management were visible, approachable and supportive and visited the clinical areas daily.
- Around the time of our inspection BMI had introduced a new programme of leadership training for all newly appointed senior managers. This was not previously available and had not yet been completed by relevant staff with managerial responsibilities. However, those we spoke with all hoped to attend in the near future and told us that in the meantime they received support and advice from their line manager(s) when needed. We saw that staff and managers communicated openly with each other throughout our visit.
- There was a lack of evidence of effective medical leadership. We saw that engagement with the medical consultants was mainly through emails and a monthly

publication of 'clinical governance and quality and risk bulletin' to highlight changes in practice guidance, incidents or medicines and medical devices safety alerts.

- The medical advisory committee (MAC) was due to meet quarterly to review clinical practice and share learning points. However, it was cancelled on two recent occasions due to the planed junior doctors strike, then rescheduled to ensure sufficient representation. We were told that the involvement of the MAC tended to be reactive for example, when there were concerns or complaints about medical practice.
- The MAC had a standing agenda, and had oncology and endoscopy representation, but no physician representation.

Culture within the service

- Data between January and December 2015 provided by hospital showed there were high levels of stability of nursing staff working in inpatient departments. All staff nurses worked at the hospital for more than one year. There were moderate levels of staff stability amongst allied health professionals (63% worked more than one year) and low level of staff stability across health care assistants working in inpatient departments (33% worked more than one year). Staff we spoke with were all positive about BMI as an employer.
- In 2015 sickness rates for nursing staff and HCAs on the ward was low, 4% and 2% respectively. Staff felt supported by human resources and occupational health.
- All staff we spoke with felt supported by their colleagues and said everyone was approachable and friendly. Staff talked about the 'family like atmosphere', and told us they 'enjoyed', and 'loved' working there.
- Staff told us their workload felt manageable, staffing levels were good and that they took regular breaks.

Public and staff engagement

- The executive and senior management team carried out walkabout rounds to engage with staff and patients and ask about their experiences. Staff, managers, and patients spoke positively about this level of engagement.
- Ward team meetings were an opportunity for staff to share feedback and discuss any concerns. Staff and managers told us they felt 'listened to'.
- The hospital held a monthly staff forum chaired by the executive director. Staff told us it was an opportunity for them to find out about service and hospital development projects, ask questions and give feedback. Although, a staff member told us they did not have opportunity to attend the forum as they were always too busy.
- The hospital produced an action plan to address staff concerns and act on feedback raised in the staff survey, with tasks assigned to an action owner and completion date. Although it was not clear from the plan whether proposed actions were completed, during inspection we saw some changes were implemented such as regular team meetings, or management visibility.
- Staff could leave feedback through suggestion boxes however these were recently introduced and at the time of inspection no feedback was available.
- The hospital regularly carried out patient satisfaction survey and results were discussed at a monthly heads of department and clinical governance meetings.
- However, we found here was a limited approach to obtaining the views of people who used the services. This meant that patients' views were not always captured to improve services. We saw in various meeting minutes that months before the inspection the hospital planned to run patient focus group however these were not organised.
- At the time of the inspection the endoscopy service had recently introduced a patient satisfaction survey following treatment. We reviewed 20 feedback forms, which were mainly positive with some patients leaving additional comments such as 'very good team', 'could not be better', and 'it was first class'.

Innovation, improvement and sustainability

- The main improvement project for medical care service were the plans to develop HDU to support more complex operations, dedicated medical unit and integrated cancer centre. Senior staff told us they actively progressed HDU and medical unit plans, while the integrated cancer centre was still in the planning phase.

Medical care (including older people's care)

- Following the staff survey, senior management recognised the need to upskill and develop the nursing staff. At the time of the inspection the hospital was conducting a training needs analysis to identify and act upon staff training and development needs.

Surgery

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

Information about the service

Surgical services at BMI The Cavell Hospital consisted mainly of adult elective surgery, including orthopaedic, gynaecology, ophthalmic and general surgery. Surgical services are provided to both insured and self-pay private patients and to NHS patients through both GP referral and hospital referal.

The inpatient rooms were contained on one ward. Each single room has en-suite facilities with either a bath or shower. There are two operating theatres (one with laminar air flow) and a 'walk in, walk out' room adjacent to recovery for those patients undergoing minor procedures under local anaesthetic.

The recovery bay was situated adjacent to theatres and was used to monitor patients following a general anaesthetic. We saw the recovery area was spacious and well equipped, with daily checks carried out and recorded for all equipment.

There were 5070 visits to the theatre between Jan 15 and Dec 15. The five most common surgical procedures performed were:

• Hysteroscopy including biopsy, dilatation, curettage and polypectomy (495)

• Image-guided injection(s) into joint(s) (311)

• Phacoemulsification of lens with implant -unilateral (212)

• Therapeutic endoscopic operations on uterus (208)

• Multiple arthroscopic op on knee (inc meniscectomy) (179).

Patients were admitted under a named consultant and the Resident Medical Officer (RMO) was available 24 hours a day. Patients were cared for by a team of nurses, physiotherapist and pharmacist who were supported by dedicated administrative staff.

We carried out an announced inspection over three days and visited the wards, pre-assessment unit and the operating theatres. We spoke with 12 members of staff (medical, nursing, allied health professional and administrative) and 10 patients and their relatives. We also reviewed 10 patient records as well as a number of policies and guidelines.

Surgery

Summary of findings

Overall we rated this service as good because;

- Staff were encouraged to report incidents. Incidents and lessons learned were discussed at clinical governance meetings and shared with all staff. However there was under-reporting of near miss incidents.
- There were adequate numbers of competent staff to meet the needs of patients in theatres and on the ward. Staff told us the management team were supportive and they had access to continual professional development opportunities.
- Nursing, medical and other healthcare professionals were caring and patients were positive about their care and experiences. Patients were treated with dignity and respect.
- There were effective systems in place to ensure patients received adequate pain relief following their operation. Patients also received a follow-up phone call within 48 hours of discharge to ensure they were coping at home.
- Care and treatment was provided in line with national guidelines and the service contributed data to relevant national audits. Patient outcomes were generally in line with national data.
- There was a good governance structure in place and staff told us the senior management team were visible, approachable and supportive.
- Staff had access to a wide range of equipment and during the inspection we observed all the equipment were clean and serviced regularly. However some of the environment did not meet infection prevention and control guidelines.
- Complaints were acknowledged, investigated and responded to in a timely manner. However, information on how to make a complaint was not displayed and some patients we spoke with were unsure of how to complain.
- Staff obtained informed consent from patients and had awareness of mental capacity principles and the Deprivation of Liberty Safeguards.
- Most of the patient rooms did not comply with the requirements of regulations for Infection control as they were carpeted.
- Consultants were transporting and storing patient records but some were not registered with the Information Commissioners Office. Some records were illegible and not dated.
- Some staff were not bare below the elbow and did not decontaminate their hands between patients.
- There was no formal anaesthetic on-call rota as this was currently not funded. There was an informal agreement that anaesthetists in charge of the list were responsible for patient up to 48 hours post-operatively.
- Documentations around the DNACPR was not in line with the BMI policy and we saw evidence discussions with family members were not always recorded.

Surgery

Are surgery services safe?

Requires improvement

We rated safe as requires improvement because:

- Twenty of the 27 patient rooms did not comply with the requirements of Health Building Notice (HBN) 00-09: Infection control in the built environment as they were carpeted.
- Consultants were transporting and storing patient records but some were not registered with the Information Commissioners Office. Some records were illegible and not dated.
- Some staff were not bare below the elbow and did not decontaminate their hands between patients.
- The temperature control system was dated and we observed during the inspection that staff reported increases in temperature. This issue was on the risk register but staff were not clear of the actions being taken to resolve this issue and the timescale.
- The hospital pharmacy did not hold an up to date list of authorised signatories for staff working in theatres and on the ward. This meant staff ordering medicines could not be identified.
- There was no formal anaesthetic on-call rota as this was currently not funded. There was an informal agreement that anaesthetists in charge of the list were responsible for patient up to 48 hours post-operatively.

However:

- Staffing levels and skills mix were planned using an acuity tool and there were enough staff on duty on every shift to ensure patient received safe care.
- There had been no incidents of hospital acquired infections such as MRSA or C Difficile and the rate of surgical site infection was within the expected range.
- Ward staff used the National Early Warning Score (NEWS) to identify deteriorations in a patient's condition and we saw the NEWS was consistently recorded for all patients in records we reviewed.
- There was a good reporting culture for incidents and we saw incidents were investigated and lessons learned shared with staff.
- Staff understood their responsibilities in relation to safeguarding and were confident to highlight any concerns to senior staff and the safeguarding lead.

Incidents

- The provider did not report any never events in surgical services in the last year (Never Events are serious incidents that are wholly preventable as guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and should have been implemented by all healthcare providers).
- There was one serious incident (SI) reported for the period of January to December 2015, relating to a post-operative complication following gynaecological surgery. Staff we spoke with were clear of the investigation process required for a SI, in line with NHS England Serious Incident Framework. We saw evidence this incident had been fully investigated; however we saw the investigation reports did not identify any actions or learning from this incident.
- Between October 2014 and September 2015, 225 other incidents were reported by the hospital, with a large majority of these being low harm incidents. However, the incidents reported did not include any near misses and senior staff acknowledged there was under reporting of near misses.
- Incidents were reported electronically, although some staff were still using a paper based incident report as they had not received training on the electronic system. Senior staff explained training was ongoing and they currently reviewed all paper incident reports and transferred the details onto the electronic system.
- There was a transparent and proactive culture that empowered all staff to report incidents in a 'no blame' environment. Staff we spoke with were aware of the types of situations where incident forms should be completed and were able to give examples of incidents they had reported. Staff told us they received individual feedback from incidents and learning from all incidents was shared as part of the monthly team meetings. Incidents from other areas and other BMI sites was also discussed and included in the monthly newsletter to ensure consistent learning from all incidents.
- Incidents review meeting took place regularly, where the senior management team discussed all reported

incidents, agreed lead investigator and monitored the progress of each investigation. Incidents were also a standard agenda item for the daily 'comm cell meeting' attended by all senior managers.

- Staff we spoke with had a good understanding of the Duty of Candour requirement and were able to explain how it applied to their specific roles.

Safety thermometer or equivalent

- The provider participated in the NHS Safety Thermometer scheme used to collect local data on specific measures related to patient harm and 'harm free' care. Data was collected on a single day each month to indicate performance in key safety areas. This data was collected electronically and a report produced for each area.
- Safety thermometer for the period of January to December 2015 showed patients had consistently received harm free care with no cases of urinary infection, falls, pressure ulcers or venous thromboembolism (VTE).
- All patients had their level of risk assessed for Venous Thromboembolism (VTE), falls and malnutrition, which was reviewed at regular intervals. We saw evidence of these in the records we reviewed.
- Display boards were visible at the entrance to the ward displaying patient survey results and staffing levels; however during our visit, we observed the daily staffing levels were not always updated. The safety thermometer data was not displayed.

Cleanliness, infection control and hygiene

- The ward environment, pre-assessment area and theatre had dedicated cleaning staff and we observed these areas to be visibly clean. Cleaning staff had received appropriate training and were supplied with nationally recognised colour- coded cleaning equipment. This enabled them to follow best practice with respect to minimising cross-contamination. Cleaning staff understood cleaning frequency and standards and said they felt part of the team.
- The patient rooms and pre-assessment unit had carpeted floors and fabric chairs were in use in the ward environment. This did not meet the requirements of Health Building Notice (HBN) 00-09: Infection control in the built environment (the hospital was built before the HBN requirement which means that compliance with the standard is not a requirement but is recommended as best practice). The provider recognised this risk and had included it on their risk register. Staff informed us a refurbishment programme was currently underway and the plan was to replace all the carpeted floorings. Staff told us deep cleaning of the carpet took place every six months but we did not see any records of this taking place. However, there were no concerns identified with infection rates.
- There was a dedicated infection prevention and control (IPC) nurse who worked closely with link nurses on the ward and in theatres. The IPC nurse carried out regular audits and reported to the director of clinical services.
- There was easy access to personal protective equipment (PPE) in all areas we inspected and staff used PPE during their activities as required. We observed most staff were bare below the elbow although we observed a consultant carrying out pre-operative assessments and not being bare below the elbow and not washing their hands between patients. Other staff we observed complied with infection prevention and control practice such as hand washing between patients.
- Handwashing audits were carried out by the infection control and prevention nurse and link nurses on a regular basis in both the ward and theatre areas. Data we reviewed for the period of January to May 2016 showed compliance with hand washing was 100% except for the month of April where the rate was 90% for the ward area. This was due to one member of staff not complying and the IPC link nurse explained that feedback was provided to the individual on the day.
- Although we observed alcohol hand gels were available in the patient rooms and within clinical areas, there was a lack of hand gel dispensers at the entrances of both the ward and the theatre.
- We looked at several pieces of equipment and found them to be clean. Staff cleaned all equipment after use and used the green 'I am clean' labels to indicate this.
- All patients were swabbed for methicillin-resistant staphylococcus aureus (MRSA) during their preoperative assessment. Staff told us patients colonised with an infection such as MRSA would be taken for surgery at the end of the theatre list to allow a thorough deep clean of the theatre prior to the next patient accessing the operating room the next day.

- The hospital had policies and procedures in place to manage infection prevention and control. Staff had access to the policies on the hospital's intranet and could demonstrate how to access these. There had been no incidents of hospital-acquired infections such as MRSA or C Difficile between January and December 2015.
- Surgical equipment decontamination was completed off-site at a BMI facility. Staff told us they had a good relationship with the decontamination staff and the arrangement worked well. The theatre manager and the manager of the decontamination centre met regularly to ensure any issues were promptly addressed.
- Dedicated cleaning staff cleaned theatres daily and a deep clean took place every six months by an external company. Microbial sampling of theatres also took place and we saw evidence of these with no concerns raised.
- Servicing of the theatre ventilation systems was undertaken by the service engineer at appropriate intervals and we saw evidence the operating theatres were complaint with HTM 03-01: Specialised ventilation for healthcare premises.
- Surgical sites infection data was collected and reviewed by the management team to identify trends. Data submitted showed there were five surgical site infections between January and December 2015.
- The patient led assessment of the care environment (PLACE) results for 2016 regarding cleanliness showed a satisfaction level of 99.4%.

Environment and equipment

- All patients 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 within the main bedroom area and the en- suite bathroom.
- Theatres were located one floor below the ward and there was controlled access via keypad lock. One of the operating theatres had laminar flow, which is considered best practice for ventilation within operating theatres. Staff explained all joint replacement surgery took place in the laminar flow theatre.
- Staff told us there was an issue with the theatre temperature control system, whereby the temperature in theatre can rise on certain days. The temperature control system was dated and had been identified for replacement. This issue had been included on the risk register but it was unclear what actions were being taken and the timescale to resolve this risk.
- Daily checks were carried out on the oxygen and suction situated in the patient rooms.
- There were dedicated rooms on the ward for the storage of equipment which was found to be tidy and equipment stored safely. Equipment was labelled with a green sticker to show it had been cleaned and was fit for use. One of the rooms was used to store physiotherapy equipment and we saw a wide range of equipment was available. More specialised manual handling equipment such as standing hoist were located at the nearby sister BMI hospital and was shared between the two sites.
- Sharps bins were located appropriately throughout theatres, recovery and the surgical wards. All bins inspected had been labelled correctly and none were overfull.
- There was adequate storage for consumables in recovery and on the ward; items were stored in labelled drawers to allow efficient access for staff.
- We saw resuscitation equipment readily available on the ward and in theatre, with security tabs present on each. Systems were in place to check equipment daily to ensure it was ready for use. We saw from records that staff complied with these systems.
- All the equipment we inspected had the necessary portable appliance testing and had been serviced in the last year. Staff were aware of how to report equipment faults and told us repairs generally took place promptly.

Medicines

- There was a pharmacist who attended the ward daily and reviewed prescription charts. The pharmacist was proactive in identifying patients due for discharge and ensuring all take home medications were available.
- We reviewed four medication administration charts and saw they were fully completed, including details of any missed doses and the reason for this. Allergies were also clearly documented on each chart.

Surgery

- We observed nursing staff administering medication, including controlled drugs (CDs) and saw correct procedures were followed such as patient identification and allergies confirmed prior to administration and two members of staff checking when it was a CD.
- Medicines were stored securely, including intravenous fluids and medicines required to be stored in a refrigerator. Ambient temperature of medicines' storage rooms and fridge were recorded on the ward and in the operating theatre department and were within acceptable limits. There was a procedure to follow should temperatures fall out of the defined range. Staff were aware of this process.
- An on-site pharmacy service was provided for inpatients and outpatients between 9am and 5pm Monday to Friday by a team of three pharmacists, and 2.6 whole time equivalent pharmacy technicians who worked across two BMI hospital sites in Enfield. There were specified arrangements for staff to gain emergency access to the pharmacy out of hours, with the resident medical officer (RMO) and senior nurse holding separate keys.
- The pharmacy manager had access to specialist advice from chief pharmacists within the BMI organisation, including a subject specialist in oncology. Staff we spoke with were consistently positive about the pharmacy information and service provided.
- Medicines were supplied to the hospital pharmacy through a centrally managed contract with the BMI procurement department. There was a top-up service for replenishing stock items and for other medicines issued on an individual basis. However, the medicines administration record did not allow for documentation of medicines reconciliation on an individual basis and therefore this was not completed.
- The hospital pharmacy did not hold an up to date list of authorised signatories for staff working in theatres and on the ward. This meant staff ordering medicines could not be identified. We brought this to the attention of the management team, who provided assurance that the issue will be looked at and rectified.

Records

- The hospital used a paper based record system to record all aspects of patients care. Patient records contained information of the patient's journey through the service including pre assessment, investigations, test results and treatment and care provided.
- Patient pathways and care plans were comprehensive and contained risks assessments such as manual handling, bed rails and pressure ulcers. We saw all care plans and risks assessments were completed in the eight records we reviewed.
- We saw documentation following consultant reviews in the notes but the quality of some of these entries were poor; we saw one entry was not dated, some were illegible and it was not always clear who had recorded the entries.
- We saw evidence the World Health Organisational (WHO) surgical checklist was completed correctly and at appropriate times. The WHO Surgical Safety Audit was completed on a regular basis and 10 sets of patient records were sampled each time. Audit data for January to June 2016 showed compliance ranged between 98 to 100%.
- The hospital policy states consultants holding practising privileges with the hospital must also be registered as independent data controllers with the Information Commissioner's Office, since they are responsible for their private patient notes. Consultants we spoke with confirmed they kept their outpatients and on some occasions surgery notes; however one consultant told us he was not registered with the Information Commissioner's Office, although he understood the requirement to do so.
- Once records were no longer required after the patient had been discharged, they were stored on site in a secure records office

Safeguarding

- Staff we spoke with were aware of their responsibilities in relation to safeguarding vulnerable adults and could locate and describe the trust safeguarding policy. Nursing staff told us they would rarely need to make a safeguarding referral but were aware of who the safeguarding lead was and had contact details for the local authority safeguarding team.

- More junior staff told us they would always discuss safeguarding concerns with the senior staff, who would review the patient and take appropriate action.
- Staff had completed safeguarding training and we saw training rates for adult safeguarding was 100% for ward staff and 95% for theatre.

Mandatory training

- Staff completed their mandatory training though the BMI online system and attended face-to-face training. Staff we spoke with was aware of their training needs and the senior nurses were informed when training for staff members were due. Staff told us they were allocated time in the rota to complete their training.
- Overall mandatory training rates were 87.7% for theatres, 88.3% for ward nurses and 93.9% for pre-assessment service, against a target of 90%.

Assessing and responding to patient risk

- All patients attended a nurse-led pre-operative assessment prior to their surgery. We observed a pre-operative clinic and found the assessment to be thorough. Any concerns identified during pre-assessment was highlighted to the surgeon and anaesthetist and a pre-operative anaesthetic review was booked as required.
- During the pre-operative assessment, the nurse recorded the patient's observation, reviewed their medical and drug history and discussed the procedure they were being admitted for and the discharge arrangements. They also completed various risk assessment such as VTE and pressure ulcers. Staff identified any special needs the patients may have and communicated this to the ward staff to ensure they were prepared to meet those needs on the day of admission.
- Data provided by the trust showed the VTE assessment target of 95% was not met between January 2015 to September 2015 but achieved 100% from October 2015 to December 2015.
- Ward staff used the National Early Warning Score (NEWS) to identify deteriorations in a patient's condition. We saw the NEWS was consistently recorded for all patients. Staff told us they would escalate to the RMO in the first instance.
- The RMO was available on site 24 hours a day and reviewed any deteriorating patients immediately. Each patient's room has an emergency call bell and this could also be heard in the RMO's rest area.
- The practising privileges agreement required the designated consultant to be contactable at all times when they had inpatients in the hospital. They needed to be available to attend within an appropriate timescale according to the level of risk of medical or surgical emergency. This included making suitable arrangements with another approved practitioner to provide cover in the event they were not available, for example whilst on holiday.
- The anaesthetists in charge of the list were responsible for patient up to 48 hours post-operatively and could be contacted to attend to deteriorating patients or for returns to theatre. However there was no formal anaesthetic on-call rota as this was currently not funded.
- The theatre 'safety huddles' took place prior to the start of every list and provided an opportunity for the team to ensure all staff understood their responsibilities, check all equipment was available and discuss the order of the list. We saw these 'safety huddles' were well led and gave all members of the team an opportunity to input into the discussions.
- Whenever a decision was made to change the order of the list, the original list was discarded; a new list was printed on coloured paper and distributed to all relevant departments. This process ensured all staff worked to the same list to maintain patient safety.
- Staff used the Waterlow Pressure Ulcer Prevention Score to assess the patients' risk of developing a pressure sore and air mattresses were available from an external company for patients with a high score. However there was no access to a specialist tissue viability professional.
- Nursing staff contacted every patient by phone within 48 hours of discharge to ensure they were recovering well at home. Nursing staff would arrange for the patient to be reviewed by the RMO or the consultant is any serious concerns were raised. Consent to contact patients and their correct contact details was obtained on the day of

discharge. We spoke to two patient due for discharge during our inspection and they both told us they had been informed to call the ward if they had any concerns post discharge.

Nursing staffing

- At the time of our inspection, there were no nursing vacancies on the ward or in theatres. Senior staff were proud of their recent successful overseas recruitment programme for nurses.
- A corporate acuity tool was used to determine staffing levels to meet the needs of each patient. Senior staff told us the current tool did not always reflect the staffing required based on the dependency of the patient but they reported the management team always supported requests for additional staff. The management team informed us the acuity tool was due to be replaced soon.
- Since the large majority of patients were elective admissions, staffing levels were planned in advance and staff we spoke with felt staffing was adequate on the ward and in theatres.
- The senior nurses completed duty rotas in advance and any change on the day was clearly documented. Staff worked flexible hours to cover the rota and shifts included day, night and twilight. Gaps in the rota were generally covered by bank staff or staff from the nearby sister BMI hospital.
- The ward manager explained agency bookings were kept to a minimum and data we reviewed confirmed this.
- Ward nurses met for a handover at the start of their shift, where all patients on the ward were discussed. We observed thorough and patient-centred handovers which took place in the patient's room.
- Administrative assistants were employed in the operating theatre and on the ward to support nursing staff and enable them to concentrate on patient care.

Surgical staffing

- Patient care was consultant led and the hospital practising privilege agreement required that the consultant visit inpatients admitted under their care at least daily or more frequently according to clinical needs. We saw evidence of daily consultant review in the records we looked at. However we also saw entries where the RMO had documented when they had left a message for the consultant and there was no subsequent entry following that to record if consultant had called back and what advice was given.
- RMOs were contracted to the hospital by an external agency and each RMO usually worked 24 hours a day for a week while on duty. They would then have one or two weeks off prior to returning for another week.
- The RMO we spoke with during the inspection felt they were adequately supported by the consultant and nursing staff. They were encouraged to contact the consultant for advice and felt the consultants were supportive when they were contacted.
- Consultants were required to be within 30 minutes journey of the hospital if they had patients under their care at the hospital. If, on occasions, this was not possible, they were required to nominate another named consultant (with practicing privileges) to provide cover. Up to date contact numbers for consultants were available to nursing staff in wards and operating theatres.

Physiotherapy staffing:

- There was one full time physiotherapist employed to work on the ward. The physiotherapist reviewed patients twice a day and also made onward referral for outpatient physiotherapy on discharge. Nursing and physiotherapy staff we spoke with told us they felt more physiotherapy staff was required on the ward, especially during periods when the ward was full.
- Band physiotherapy staff covered period of leave during weekdays and provided input at weekends.

Major incident awareness and training

- The provider had a business continuity plan in place with various scenarios that may affect the day-to-day running of the ward and theatres such as a lift breakdown. Copies of the business continuity plan were available on the ward and in theatres and staff were aware of these plans.
- All staff received fire training as part of their mandatory training programme; staff told us they had the opportunity to rehearse scenarios and we saw evacuation equipment was available on the ward.

Are surgery services effective?

Surgery

Good

We rated effective as good because:

- Patients told us their pain was well managed by staff and we saw evidence of regular pain assessments.
- Staff had access to information within the hospital and through the corporate intranet. Staff were supported with opportunities for further professional development and underwent competency-based assessment prior to working independently.
- Care and treatment was provided in line with National and Royal Colleges guidelines and most outcomes for patients were within the expected range.
- Staff obtained informed consent from patients and had awareness of mental capacity principles and the Deprivation of Liberty Safeguards.

However:

- Documentations around the DNACPR was not in line with the trust policy and we saw evidence discussions with family members were not always recorded.
- Staff appraisal rate did not meet the hospital target for some groups of staff.

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) and Royal College guidelines.
- All staff knew how to access policies online, although printed copies were available in folders on the ward. The folders contained the most up to date versions of the guidelines and register lists were kept to record which members of staff had read the document.
- The service was compliant with NICE guidance CG 74: Surgical site infections: prevention and treatment in the preoperative, intraoperative and postoperative phases of care.
- Best practice guidance advises the use of enhanced recovery programmes (ERP) for certain types of surgery. ERPs were in place within the care pathways used on the wards for knee and hip replacements and we saw these were fully completed in the records we reviewed.

Pain relief

- Pain relief for surgical patients was managed by the anaesthetist, who prescribed regular and 'as required' analgesia to be administered post-operatively. The RMO on the ward would review the painkillers if the patients' pain was not controlled. Most patients received oral painkillers although some patients had intravenous (IV) patient controlled analgesia (PCA). Staff underwent additional training to care for patients on a PCA.
- Pain was assessed regularly using a patient reported scoring system of 0-3, where 0 was no pain and 3 was severe pain. We saw evidence of pain scores in all the records we reviewed.
- Pain management was included in the nursing handover and staff administered analgesia as required prior to physiotherapy sessions to ensure pain did not limit the rehabilitation of post-operative patients.
- Pain management was discussed at the pre-operative assessment and patients were familiarised with the pain scoring system and informed of the 'as required' medication they were able to request if their pain was not controlled with the regular medication.

Nutrition and hydration

- Nursing staff assessed nutrition on admission using the Malnutrition Universal Screening Tool (MUST) and we saw the MUST was completed in all the records we reviewed.
- The hospital did not have a dietician but staff told us they were able to access a dietician, through an external organisation when required. This was usually via a telephone referral and staff reported the dietician would usually assess referred patients within 24 hours.
- Pre-assessment and ward nurses advised patients of fasting times before surgery and we observed this was in line with the Royal College of Anaesthetists (RCOA) guidelines.

Patient outcomes

- Between January and December 2015, there were nine incidents of unplanned transfers of inpatients to

another hospital because their condition had deteriorated. There were no trends, with regards to types of surgery, or concerns with individual surgeons, identified. Staff told us they expected this number to decrease once the hospital's plan to create a high dependency unit (HDU) was implemented.

- Patient related outcome measures (PROMs) showed the hospital adjusted average health score was within the England average for total hip replacement and total knee replacements.
- EQ-VAS or EQ-5D indexes, both of which are additional measures of patient health outcomes, showed health gains were slightly higher when compared to the national score for total hip replacements. However, health gains were slightly lower for total knee replacements.
- There had been five cases of unplanned readmission between January and December 2015 and six cases of returns to theatre following a surgical procedure. We reviewed the data provided by the trust and no trends were identified.
- Hospital staff told us the organisation was working with the 'Private Healthcare Information Network' to improve reporting of patient outcomes across the independent healthcare sector. They hoped this would make patient outcome data more easily comparable with NHS providers.
- PROMs data for groin hernia was not available due to insufficient number of cases performed at the hospital.
- Data provided by the hospital for the period of June 2015 to May 2016 showed there had been five cases of surgical site infections, of which two were following joint replacement surgery.

Competent staff

- There was a process for checking General Medical Council and Nursing and Midwifery Council registration, as well as other professional registrations. We reviewed this data which showed consultants had up to date GMC registration and were on the specialist register.
- Consultant were required to show evidence of their annual appraisal/revalidation in order to maintain their practicing privileges. Consultant we spoke with confirmed their appraisal was carried out by their main NHS employer.
- Staff appraisal rates were 80% for nurses and 75% for healthcare assistant working on the ward. Only 40% of physiotherapists had received an appraisal in 2015; however during the inspection, the new physiotherapy manager informed us only three staff members were still due an appraisal.
- The hospital did not hold records of appraisals for theatre staff for the period of January and December 2015, but the theatre manager, who was new in post, told us she was in the process of apprising each member of the theatre team.
- Surgical staff, both in theatres and the ward, had specific competency documents and we saw evidence staff underwent training and competency based assessments prior to working independently.
- All new staff including agency staff were inducted into their area of work. We were shown completed induction checklists which outlined department orientation and familiarisation with specific policies.

Multidisciplinary working

- Pre-operative assessment nurses worked closely with individual consultants to ensure any issues identified was clearly communicated and necessary actions, such as an anaesthetic assessments or additional tests, were taken promptly.
- A dedicated physiotherapist received a handover from the nurse in charge daily and staff we spoke with told us the nurses and physiotherapist worked as a team to plan patients' discharges and address any social issues identified. The physiotherapist told us nursing staff assisted with therapy sessions when more than one person was required to support patients' rehabilitation.
- Patients who required adaptive equipment or assistance with activities of daily living on discharge were referred to an occupational therapist. The occupational therapy service was provided by an external provider.

- There were no formal multidisciplinary meetings held for surgical patients, although staff told us this would be considered for particularly complex patients and discharge planning, although consultant led, involved the therapists and nursing staff.
- During the inspection, we observed good team working between nurses, the physiotherapist, pharmacist and RMO.

Seven-day services

- Patients received physiotherapy seven days a week. The physiotherapy input at weekend was usually provided by bank physiotherapy staff.
- RMOs were available on site 24 hours per day, seven days per week. They were expected to review patients whenever needed and complete day to day tasks on the wards.
- Consultant reviewed their patients daily and we saw evidence of this when looking at patient records. When consultants were on leave, they arranged for another consultant (also with practicing privileges at the hospital) to review their patients and the ward nurses were informed of this arrangement in advance.
- An on-call theatre team were available for emergency returns to surgery out of hours. The team comprised of a theatre scrub practitioner, a health care assistant and recovery staff. The anaesthetist was generally the person completing the theatre list that day.
- Diagnostic imaging was available 24 hours per day, seven days per week by an on call radiologist who was available via a bleep system within a 30 minutes response time.
- There was no onsite pharmacist out of hours and at weekends, but there were specified arrangements for staff to gain emergency access to the pharmacy out of hours, with the RMO and senior nurse holding separate keys.

Access to information

- Staff had access to electronic and paper copies of hospital policies and guidelines on the ward and in theatres.
- Staff had access to patient records, including all pre-assessment documentation. Staff told us the records were kept on the ward until the follow up phone call to patients had been completed on discharge.
- Staff were able to access records for all discharged patients as these were stored on-site. Staff told us of examples of when they had to do so, such as re-admissions and told us the process was straightforward.
- Communication from senior management was usually cascaded to staff via team meeting, emails or through the hospital and BMI newsletters.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- The records we reviewed showed all patients had been consented for their surgical procedure. Consent forms fully described the procedure completed as well as risks associated with it and full signatures from the consenting clinician and patient. Consenting generally took place on the morning of the surgery. Staff told us this was not the case for cosmetic surgery in order to comply with guidance on the two-week 'cooling off' period.
- Patient information was submitted to the national joint registry when knee and hip replacements were completed; data showed 99% of patients provided written consent for this information to be shared between during 2015.
- Staff received training on the Mental Capacity Act (MCA). Capacity assessments were generally carried out by consultants but staff told us they would inform senior nurses and the safeguarding lead if they had concerns.
- Staff we spoke with had received training and were aware of Deprivation of Liberty Safeguards (DoLS) principles. However they explained they did not have experience of completing a DoLS application because they would escalate it to the director of clinical services who would complete the DoLs application.
- Decisions about DNACPR forms were clearly communicated during staff handover. However, we found the name of 'relevant other' (relatives or friends who were consulted) was not recorded on the form. The patient records did not contain documentation of the discussions with the patient or their relative around the DNACPR decision.

Are surgery services caring?

Surgery

Good

We rated caring as good because:

- Friend and family test results were consistently high.
- Patient spoke positively about the care they received and gave us examples of when staff had displayed kindness and compassion towards them and their relatives.
- All patients and relatives we spoke with told us they were fully involved in their care and were complimentary about the information they were provided to allow them to make an informed decision about their care.
- Patients were given appropriate and timely information about their care and there were appropriate arrangements to support and meet the emotional needs of patients.

Compassionate care

- All patients and relatives we spoke with during the inspections told us staff always introduced themselves, were polite and treated them nicely. The ward encouraged patients to complete the Friends and Family Test (FFT) and we saw the FFT scores for the period of July to December 2015 were consistently between 98% and 100%.
- Patients and those close to them spoke positively about the treatment received from all the hospital staff including the non-clinical staff such as receptionists, housekeepers, porters and catering staff. People felt supported and said staff cared about them.
- We observed patients were treated with dignity, respect and kindness during all interactions with staff. A patient informed us that "I am not afraid or nervous to use the call bell or speak to staff, they are friends".
- Some patients had been attending the hospital for some time and described the good rapport they had with staff. They told us they told us staff provided that personal touch by remembering their preferences and ensuring all their needs were met.
- Patient's privacy was maintained by ensuring the doors were closed during personal care or whenever patient needed some privacy with their relatives.
- Patients knew who their doctor, duty nurse and health care assistant were. The name of the duty nurse and health care assistant were written on the board in the patients room. The named consultant was indicated on the door of the patients' rooms.
- We saw a number of thank you cards on the ward. A patient had written, 'thank you for all the kindness you have shown'. Another patient wrote '…I want to say thank you for professional work you do, which has put me back on the road to recovery'.
- Patients felt pleased and respected as they were are involved, supported and encouraged to be partners in their care and decision making right from the consultation meeting with the consultant, pre-assessment and discharge planning with any support they need.
- Patients expressed that staff including the consultants spent time talking to them and their relatives in a way they understood and answered all their questions patiently without been abrupt. People understand their care, treatment and condition. Patients gave several examples to us where they were involved in the decision making about their treatment, surgery, pain relief, food choices and care plan.
- Relatives told us they felt confident and reassured to leave their loved ones in the hospital as they know they are in "good hands" and "excellent care".
- Every patient we spoke with was extremely complimentary about the care they received. Patients described the continuity of care as good, as they saw the same team of medical, nursing and physiotherapist staff at each appointment. Patients informed us that they saw their consultant daily, the physiotherapist twice a day and the nursing staffs are always in and out of their room to check how they were feeling.

Understanding and involvement of patients and those close to them

- We observed staff being caring and respectful to patients and their loved ones. They explained treatments in a way patients and relative could understand and kept them informed about their care. Patients told us they felt well supported and were given appropriate and timely information to participate in their care and treatment right from their first meeting with the consultant to discharge.

- All the patients spoken with told us they understood all the information given to them about their operation/ procedure, anaesthetic, discharge information and their follow-up clinic. A patient described how the consultant had eased her anxiety by taking the time to answer all her questions about her procedure.
- All the relatives we spoke with informed us their questions and concerns during consultation and pre-assessment appointment were addressed patiently by the consultants and nurses. A relative stated, “when doctors are here and I asked them questions, they took the time to answer questions and advised what to look following discharged”.
- Relatives informed us they were actively encouraged to be involved in the treatment and discharge plans where appropriate and were able to speak to a doctor when needed
- Patient and relatives described their experience with doctors and nurses as “a very collaborative experience." They told us staff “didn’t talk down to me” and were polite, helpful and thorough.”
- All the patients we spoke with were aware of what to do if they felt unwell during admission and when discharge home.

Emotional support

- Staff understood the impact the patient’s care, treatment or condition had on their wellbeing and on those close to them. A patient who was worried about her salary and finances described to us how she was given a sick note to give to her employer which helped ease her worries about getting her salary on time.
- We observed staff communicating in a sensitive and calm manner, offering reassurance to concerned patients and their relatives. Relatives gave examples were staff came to check on them in the reception area while there relatives were in the theatre. Patients gave several examples were staff sat down with them to give reassurance, ease their anxiety and motivate them to use the call bell to call for help when in pain.
- Patients and relatives told us they were asked if they needed support from chaplaincy services. Staff told us there was no formal arrangement in place but they would usually contact the nearest place of worship for the patient’s religion and arrange for a visit.
- Staff told us they were able to refer patients to a psychologist if required. This service was provided by an external company but most patients we spoke with were not aware of it.
- Patients were given appropriate and timely support and information to cope emotionally with their care, treatment or condition. Patients we spoke with informed us staff were supportive and reassuring and gave them and their family the reassurance to ease their anxiety before and after their procedure.

Are surgery services responsive?

Good

We rated responsive as good because:

- Access to surgical services was planned to meet the need of local patients and there was easy access to the services for both NHS and private patients. Referral to treatment time targets were met for most of last year.
- Patients were given a choice of date and time for their procedure and staff worked hard to meet patients’ preferences.
- All patients received a follow-up call within 48 hours of discharge to check on their welfare and answer any questions they may have. Patient were also able to call the ward 24 hours a day and speak to a nurse for advice if they were concerned.
- Staff had attended training on dementia and had access to resources to assist them in caring for patients living with dementia.
- We saw complaints were investigated within appropriate timescales and lessons were shared with staff during team meeting.

However;

- There was a lack of information in the ward area, such as information on how to make a complaint or how to access external organisations for additional support.
- Between May 2015 to June 2016, 22 operations were cancelled for non-clinical reasons and 48 for clinical reasons. We did not see evidence of any actions to reduce the number of cancellations.

Service planning and delivery to meet the needs of local people

Surgery

- All surgery carried out at the hospital was elective; hence staff reported it was easy to plan the workload.
- NHS patients were referred to the hospital by local Clinical Commsioning Groups (CCGs) via the Choose and Book system and the hospital also had contracts with a few local NHS trusts.
- Private patients were generally referred to a consultant by the GP although a small number of patients were self-referrals.
- Operating theatre lists for elective surgery were available in advance and patients could select times and dates to suit their family and work commitments.
- Surgeons were provided with allocated operating theatre times for the next year to allow prior planning of patients and operating theatre activity. There were some evening theatre lists for minor procedures and a theatre list every Saturday.
- There was a plan in place to open a high dependency unit in order to allow for more complex surgery to be carried out at the hospital and reduce the number of transfers to NHS acute hospitals due to patients deteriorating or having post-operative complications.
- All surgical patients discharged from the hospital, including those who had day case procedures, received a follow-up telephone call 48 hours later to ensure they were managing at home. Any issues would be addressed during the phone call, if possible, or patients would be booked in for an outpatient review with the consultant or nurse. These calls were completed by an allocated member of staff on the ward.

Access and flow

- The majority of the hospital's inpatient activity was surgical cases. In 2015, there were 5070 visits to theatre; 1076 surgical procedure required an inpatient stay, with 563 of those being NHS funded patients.
- Once a decision to operate was made in clinic, the bookings team worked closely with the consultant, ward staff and the patient to agree a suitable date for surgery. Patients were offered a choice and staff strive to meet individual surgeon's and patients' requirements.
- The referral to treatment time (RTT) target of admitting 90% of patients within 18 weeks of referral was met for most of 2015, except for the months of January, February and May.
- Data provided by the hospital for the period of May 2015 to June 2016, 22 operations were cancelled for non-clinical reasons and 48 for clinical reasons. Non-clinical reasons included issues with the environment such as theatre temperature or lift breakdown and consultants not being available. The main clinical reasons were surgery no longer being required was due to improvement in symptoms or patient being unwell. We did not see evidence of any actions taken or planned to reduce the number of cancellations.
- Discharge planning was started during the pre-assessment stage of the pathway and patients' needs post discharge were identified. Staff told us referrals to occupational therapists took place pre-admission for patients undergoing hip and knee replacement.
- Discharge summaries and a list of take home medication were sent to each patient's GP on discharge.
- The hospital had an admission policy to ensure only patients whose needs could be met were admitted to the ward. Senior nurses on the ward worked closely with consultants to ensure the policy was being adhered to.
- All patients were admitted to the ward and allocated a room prior to theatre. This meant there were no delays in discharging patients from the recovery area back to their room on the ward.

Meeting people's individual needs

- All patients had individual rooms with ensuite facilities. Intentional rounding by care staff was completed throughout the patients stay. These meant patients were visited in their rooms hourly to check for example, if call bells and a drink were in reach, if the patient had pain or had any other requests.
- During our inspection, we observed call bells were answered immediately and staff were attentive to patient needs.
- Patients were offered a choice of food and drinks from a menu. Special dietary requirement such as Halal or Kosher were available and all patients we spoke with told us their dietary needs were catered for.
- Staff had access to language line to assist communication with non-English speaking patients.

Staff we spoke with were aware of this but reported it was not often used. We observed patients' relatives acting as interpreters during our inspection. This is not considered to be best practice.

- Dementia training was included in the mandatory training programme and we saw that 95.4% of staff had completed this training. Staff we spoke with were able to explain how they would care for a patient living with dementia, such as the red tray and jug system (a way fo identifying patients who need additional support) and understanding the patients' specific needs by discussing with family members or referring to the completed 'This is me' booklet when available. There was a dementia box available on the ward to further assist staff in caring for patients living with dementia.
- Staff told us they did not often admit patients with a learning disability. However they explained that in those circumstances they would involve the patients' family or carer early on and ensure staff understood the needs of individual patients. Carers were welcomed to stay overnight and accompany patients to the anaesthetic room if this was required.
- Information on special cultural, religious or dietary needs was gathered at the pre-assessment stage and this information was passed onto the ward and theatre teams. Patients we spoke with told us staff knew of their individual needs and consistently ensured these were met.
- There was a general lack of information in the ward area, such as information on how to make a complaint or how to access external organisation for additional support. Patients and their relatives had access to a day room but staff reported this was rarely used. We found the environment in the day room to be dated and bare, with no patient information leaflets available. The few leaflets we found on the ward were in English and staff we spoke with were not aware if these were available in other languages.

Learning from complaints and concerns

- The hospital received 21 complaints in 2015; the main complaint themes were staff attitude and appointment delay/cancellation. All complaints were escalated to the clinical director and director of clinical services. Complaints were investigated in line with the BMI complaints policy and we saw evidence patient complaints were discussed at the complaints review forum, clinical governance and daily 'comm cell' meetings.
- Complaints were entered onto an on-site complaints tracker to allow the management team to allocate a lead investigator and ensure the investigation was carried out within the timescale outlined in the BMI complaints policy.
- Patients we spoke with were not clear on the complaints procedure but told us they would raise any issue with a member of staff. Information on how to make a complaint was not displayed on the ward, although staff told me patients were made aware of this at pre-assessment.
- Staff told us that if a patient was unhappy with any aspect of their care, they would try to resolve the issue verbally by asking the relevant professional to speak to the patient. They would also offer for a member of the hospital management team to meet with the patient.
- Learning from complaints was shared with all staff at clinical governance meetings, department meetings and via email.
- Staff told us they had received several complaints relating to the food and were working closely with the external catering company to address this issue.

Are surgery services well-led?

Good

We rated well led as good because:

- The clinical governance structure was robust and the senior management team met regularly to review quality and safety of the surgical services. The risk register was regularly updated and we saw the senior management team were aware of the main risks to the service and mitigating plans were in place.
- Staff received recognition for performing beyond expectations and spoke positively about the senior management team.
- The management team held a regular staff forum and staff were encouraged to contribute ideas to further develop and improve the service.

- Staff told us there was a 'no blame culture' and the senior management team were very visible and approachable.
- There were low sickness rates and a high level of stability amongst the surgical workforce.

However;

- Patient engagement in developing the service was not well established although there were plans to start a patient forum in the future.
- Although there was an audit calendar in place, we saw some audits were not regularly completed such as CD audits and it was unclear how the senior management team was addressing this issue.

Vision and strategy for this core service

- Staff knew the vision for the hospital and plans to develop it. They told us the hospital was actively working on developing a high dependency unit (HDU), a dedicated medical care unit and an integrated cancer centre. Business plans to open the HDU and medical unit were already in place. The integrated cancer centre was a longer term vision.
- Surgical staff understood the hospital's aim to continuously improve quality and enhance patient experience. Staff felt the ongoing refurbishment plans will play a great role in enhancing patients experience and the creation of a HDU will also increase activity.

Governance, risk management and quality measurement for this core service

- Senior staff from the surgical services were engaged with governance activities at the hospital and represented theatres and the wards at various meetings, such as the incident review, infection control, blood transfusion and clinical governance meetings.
- The hospital had a schedule of audits performed throughout the year showing the frequency of audits such as medicines and records. There was a framework showing how the information was to be reviewed and shared. Results were reviewed locally at governance meetings and the Medical Advisory Committee (MAC) meetings. Following that results were shared with clinical departments.
- Audit results were discussed at the clinical governance and team meeting and actions plans were implemented when poor compliance was noted. However we saw that some audits, such as CD audits had not taken place in 2015 and no actions had been taken by the senior management team to address this issue.
- Clinical governance meetings were held monthly and the minutes we saw showed these meetings were structured and well attended. Discussions at these meetings were focused on quality and risks and we saw areas such as incidents, complaints, risk register and the audit calendar were discussed. The surgical department was represented by a consultant anaesthetist and consultant surgeon as well as the ward and theatre manager. Feedback from the Medical Advisory Committee (MAC) was a standing agenda.
- The MAC meetings took place quarterly and practicing privileges, quality assurance and new national guidelines were discussed. However some consultants we spoke with told us they were not very engaged with the MAC and did not receive minutes of the meetings.
- Feedback from hospital wide meetings were disseminated to staff at local team meetings, via email or newsletter. Team meeting minutes were shared with staff unable to attend and they were asked to sign to indicate they had read the minutes.
- Senior staff we spoke with told us they understood the performance of their areas and were able to benchmark their services against similar sized hospitals in the BMI group.
- The risk register for the surgical wards and theatres was held and maintained by the Risk and Quality Manager within the hospital and was reviewed at comm cell and clinical governance meetings. We saw the risk register included the risks we identified during the inspection such as the infection control risk due to the environment and the theatre temperature control unit.
- There was no formal Service Level Agreement (SLA) in place with local acute NHS hospitals to facilitate transfer of any deteriorating patients. The senior management team explained they had tried but had been unable to obtain this SLA with the local NHS facility.

Leadership / culture of service related to this core service

Surgery

- Staff were proud to work for the hospital and enjoyed their role within the surgical team. Staff told us they worked well together and had good relationship with the consultant they worked with regularly.
- Staff on the ward and in theatre told us their manager was approachable and supportive and there was a 'no blame culture'.
- The senior management team was very visible and staff told a member of the executive team came to the ward and theatre area daily as part of the executive rounding. Staff felt this was helpful as they could feedback any issues straightaway.
- Staff told us the senior management team was approachable and accessible. A staff nurse reported, "I can just knock on their door" for support.
- Staff told us they received training and were empowered to acquire new skills. We were given examples of how a theatre porter had been supported with further education and training and was now working as a theatre practitioner.
- The sickness rate was less than 10% for all staff groups during the reporting period of January to December 2015.
- There was a high level of staff stability for nurses in theatre and on the ward.

Public and staff engagement

- The senior management team held regular staff forums, where representatives of staff groups from all clinical areas were invited to share their concerns and ideas for improvement. The forum also provided the senior management team with the opportunity to inform staff of upcoming development within the hospital and the BMI group. Staff we spoke with told they had attended the staff forum and found them to be very helpful.
- Theatre staff told us it was not always possible to attend the staff groups, therefore the executive director brought the staff forum to them by attending the theatre team meeting and encouraging staff to speak up.
- The hospital had implemented a staff recognition scheme based on the 6 C's (care, compassion, communication, courage, competence and commitment). Staff were awarded certificates to recognise situations where they had displayed these qualities.
- All patients were actively encouraged to provide feedback but there was currently no formal patient forums in place. We saw patient forums had been discussed at the clinical governance meeting and plans were in place to recruit a group of staff on the patient forum steering group to drive this initiative forward.

Innovation, improvement and sustainability

- The hospital had recently introduced 'joint school', a pre-operative education class for patients undergoing joint replacement. The purpose of the sessions is to provide patients with information about their surgery, manage their expectations and start discharge planning.
- The evidence based Enhanced Recovery Programme was in place for all patient undergoing joint replacement. Staff told us of plans to apply the principles of enhanced recovery to other surgical procedures, such as gynaecology.
- Hospital staff told us the organisation was working with the 'Private Healthcare Information Network' to improve reporting of patient outcomes across the independent healthcare sector. They hoped this would make patient outcome data more easily comparable with other Independent and NHS providers and drive improvements in quality.
- Theatre staff told us of plans to open a HDU would mean an increase in the range of surgical procedures carried out at the hospital. Some ward staff we spoke with had already attended a HDU course in preparation.

Outpatients and diagnostic imaging

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

Information about the service

BMI The Cavell Hospital is a private hospital in Enfield. The hospital provides a range of services including outpatient consultations and diagnostic imaging services. Services are provided to the insured, self-paying private patients and NHS patients through both GP referral and local contract systems.

Outpatient services are provided from 13 consulting rooms, in addition to a nurse treatment room, and imaging suite and a physiotherapy department. Diagnostic imaging department consisted of a general X-ray room, ultrasound room, dual-energy X-ray absorptiometry room, and room where panoramic X-ray of the lower face was taken. The hospital provided services to the adult population only. Clinics held in outpatients' areas included cardiology, dermatology, dietitian, endocrinology, general medicine, general surgery, gynaecology, haematology, neurology, oncology, ophthalmology, maxillofacial, orthopedics, pain management, podiatry, psychology, rheumatology and urology. Outpatient consultations were all consultant led. There were over 27,552 first (46%) and follow-up (54%) outpatients appointments booked at the hospital in 2015/2016. 22% of patients received NHS funding while the majorities were either privately funded, or costs of their treatment was covered by an insurance company.

We spoke with 14 patients and some of their relatives or carers. In addition, we spoke with 22 members of staff, including managers, doctors, nurses, radiographers, physiotherapists, administrators, medical secretaries and receptionists. We observed care and treatment and looked at care records. Before our inspection, we reviewed performance information from and about the hospital. We also requested additional information from the provider after our inspection.

Outpatients and diagnostic imaging

Summary of findings

We rated this service as good overall because:

- There were systems for reporting incidents and raising concerns. Staff told us they felt able to raise concerns and discuss issues with the managers of the department. They felt they were able to influence decisions taken by their local managers and their opinion was valued.
- There were effective systems minimise risk through monitoring patients' referral to treatment times and cancellations.
- Medicines and records were stored securely.
- There were protocols in place for obtaining consent before medical treatment was given and staff were aware of it.
- There were clear lines of management responsibility and accountability within the outpatient's and diagnostic imaging departments. Staff were competent, knowledgeable and appraised annually to ensure they continued to develop their practice. We observed that staff worked well as a team supporting one another.
- Patients were treated with dignity and their privacy was respected. They provided positive feedback when talking to us and through patients' feedback forms. Patients' complaints were addressed appropriately.
- Staff were able to recognise where patients were distressed and act appropriately.
- The hospital consistently performed better than the England average for independent acute hospitals for referral to treatment (RTT) pathways in 2015.
- There was a system to monitor repeat cancellations of appointments by the hospital and by the patient which helped to avoid treatment delays linked to multiple cancellations.
- Staff had completed dementia awareness training. Staff ensured patients who lived with dementia or had a learning disability were seen quickly to minimise the possibility of distress.

However:

- The environment did not comply with national infection prevention and control guidelines.
- Staff did not have access to full information relevant to patients' treatment to support decision-making.
- There was no single patients file or a record system, which combined all available information to support clinical decisions made by doctors, nurses or allied health professionals. Patients' records were not comprehensive as they did not describe all patients' care plans and treatment offered.
- The department did not meet their own target for compliance with mandatory training.
- There were limited opportunities for multidisciplinary (MDT) involvement with minimal MDT engagement which prevented full analysis of individual treatment options and knowledge sharing.
- The hospital did not routinely monitor if patients with suspected cancer were seen promptly as this was not a standard performance indicator.
- They also did not monitor diagnostic imaging and procedures waiting times or the time it took to issue an appointment letter from receipt of referral.

Outpatients and diagnostic imaging

Are outpatient and diagnostic imaging services safe?

Requires improvement

We rated safe as requires improvement because:

- The environment did not comply with national infection prevention and control guidelines.
- Patients' records were not comprehensive as they did not describe all patients' care plans and treatment offered. Records were not accessible to all professionals involved in patients' treatment.
- The department did not meet their own target for compliance with mandatory training.

However:

- There were effective systems that minimised risk through monitoring patients' referral to treatment times and cancellations.
- There were systems for reporting incidents and raising concerns.
- Medicines were managed safely as directed by national guidance.

Incidents

- Staff told us they were confident in raising concerns with their line managers. Themes from incidents were discussed at team meetings. Staff told us they were encouraged to report incidents and received direct feedback from their line managers. There were morning operational meetings, attended by the hospital's senior management team and head of department where incidents were discussed and learning was shared to prevent future occurrences.
- We noted that incidents were reported correctly. For example incident which took place on the week of inspection, where a referral letter was stapled to another patient's referral letter, was classified as a near-miss and reported. It was recorded in the electronic database, reviewed by a quality and risk manager and discussed during a morning meetings with heads of department.
- Staff were aware of actions they should take in cases were 'reportable patient safety incident' occurred and assured us they were open and transparent. They were aware of the duty of candour. The duty of candour is a regulatory duty that relates to openness and transparency and requires providers to notify patients (or other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support to that person.
- Staff working in diagnostic imaging knew they were required to report Ionising Radiation (Medical Exposure) Regulations (IR(ME)R) incidents, in cases where exposure was 'much greater than intended', as soon as practicable .
- There were no never events related to delivering outpatient services at the hospital in 2014 or 2015. Never events are are serious incidents that are wholly preventable as guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and should have been implemented by all healthcare providers.
- The provider told us, as guided by the regulations related to their registration, there were no serious incidents which they would be required to report to the Care Quality Commission in 2015.

Cleanliness and infection control

- All staff in the clinical area were wearing appropriate uniforms that complied with the hospital's 'bare below the elbow' policy to allow for appropriate hand washing and prevent infections. Hand hygiene audit carried out by the hospital did not involve outpatient and diagnostic imaging department.
- We observed that hand sanitisers were easily accessible to staff and patients and others visiting the hospital. They were routinely placed near an exit or entrance to the area, encouraging people to sanitise their hands there and then.
- There were members of staff allocated to monitor waste compliance and contracts with external providers responsible for clinical and non-clinical waste management.
- There was a nominated waste management officer allocated to the hospital who completed annual waste audit. Full compliance and no improvements were noted in the audit they undertook between April and May 2016 for outpatients and diagnostic imaging areas.

Outpatients and diagnostic imaging

- Clinical areas we visited appeared clean, and we saw staff washing their hands between treating patients. Toilet facilities and waiting areas were also clean in all areas we visited. Personal protective equipment, such as gloves and aprons, was available for staff use in all areas where it was necessary. Cleaning staff completed cleaning checklists daily to confirm which areas were cleaned. Staff were unable to demonstrate that periodical cleaning audits were undertaken to monitor the cleanness of the environment.
- Hand washing basins and floor covering did not comply with infection control in the built environment guidelines issued by the Department of Health (Health Building Note 00-09). The provider did not carry out regular environmental audits to ensure the environment met requirements of guidelines related to infection prevention and control. The hospital had an allocated nurse with responsibility for infection prevention and control; they were informally supported by the director of clinical services and a consultant microbiologist.
- Results from the 2015 Patient-Led Assessments of the Care Environment (PLACE) programme indicated that the outpatients' areas were mostly clean achieving score of 98% which was in line of the England average (98%). These self-assessments are undertaken by teams of independent health care providers, and include at least 50 per cent members of the public.

Environment and equipment

- All equipment we looked at was safety tested and in date and appeared safe to be used. Each item of equipment was recorded on corporate database and tested periodically as guided by the schedule. Equipment identified by the system as reaching the end of its useful life would go into a replacement programme. There was a provider-wide system for replacing equipment.
- Resuscitation equipment was available and checked daily, we saw evidence these daily checks were recorded by staff.
- Equipment used in the diagnostic imaging department had been checked regularly and serviced in line with published guidance. The provider had protocols to ensure safe operation of visible and invisible beams generated by lasers and radiation equipment. Staff were aware of how to operate it safely and were trained to do so.
- Approximately half of the consulting rooms had carpeted floor and did not meet the infection prevention and control guidelines. Senior managers told us of a rolling refurbishment which included replacing the outpatients' corridor flooring as well as carpet removal from consulting rooms. We noted approximately half of the work had been completed carried out within outpatients' areas before our inspection. It was not clear if clinical areas were prioritised and what was the time scale for work completion. There was no environmental risk assessment which would guide the refurbishment plans.
- Results from the 2015 Patient-Led Assessments of the Care Environment (PLACE) programme indicated that outpatients' areas needed to be improved. The hospital achieved 85% score for condition appearance and maintained of the environment, which was worse than the England average (92%).

Medicines

- Patients told us that their medicines were dispensed promptly and staff informed them of the purpose of the medication they were to take home and side effects to watch for.
- Medicines were kept in a locked medicines cupboard, and those that require refrigeration were kept in a fridge. Where medicines required cool storage, refrigerator temperature checks were carried out and recorded, and were all within the required range. Staff were aware of the process to follow if the temperature should fall out of the safe range.
- Prescription forms were traced and securely stored. When doctors used them to prescribe medications they needed to print and sign their name to confirm they used the form.
- All areas used to store medicines were secure, with access restricted by named staff using a keypad and a key. There were specific procedures for staff to gain emergency access to the pharmacy out-of-hours.
- All emergency medication and emergency equipment and resuscitation trolleys were available. Some staff we spoke to were not aware which emergency medication was available to them and how to use it. They told us they would call the hospital's internal emergency

number should there be a need to use it. Emergency medicines used for the treatment of anaphylaxis or cardiopulmonary resuscitation, for example, were clearly labelled, available for use, and regularly checked.

- Staff were aware that medicines error and incident need to be reported, no errors occurred in 2015, therefore we were unable to assess if they followed the procedure accurately.
- The newly appointed pharmacy manager did not have access to controlled drugs audits or any other medicines audits. Neither they nor our inspection team could find evidence that these had been undertaken.
- There was an up-to-date antibiotic protocol which included first and second choice medicines to use, and the dosage, and duration of treatment. However, the planned audit to monitor antimicrobial stewardship had not taken place in March 2016.
- The pharmacy manager had access to specialist advice from chief pharmacists within the BMI organisation. Staff we spoke with were consistently positive about the pharmacy information and service provided.
- The hospital did not audit turnaround times for dispensing prescriptions. Pharmacists told us these were routinely dispensed in a timely manner immediately upon receipt; however, it was dependent on staff availability. The chief pharmacist told us audit of turnaround times was added to the corporate audit calendar from October 2016.

Records

- Clinical records kept were a combination of electronic records and paper records. Paper records, currently in use in the outpatient department were stored securely behind the reception desk. Electronic records were available only to authorised people. Computers and computer systems used by the hospital were password protected. Individual login details were used by all members of staff including those who worked part-time and temporary staff.
- Nurses did not have access to doctors' records at the time when their provided treatment to patients. Nursing records were not accessible to doctors or physiotherapists as the paper records were stored separately and not readily accessible.
- Patients' records were not comprehensive as they did not clearly described all patients' treatment plans and treatment offered. Individual health professionals would store their own records and these were not joined together. For example, one patient's medical record mentioned that patient had a fistula but failed to describe the location or the type of fistula. Another patient's record noted "stiches removed" but did not describe the procedure and did not note from which part of the body and how many stiches were removed. Nurses took a photograph of an infected wound, if the patient consented for them to do so, to monitor any further complication or improvement.
- There was no list of key signatures of core staff and most of the records were not signed by a full name. We were unable to track the person recording as signatures were not legible.
- There was no wound assessment or pain assessments as staff did not use body maps or standardised pain assessment tool.
- There was a policy of records retention which advised staff when and how to safely dispose records as prescribed by relevant information governance standards and staff were aware of it.
- We observed that records containing personal information were left in unstaffed consulting rooms, in one case for over a year without staff taking action to ensure these were stored securely to safeguard personal data.

Safeguarding

- The hospital had policies for safeguarding children and vulnerable adults. Staff we spoke with were aware of the policies and procedures with regard to safeguarding, and they knew how to raise a safeguarding alert.
- All staff, including administrative staff, outpatients booking team and reception staff received level 1 adults safeguarding training bi-annually. Only one, out of five physiotherapists completed level 2 training. None of the staff working in outpatients department received level 2 training and one out of five staff working in diagnostic imaging department. Organisation policy stated that level 2 training was provided only to staff in a management or supervisory role.

- Level 3 safeguarding vulnerable adults or any level children safeguarding training were not routinely provided to staff except for director of clinical services. The hospital did not treat children at the time of the inspection, however, some patients would come with their children to see a doctor or receive a treatment.
- The director of clinical services was the safeguarding adult lead. They told us that they attended local safeguarding board meetings where appropriate.

Mandatory training

- All staff were required to complete mandatory training in health and safety, manual handling, infection control, information governance, equality and diversity, basic life support, conflict resolution, and waste and environmental management. Most of the courses were completed every two years with others every three years and some only on induction.
- The hospital set a 90% target for compliance with mandatory training. The medical records team, medical secretaries, outpatients booking and reception staff achieved this target. Outpatients department achieved 89% compliance. However, diagnostic imaging staff did not meet the target with records indicating a compliance rate of 83%. Similarly, physiotherapists achieved 80%. The imaging and radiology manger told us that all staff working in the diagnostic imaging completed mandatory training prior the inspection taking place but it was not yet reflected in records. They also said that there were some malfunctions with e-learning system which led to data not being collected adequately.

Assessing and responding to patient risk

- There was emergency equipment available to respond in the event of emergency. The equipment was easily accessible . There was always a resident medical officer (RMO) on site who had completed advanced life support training, who was able to provide first line emergency treatment. Two nurses in the endoscopy service had also recently successfully completed advanced life support training. Staff told us that in an event of emergency they would call 999 and request for an ambulance service to assist.
- Staff were aware of local rules for checking that the patient consent including checking that all female patients between the ages of 12-55 had signed the relevant section of the consent form relating to pregnancy status. Local rules stated that operators must not expose any female patient between 12-55 years old who did not sign the form. If the patient was pregnant and required exposure, for example within the radiotherapy department, staff were advised to contact the consultant to confirm treatment options and risks involved.
- Operation of diagnostic imaging equipment, when initiating the exposure, ensured that the patient was correctly identified to prevent unnecessary exposure and potential incidents.
- There were effective systems which minimised risk through monitoring patients' referral to treatment times and cancellations. Patients' referrals were reviewed timely to minimise any potential delays to treatment.

Nursing staffing

- There were three nurses and two healthcare assistants working within the outpatients services. They told us there was a sufficient number of staff in post to run all of the scheduled clinics and extra evening and weekend clinics when required. The sickness rate for the outpatient departments was 2%, it was better than the hospital average 4% (2015). Sickness record amongst allied health professionals, including physiotherapists and staff working within the diagnostic imaging department was 4%. The same rate was recorded amongst administrative and clerical support staff.
- There were no vacant posts and records indicated that no agency staff were used within the outpatients and diagnostic imagining services.
- Overall there was a good level of retention of staff within outpatients and diagnostic imaging with turnover rate of 10% (2015) amongst nursing staff. Healthcare assistants' rate in 2015 was 0% and approximately 20% turnover was reported amongst allied health professionals and administrative and clerical support staff. It was slightly worse than the hospital average of 16% (2015)
- Staff working in diagnostic imaging told us there was sufficient number of staff working within the department to accommodate the current level of activity and effectively meet patients'' needs.

Medical staffing

Outpatients and diagnostic imaging

- There were 153 doctors with practicing privileges, who were able to consult patients at the hospital. Only 58 of them practiced regularly (more than ten consultations in 2015). There were 18 consultants who worked regularly at the hospital (100 or more consultations in 2015). Patients always see a consultant when they visit the hospital to see a doctor.
- There was a medical advisory committee (MAC) responsible for consultant engagement. For a consultant to maintain their practising privileges at the hospital there were minimum data requirements with which a consultant must comply. These included registration with the General Medical Council (GMC), evidence of insurance and a current performance appraisal or revalidation certificate.

Major incident awareness

- There were plans drawn up for the hospital to ensure business continuity and that essential services were not disrupted as a consequence of emergencies such as flooding or power failure.
- Staff working within outpatients and diagnostic imaging received major incident awareness training.
- Staff used dosimeters to ensure unintended exposure was detected. Standard preventive measures were implemented as instructed by relevant regulations related to ionizing radiation and to radioactive material. Heads of departments monitored radiation safety in their departments and reported results of that monitoring to the radiation protection advisers and radioactive waste advisers.

Are outpatient and diagnostic imaging services effective?

Not sufficient evidence to rate

We did not have sufficient evidence to rate effectiveness of the outpatients and diagnostic imaging services.

- The hospital did not audit use of National Institutes for Care Excellence (NICE) guidelines and other evidence based practice when providing treatment.
- There were limited opportunities for multi-disciplinary (MDT) involvement with minimal MDT engagement which restricted full analysis of individual treatment options and knowledge sharing.
- Staff did not have access to full information related to patients' treatment to support decision making. There was no single patients file or a record system which would combine all available information to support clinical decisions made by doctors, nurses or allied health professionals.
- Staff were competent and knowledgeable. Managers provided staff with development opportunities and appraised them annually to ensure they continued to develop their practice.
- The department had protocols in place for obtaining consent before giving medical treatment and staff were aware of it.

Evidence-based care and treatment

- Staffs working within diagnostic imaging department were aware of Ionising Radiation (Medical Exposure) Regulations (IRMER) procedures, which described role specific duties and local rules.
- The department's radiation safety policy was last reviewed in August 2013, although containing relevant and mostly up to date information, was due to be reviewed in June 2016. It took into consideration relevant legislation, regulations and guidance such as The Ionizing Radiations Regulations 1999; The Ionising Radiation (Medical Exposure) Regulations 2000 (IRMER); Radioactive Substances Act Guidance issued by the Environment Agency; The Ionizing Radiation (Medical Exposure) Regulations (2000) Guidance and Good Practice issued by the Department of Health; and guidance published by Health and Safety Executive.
- The provider told us that NICE guidelines for management of chronic obstructive pulmonary disease (COPD) were implemented. However, they did not monitor compliance to evidence this.
- Although the provider told us NICE guidelines for management of type 2 diabetes were followed they did not audit implementation of it.
- Similarly compliance with colonoscopy surveillance for prevention of colorectal cancer in people with ulcerative colitis, Crohn's disease or adenomas (where relevant) was not audited.

Outpatients and diagnostic imaging

- There were patient access policies and protocols, guided by Department of Health guidance, for non-urgent referrals. These set out the overall expectations for managing NHS funded patients, referrals and admissions into and within the organisation. It also set out the responsibilities of staff and administration processes that should be followed to prevent delays and ensure care was delivered in line with clinical guidance.
- The provider did not assure us there was an escalation process, relevant to outpatients and in line with national guidance, for patients with suspected cancer and those who required urgent referral.

Pain relief

- Patients said they had access to pain relief when required. Doctors could refer them to the pain management consultant.
- Staff did not use any standardised tools to monitor patients' pain and changes in perception of it.

Patient outcomes

- The follow-up outpatient appointment to new appointment rate for the hospital (1:1.2) was below the England average (1:2.3) in 2015/2016. Highest rates were recorded in psychology (14.9), oncology (9.5) and psychiatry (6.9). The lowest rate was noted for plastic surgery (0.1), gynaecology (0.2), haematology, neurology, podiatry, orthopaedic surgery (approximately 0.6 each) and dermatology (0.8).
- The hospital did not collect cancer staging data (data collected on identifying the severity of cancer) for patients diagnosed with cancer. It prevented them from benchmarking themselves against other organisations to establish how they performed in relation to cancer staging. The provider told us that each consultant was registered with a cancer network and they fed their data from private and NHS practice together.
- The hospital did not gather data related to patients outcomes, nor participate in local and national audits which would allow them to benchmark patients' clinical outcomes for outpatients department.

Competent staff

- Staff were competent and had sufficient skills which allowed them to perform their job effectively. The hospital provided them with induction which included competency based assessments. Staff training and professional development needs were identified through informal one to one meetings with their managers, and via annual appraisals, where personal development goals were agreed, and individual performance reviewed.
- Records indicated 100% appraisal completion rate amongst nurses. However, much lower rate of 40% was noted for allied health professional working at the hospital, which included physiotherapists and staff working in diagnostic imaging. Only 61% of administrative and clerical staff received appraisals in 2015.
- Doctors were responsible for arranging their own revalidation with either their NHS trust or the independent provider. Compliance was monitored by the medical advisory committee. Similarly nurses and allied health professionals were to ensure their professional registration requirements were met and reviewed periodically as required by their professional registration organisations.

Multidisciplinary working

- We observed that staff did not utilise multidisciplinary team working and there were limited opportunities for different medical professionals to share knowledge and experience. For example physiotherapist did not routinely discuss patient's progress with consultant or nurses who were involved in patients care. Similarly doctors were unaware of nurses' interventions and did not have access to their notes.
- The hospital did not employ consultant nurses and they did not run specialist nurses clinics.
- There were no one stop clinics where patients could see different specialist and undergo various diagnostic procedures and consultations on the same day.

Seven-day services

- Diagnostic imaging services were available from 8am until list finished, usually around 8pm or 9pm Monday to Friday. If referred, patients had access to MRI seven days a week; it was located within the same building but operated by another provider. There was an on-call rota of radiologists at other sites that could report out of hours should there be a need.

Outpatients and diagnostic imaging

- An on-site pharmacy service was provided for outpatients between 8am and 5pm Monday to Friday. There were specified arrangements for staff to gain emergency access to the pharmacy out-of-hours.

Access to Information

- All NHS inpatient and outpatients records were stored on site. Consultants were not permitted to remove patient's NHS records from site.
- Consultants were responsible for the outpatient records for their private patients and stored these off site, except where their medical secretary was employed by the provider then records were stored on site. Consultants holding practicing privileges with the hospital were required to be registered as independent data controllers with the Information Commissioner's Office, the provider did not monitor if they complied with this requirement.
- Patients attending outpatients either had an accompanying GP referral letter, or if they attended outpatients previously, the patient's notes would be provided by the consultant. GP referral letters for NHS patients were supplied by the hospital for the clinic in addition to any triage notes taken from the referral centre. There was no single patients file or a record system which would combine all available information to support clinical decisions made by doctors, nurses or allied health professionals.
- If records were not available when a patient attended for an outpatient consultation, the nurse in charge would retrieve any inpatient notes from the on-site medical records department. If the patient did not have any inpatient notes, the consultant could view patient electronic records to review appointment dates and imaging reports.
- If no previous medical records or a GP letter was available for a private patient, the consultant would complete a full previous medical history and presenting condition assessment as part of their consultation.
- We saw that letters of the outcome of an appointment were sent to a GP and other health professional when appropriate and patients were sent a copy of the correspondence.
- If NHS patients were seen at another BMI hospital, notes were sent over in secure containers and registered as removed from site for traceability.
- The hospital did not monitor records availability for outpatients department.
- The service had access to a secure portal to send scans to other sites to report, however there were occasional problems with downloading images onto the local computer. Physiotherapists told us that they had restricted access to diagnostic imaging system and frequently, to view an image they were required to visit the department as they could not do so, on their computer screens.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- We saw that there was a policy and protocols in place for obtaining consent before medical treatment was given. However, when staff obtained verbal consent for simple medical procedures they did not record that it was granted. The provider's policy did not specify verbal consent was to be recorded, however, it instructed staff to be guided by a 'principle of empowerment' and safeguard the interests of people who lack capacity.
- Nurses and doctors were clear which procedures they would follow should patient's capacity to consent be in question. Staff spoke about a need for a mental capacity assessment to take place and said they were guided by procedures used for reaching 'best interest' decision prior to treatment being offered or the procedure being performed.

Are outpatient and diagnostic imaging services caring?

Good

We rated caring as good because:

- Patients were treated with dignity and their privacy was respected.
- Patients provided positive feedback when talking to us and through patients' feedback forms. They told us they understood choices of treatment offered to them.

- Staff were able to recognise where patients' were distressed and act appropriately.
- Patients and their relatives could access services which helped them with overcoming emotional difficulties related to illness or bereavement.

Compassionate care

- During our inspection we spoke to 14 patients and relatives. They told us that they felt treated well and staff were always polite, explained everything and introduced themselves when they first approached them.
- Throughout our inspection, patients and those close to them spoke positively about the treatment received from all the hospital staff including the non-clinical staff like receptionist, housekeepers and porters. People felt supported and said staff cared about them. Patients described staff as "excellent" and "great". We observed that people were treated with dignity, respect and kindness during all interactions with staff. Patient informed us that felt comfortable to speak to staff about their concerns or questions. We observed a radiographer assistant preparing a cup of tea for a patient after their scan. We observed patient was given a free parking pass by the receptionist to use at car park as their parking ticket ran out.
- Some patients had been attending the hospital for some time and described the good rapport they had with staff. They were able to identify and told us the name of the nurse, health care assistant, consultant and receptionist that cared for them.
- Patients were asked about their preferences for sharing information with family members.
- Patient's privacy was maintained by ensuring the doors and windows were closed and covered during treatment, consultation, or giving personal care.
- We saw and heard of examples of compassionate care. Relatives felt confident and reassured about the care delivered in the hospital as they "knew their relatives were in good hands" and receiving "excellent care". Patients described the continuity of care as good, as they saw the same team of medical staff at each appointment. Patients informed us that they saw their consultant and anaesthetist before and after surgery, and the nursing staff always checked how they felt.
- Examples of some of the quotes used by patients and relatives to describe their care experience and staff included: "they are good at follow-up", "[staff] treated patients nicely, everything was done well when they said it would be and we [patient and their family] are leaving happy", "excellent care", "staff always helpful", "courteous and respectful of privacy and dignity" and "very good communication via letter and over the phone".
- Patients could request a chaperone to accompany them during their consultation and information on how to access this service was displayed in consultation rooms.
- We observed that staff, when able to, allowed patients who presented earlier than their appointment was scheduled for to be seen early.
- Results from the 2015 Patient-Led Assessments of the Care Environment (PLACE) programme indicated that patients' privacy, dignity and wellbeing were mostly maintained within outpatients' areas. However, the hospital achieved only 76%, which was lower than the average for independent sector acute hospitals (87%).
- The provider encouraged patients to provide feedback via use of feedback cards. These were summarised monthly and an annual report was prepared to establish trends and areas where improvement was needed. The report prepared in May 2016 indicated that satisfaction scores for diagnostic imaging had improved (by 1.7%) when compared with the previous year with 97.6% of patients were satisfied with the service rating it excellent or very good. Results for outpatients department indicated 98.9% of patients would recommend the hospital to their friends and family and 0.3% would not. We noted that patients' comments were very positive. For example one patient said "everyone I came into contact with was kind and helpful, and explained everything very well" another one that a "physiotherapist was very professional and pleasant."

Understanding and involvement of patients and those close to them

- We observed staff being caring and respectful to patients and their loved ones. They explained treatments in a way patients and relative could understand and kept them informed about their care. Patients told us they felt well supported and were given appropriate and timely information to participate in their care and treatment.
- Patients felt involved, supported, and encouraged to be partners in their care and decision making. They said it

was the case "right from the consultation meeting with the consultant" and during pre-assessment clinic. Patients expressed that staff, including the radiographer and consultants, spend time talking to them and their relatives in a way they understood. They also answered all their questions patiently. People understood their care, treatment and condition. Patients gave several examples where they were involved in the decision making about their treatment, surgery, pain relief and care plan.

- All the patients spoken to, report they understood all the information given to them about their operation/ procedure, anesthetic, scans and their follow-up clinic. One person said they were initially "anxious and scared" about their surgery but the consultant was "supportive" and explained the whole process.
- Patients and those close to them were given support and as much or as little information as they wanted (access to specialist advice and support). If they needed time to make a decision, this was supported by staff. All the Patient's relatives we spoke to informed us that all their questions and concerns during consultation and pre-assessment appointment were addressed patiently by the consultants and nurses. A relative told us "when I asked them questions [doctors], they take the time to answer and advise what to look for when discharged home".
- Relatives informed us they were actively encouraged to be involved in the treatment and discharge plans where appropriate, and were able to speak to a doctor when needed. We saw record from appointments, which indicated patients were encouraged to bring their loved ones for support or for their questions to be addressed where necessary. Patient and relatives described their experience with doctors and nurses as a "very collaborative experience", "[doctor] didn't talk down to me".
- All the patients we spoke with were aware of what to do if they felt unwell, had any concerns or questions before going home, or before the pre-assessment appointments. They had their dates for their follow-up appointments set before leaving the clinic.

Emotional support

- Staff understood the impact the patient's care, treatment or condition had on their wellbeing and on those close to them. The patients and nurses gave several examples were patients and relatives were supported emotionally. For example with overcoming medical phobia, deal with a new diagnosis, or family issues. We noted that on one occasion a nurse spent over an hour with a patient to discuss personal circumstances. The patient said they "felt like a weight is lifted" and the nurse helped them to achieve that.
- Most of the staff we spoke to including senior staff nurses were not aware of how to signpost patients for financial support, however, they mentioned the hospital 'credit package facility' available to the self-funding patients. There was no easily accessible information on financial, psychological, or psychiatric help available. A consultant told us that if a patient was unable to carry on with their treatment due to financial restrictions, they would refer them to their GP.
- We observed staff communicating in a sensitive and calm manner, offering reassurance to concerned patients and their relatives. Relatives gave examples were staff came to check on them in the reception area while there relatives were in the theatre.
- The service provided emotional support to both patients who attended the hospital, and their families. This service extended to counseling and one to one consultations with psychologist, psychiatrist, specialist nurses and consultant. Psychologist support was available to patients at early stage after diagnosis of long term condition. For example a patient diagnosed with cancer was referred to psychologist and advised by the nurses and consultant on how to inform their relative about the condition. The service did not offer bereavement, or communication training for staff to help them deal with difficult conversations. Some nursing staff working in outpatients had these skills as they received the training in their previous job. Other outpatient nurses said if they came across a patient with emotional or psychological needs they would discuss it with their line managers or the director of nursing.
- The department's psychologist told us that they received referrals from doctors and nurses working in a breast clinic as well as from GPs and directly from patients' insurance companies.

Outpatients and diagnostic imaging

Are outpatient and diagnostic imaging services responsive?

Good

We rated responsive as good because:

- The hospital consistently performed better than the England average for independent acute hospitals for referral to treatment (RTT) pathways in 2015.
- There was a system to monitor repeat cancellations of appointments by the hospital and by the patient which helped to avoid treatment delays linked to multiple cancellations.
- Staff completed dementia awareness training. Staff ensured patients who lived with dementia or who had a learning disability were seen quickly to minimise the possibility of distress to them.
- Patient complaints were addressed appropriately.

However:

- Although we did not observe any delays the hospital did not routinely monitor if patients with suspected cancer were seen promptly as this was not a standard performance indicator.
- They also did not monitor diagnostic imaging and procedures waiting times or the time it took to issue an appointment letter from receipt of referral.
- The hospital did not monitor patients' waiting times from the time to arrival to the appointment.

Service planning and delivery to meet the needs of local people

- Patients had access to hot and cold drinks in the reception areas. There were also magazines to keep them occupied while waiting for the appointment.
- There was sufficient seating available to patients in general outpatients areas and diagnostic imaging areas.
- The hospital did not run 'one stop' clinics where patients could see multiple clinicians and complete necessary diagnostic procedure during one appointment to provide quicker access to a diagnosis. If patients required such a service they were advised to attend another BMI hospital. There was availability of 'rapid access' appointments slots if patients wanted to see a clinician within a short notice period.
- There were no Commissioning for Quality and Innovation payment framework local quality improvement goals related to outpatients or diagnostic imaging for 2015/2016.
- The hospital did not provide patient transport services, patients were required to organise their own transport as there was no agreement with any of the local providers.

Access and flow

- There were effective systems for managing non-urgent referrals described by the access policy. The hospital accepted referrals made via electronic referral system, whereby patients were referred by their GP or consultants working in local NHS trusts.
- The hospital consistently performed above 92% in relation to the referral to treatment (RTT) incomplete pathways in 2015. They consistently achieved 100% for non-admitted 18 weeks RTT in 2015.
- The hospital did not measure if patients with suspected cancer were seen promptly as this was not standard performance indicator. Doctors and senior managers told us that patients were seen "immediately". We did not have any evidence which would suggest there were delays to treatment provided to patients or to external specialist referrals where it was required.
- Reporting times for diagnostic imaging were very short, however, it was not a standard performance indicator measured by the hospital. The team was able to provide the same-day result. For most diagnostic procedures they were able to report on the same-day result. 24 hour if consultant asked for a specific radiologist to review the diagnostic image.
- The hospital monitored its 'did not attend' (DNA) rate and the data collected was analysed to established trends and patterns and improve attendance levels and overall experience. Record indicated that the highest number of non-attended appointments was within plastic surgery speciality (757; June 2015 to May 2016); nurse led appointments (321), and gynaecology (184). The lowest numbers were recorded for podiatry (2),

endocrinology (4), and dermatology (8). We were unsure how this corresponded to number of all appointments within each of the specialities as the provider did not analyse data to allow comparison.

- The hospital did not monitor waiting times in clinics from the time to arrival to the appointment. Patients told us there were no delays and they were seen at the time their appointment was booked for.
- There was a system in place to monitor repeat cancellations of appointments by the hospital and by the patient. This allowed monitoring clinical risk related to treatment delays to individual patients who experienced cancellations. There was no minimum notice period set for appointment cancellation by the hospital or clinician. When cancellation was required the booking team would look to organise an appointment within another BMI hospital.
- The overall hospital cancellation rate in 2015/2016 was low (3.2% cancelled by the hospital). The highest appointment cancellation rate in 2015/2016 was recorded for physiotherapy (17.4%) with majority of appointments being cancelled by patients (14.6%). We also observed high patient-led cancellation rates within dermatology (13.2% of 14.5% cancelled appointments) pain management (11.6% of 13.4%) and psychiatry (12.1% of 16.8%).
- The highest percentage of appointments cancelled by the hospital was recorded for oncology (6%), acupuncture (5.6%) psychiatry (4.7%) and urology (4.2%).
- We also analysed appointment cancellation by clinicians and noted highest cancellation rates for patients who attended psychiatry (3.7%), cardiology (3.5%), and urology (2.6%). Staff said they cancelled appointment only when it was absolutely necessary and they explained the reason for cancellations. They also offered the first available appointment to ensure patients were seen as soon as possible.
- The hospital monitored multiple cancellations and records indicated that in 2015/2016 and the overall repeat cancellation rate was 13% (of all hospital cancelled appointments). In 49 cases appointment was cancelled on more than one occasion by the hospital, majority of these were related to diagnostic imaging (21), others to oncology (11), physiotherapy (8). There were three patients whose appointment with an oncologist got cancelled on five occasions another one who had four cancellations. Two patients who attended diagnostic imaging appointment had their appointment cancelled four times with another one having three cancellations. Staff were unaware of any harm to patients as a consequence of an appointment cancellation.
- The provider did not monitor the time it took to issue an appointment letter from receipt of referral**.** They told us consultants kept separate outpatient records and sent letters directly to patient's GP or a referrer. We were unable to assess how the hospital performed in relation to it. Medical secretaries working at the hospital told us they sent all letters on the same day.

Meeting people's individual needs

- There was information about treatment and side effects, and ongoing support groups.
- Easy to read information leaflets and information in other formats, such as large font or braille, were not readily available. There was no information to advise patients where they could obtain such information.
- For those patients who required translation services there were posters in various languages displaying information on language helpline within the reception area. Patients were encouraged to approach the receptionist should they need it.
- There were car parking facilities and the service was partially accessible to people who used wheelchairs and those with mobility difficulties. Toilets, although equipped with hand rails and partially adapted, could not be accessed from a side if a person was required to use a slide board to transfer. The toilet adjoined to physiotherapy gym was not fully accessible to people with mobility difficulties.
- All staff working in the department completed dementia awareness training.
- The department scored 81% for general experience for patients' living with dementia in the Patient-Led Assessments of the Care Environment (PLACE) 2015 programme. It was in line with the England average for independent acute hospitals (81%). These self-assessments are undertaken by teams of independent health care providers, and include at least 50 per cent members of the public.

Outpatients and diagnostic imaging

- Chaperone policy and posters were available in imaging patient waiting area to inform patients about availability of chaperone for any procedure.
- Staff working in outpatients and diagnostic imaging told us that sometimes referrer would indicate if person had special needs. Other times they would only find out on the day of their appointment, for example if patient had learning disabilities, communication difficulties or dementia. There was limited awareness of how to accommodate needs of those who potentially required reasonable adjustments or additional support at the time of their appointment. Two members of staff told us they "did not do anything different for patients with special needs".

Learning from complaints and concerns

- In 2015 the hospital received 12 formal complaints, two of these related to outpatients and diagnostic imaging services. In one case a patient had not been called for their appointment as the consultant and receptionist were working from two different lists. In the second case there was a delay in results being available from imaging department. Staff we spoke to were unaware of these complaints.
- Complaints were discussed at the complaints review forum. Staff said that they would direct formal and informal complaint to the director of clinical services or to the executive director. They would complete a formal electronic record to allow for tracking progress of the investigation and ensure all relevant people are informed of it.
- Formal complaints were acknowledged in writing within two working days by the executive director who then forwarded the complaint to the relevant consultant if applicable for investigation or comment. The hospital aimed to respond within 20 working days.
- Comments boxes were available in reception areas and patients told us they would make use of these should there have any concerns.

Are outpatient and diagnostic imaging services well-led?

Good

We rated well led as good because:

- There were clear lines of management responsibility and accountability within the outpatient's and diagnostic imaging departments.
- We observed that staff worked well as a team supporting one another.
- Staff told us they felt able to raise concerns and discuss issues with the managers of the department. They felt they were able to influence decisions taken by their local managers and their opinion was valued.

However:

- Risks listed on local risk register were generic and not relevant to the department.
- Medical exposure committee, tasked with monitoring the use of ionising radiation and health and safety risk related to it, had not met since December 2013.

Vision and strategy for the service

- There was a plan to create an interventional radiology suite and to move a mammography unit from another BMI Hospital to improve the experience for patients using the breast service with a possibility of opening a one-stop breast clinic.
- Staff said that occasionally they "get overwhelmed" by changing corporate messages about what priority is, can change almost "day by day". One person said they were not clear what managers and heads of department were meant to be achieving and aiming for because priorities changed so much. Staff we spoke to did not feel involved in corporate vision or had any say in developing it to ensure their departmental needs were reflected in it.

Governance, risk management and quality measurement

Outpatients and diagnostic imaging

- Senior members of staff worked across two sites BMI Cavell and a "sister site" BMI Kings Oak Hospital. Governance management were spanning over both sites and both hospitals were working in close partnership.
- There were monthly heads of departments meetings which were attended by an outpatients manager, imaging and cardiology manager, and physiotherapy manager. These meetings were chaired by the executive director and were also attended by the quality and risk manager, admin and support services manager and other managers working at the hospital. Standard agenda items included; risks, recruitment and staffing issues such as training compliance, complaints and patients satisfaction amongst others.
- The provider had a medical exposure committee consisting of radiation protection advisor, radiologist, imaging manager, quality and risk manager and those working in theatres. However, the committee did not meet since December 2013 therefore did not oversee issues related to IRMER compliance.
- Departmental meetings were held monthly. There were also weekly imaging leads meetings attended by a lead nurse, lead admin, deputy manager and a mammographer.
- The hospital risk register did not highlight any risks which would be specific to diagnostic imaging or outpatients department, except for the need for removing carpets from imaging rooms. It was a shared risk register with BMI Kings Oak Hospital; risks highlighted were generic and did not refer to site or department specific issues.
- The hospital used a fingerprint system for electronic timesheets which was linked directly to payroll. Heads of departments felt they did not receive adequate training to ensure effective operating. They also felt they were unnecessarily involved with simple admin tasks, such as scheduling shift patterns onto computer system in advance and daily approval of any variances from the original shift pattern. For example when staff arrived more than 10 minutes late to work.

Leadership of service

- Staff felt supported by their manager and team. They said that senior managers were open to staff, approachable and accessible. One member of the team said "I can just knock on their door" for support.
- There were clear lines of management responsibility and accountability within the outpatient's and diagnostic imaging departments. Staff, including senior management, were aware of departmental strengths and weaknesses and able to explain clear objectives for the development of the department.
- Although senior managers were visible and present in each of the department, some staff told us they found difficult to get time with executive director or director of clinical servicers to "talk about important issues".

Culture within the service

- Staff told us they felt able to raise concerns and discuss issues with the managers of the department.
- They felt all staff worked as one team and they were able to challenge one another.
- They were aware of the duty of being open and transparent with patients, in situations when error or an incident concerning the patient occurred. They were ready to provide any reasonable support to the concerned patient should there be a need.
- We observed positive interactions and good communication between all staff. Staff told us they felt they were able to influence decisions taken by their local managers and their opinion was valued.

Public and staff engagement

- There were monthly staffs meetings. The provider also produced a regular newsletter to share news with staff.
- The provider organised an annual staff survey. Findings of the survey undertaken in 2016 were mostly positive. Where improvements were needed the provider prepared an action plan in response. The action plan highlighted key areas for improvement to ensure better inter-departmental communication, improve recruitment, and provide staff with more development opportunities. It was not specific to outpatients and diagnostic imaging.
- The provider encouraged patients to provide feedback via use of feedback cards. These were summarised monthly and an annual report was prepared to establish trends and areas where improvement was needed. The

report prepared in May 2016 indicated positive findings and overall very good satisfaction. We observed that participation rate in the survey was good with 19% of all outpatients responding to it in 2015/2016.

- Staff participated in training sessions which focused on general patient experience to facilitate better understanding among the staff and help to ensure good patient experience. Staff were encouraged to try to understand patients' expectations and provide excellent 'customer service'.

Innovation, improvement and sustainability

- The service was looking to improve availability of breast screening services by introducing a one stop clinic where diagnostic would be provided and discussed with a doctor on the same day. The provider did not have a business plan to support the project.

Outstanding practice and areas for improvement

Areas for improvement

Action the hospital MUST take to improve

- Review the governance arrangements to ensure structures, processes and systems of accountability for the medical service are clearly set out, understood and effective.
- Ensure the chemotherapy service is complying with national guidance for monitoring and reporting neutropenic sepsis and other patient outcomes.
- Keep an up to date list of authorised signatories of staff that can order medicines in the hospital pharmacy, so that staff who undertake this responsibility can be identified.
- Ensure that when risks are identified that they are recorded, reviewed regularly and timely action is taken to mitigate them.
- Ensure patient records are complete and up to date, including care plans, nursing assessments and do not attempt cardiopulmonary resuscitation orders.
- Improve staff attendance at mandatory training.
- Ensure all relevant staff can access records in the chemotherapy service out of hours.
- Ensure all staff have an annual appraisal.

Action the hospital SHOULD take to improve

- Ensure all staff comply with infection prevention and control practices such as being bare below the elbow and decontaminating hands between patient contacts.
- Ensure all clinical areas comply with the requirements of Health Building Notice (HBN) 00-09: Infection control in the built environment.
- Ensure all consultants who are transporting and storing medical records are registered with the Information Commissioners Office.
- Pharmacy should hold an up to date list of authorised signatories for all staff ordering medicines.
- Ensure patients have access to information on how to make a complaint as well as information on how to access external support.
- Ensure the medical service benchmarks its performance so it can monitor and improve its service. This includes ensuring the audit schedule and calendar are followed.
- Review the multidisciplinary arrangements for all medical patients and ensure they meet national requirements.
- Improve the provision of translation services and availability of written information in a range of languages other than English.
- Establish a formal service level agreement for the emergency transfer of unwell patients for treatment in local NHS facilities.
- The provider should ensure the environment complies with national guidelines related to infection prevention and control.
- The provider should ensure all staff involved in care and treatment have access to full information related to patients treatment to support decision making and provide treatment which takes into considerations all available information.
- The provider should ensure all staff completes mandatory training.
- The provider should audit use of National Institutes for Care Excellence (NICE) guidelines to ensure these are followed when providing treatment.
- Staff should utilise opportunities for multi-disciplinary involvement to ensure treatment options are considered in full and allow for knowledge sharing.
- The provider should monitor key performance indicators, such as whether patients with suspected cancer were seen promptly, diagnostic imaging and procedures waiting times or the time it took to issue an appointment letter from receipt of referral, to ensure quality monitoring and continuous improvement.