BMI The Edgbaston Hospital

Quality Report

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Date of inspection visit: 18 February 2016
Date of publication: 15/02/2017

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

Ratings

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

Summary of findings

Letter from the Chief Inspector of Hospitals

We inspected BMI The Edgbaston Hospital as an announced comprehensive inspection. We inspected the core services 18 February 2016. We did not need to undertake an unannounced element of the inspection.

The hospital provides a range of surgery, outpatients and diagnostic services. On-site facilities include two suites Harborne that has 30 rooms and two observation beds, and Forelands which has 20 rooms but was not in use at the time of the inspection. There are three laminar flow operating theatres, one endoscopy suite, plus a consulting room with waiting area for ambulatory care patients. Within outpatients, there are 10 consulting rooms, two dedicated ENT rooms and one treatment room for minor procedures. Within the imaging department, there was one x-ray room, one ultrasound room and a mobile MRI on site two days per week, though this was supplied by another provider. Pre-assessment had four consulting rooms and a phlebotomy room. The physiotherapy suite has two consulting rooms and a dedicated gym.

Services offered included general surgery, orthopaedics, and gynaecology. Medical services offered were mainly endoscopy, diagnostic imaging and physiotherapy.

The BMI Edgbaston Hospital does not admit paediatric patients for surgery.

To meet the commitment we had made to inspect independent hospitals this service was scheduled and considered low risk. We had no prior concerns to make this service high risk. We inspected surgery and outpatients diagnostics. At the time of our inspection there were four medical patients receiving care via the Endoscopy suite, plus one patient on a ward for discharge that day. We have not written a medical report but referred to medical care within the surgical report. 56% of patients using the hospital were NHS funded.

The hospital was rated Requires improvement overall, we looked at two core services which were surgery and out patients and diagnostic imaging. We have written some of the medicine we saw at the time within the surgery report. This was because of the small numbers of patients in the hospital at the time of inspection.

Are services safe at this hospital

- Incident management process was robust.When incidents required investigation, the subsequent investigation was thorough and the root cause and learning identified. Learning was disseminated amongst the staff groups. The Director of clinical services reviewed all incidents to ensure correct next steps were taken. However, within surgery we did see two occurrences we thought should have been raised as incidents.
- Staff received duty of candour training and were able to describe the process required of them.The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support to that person. However, although we saw some meeting of the regulation, where staff were open and gave verbal apologies.Not all the letters to patients were sent relating to duty of candour.Also we noted that not all the steps to comply with the regulation were consistently applied.
- The 'five steps to safer surgery' was not consistently followed.The inspection team found many errors and or omissions in the records. Following feedback, the provider undertook training with staff to improve engagement with this safety process.
- The hospital employed a lead infection control nurse to support the staff who was shared with the nearby sister hospital.We found the hospital was visibly clean in all areas.Staff followed the hospital infection control policy.The exception was theatres, where we noted staff were not always bare below the elbows and used incorrect doors to access theatres for example.

Equipment was in good working order, maintained regularly and replacement plans were in place and adhered to. Safeguarding adult training level two was at 28%.The hospital had delivered level two training to 10 staff.We reviewed documents sent by the provider that identified 36 staff had professional registrations employed by the hospital (October 2015).This meant they were involved in clinical and assessment work, which would require them to be trained to level 2.We noted that the policy in place did not identify the staff that were required to be trained to level two.The hospital has since changed the training matrix which means that all clinical staff will be trained to level 2.

- The director of clinical services was trained to level 3 for safeguarding adults and children. Along with another member of staff who worked with children. The number of children in the hospital represented 4% of the work in outpatients department, so this appeared adequate.Children were not treated as inpatients within the hospital. At the time of the inspection, the senior management had made contact with the local safeguarding board to ensure their practices were in line with multiagency protocols.
- Mandatory training figures demonstrated that staff were able to access and complete the training the provider had identified as mandatory.95% of staff had completed the training the target was 85%.
- The hospital used an acuity tool to identify the numbers of staff required; this is based on clinical hours used compared to those covered.When there was a shortfall agency staff were used.We noted the area which used the highest number of qualified agency staff was in Theatres.The hospital used one main agency to maintain continuity.
- At the time of the inspection, there were some vacancies still outstanding in Theatres, Outpatients and one the suites. The hospital had undertaken an initiative to employ newly qualified nurses direct from a university, which it linked withStaff turnover rate which was extremely low at 1% (October 2014 to September 2015).
- The hospital had one Resident Medical Officer (RMO) for the hospital. RMO's worked one week on and one week off. Staff were confident in the clinical support they received. Staff had good access to the consultants who reviewed their patients daily and were contactable by the nursing staff and RMO's to seek advice for their patients.

Are services effective at this hospital

- We noted that patients received care in line with national best practice and guidance. We noted the American Society of Anaesthesiologists (ASA) physical status classification system was in use.Effective patient pathways were also in use by physiotherapy staff.
- Polices are written by BMI head office, if there were local variance a standard operating procedure would be produced. The hospital had produced a policy directory, available in all clinical and non-clinical areas.
- The hospital took part in national audit activity mostly related to joint surgery.The results demonstrated that results were above the England average.
- An enhanced recovery programme was in place to reduce length of stay.
- Other clinical audit took place across the hospital; we saw that audit activity in diagnostic imaging resulted improved outcomes for patients.The hospital had annual audit plan identifying the audits to take place on a month-by-month basis.
- There was a comprehensive programme to ensure practicing privilege criteria was met.The nearby sister hospital undertook this function on behalf of The Edgbaston.
- Revalidation was undertaken by the NHS employer where the consultant held their substantive post.Where consultants only worked in the private sector the Group Medical Director undertook their revalidation.
- Pain relief was managed effectively for patients. At pre-assessment, pain control was discussed.We saw that complimentary therapies were used in addition to analgesia to reduce and control pain.

Summary of findings

- Consent was sought for all procedures; patients were given sufficient information to make informed decisions.Staff sought verbal consent to deliver any care interactions.
- Staff had received mental capacity training, but had little opportunity to use the knowledge.Due to the process of access to the hospital, there were little occasions where patients mental capacity was required to be tested.

Are services caring at this hospital

- The hospital participated in the Friends and Family Test for the period of April 2015 to September 2015.100% of NHS patients would recommend the hospital to friends or family.The response rate for this feedback was on average 38% of patients.
- All interactions we observed demonstrated that staff treated patients with compassion and with dignity.Patient privacy was maintained, however, in outpatients where there was a risk that patients could be overheard at the reception desk.Mitigation was in place as there was an office behind main reception where patients can utilise if they have confidential details to discuss.
- Patients were given ample information to make informed decisions about their care.
- Patients were emotionally supported by staff especially if they were delivering upsetting or difficult news.

Are services responsive at this hospital

- Service planning to meet the needs of the patients was evident as the majority of the service was elective.This meant that patients both private and NHS had choice when accessing the service they required.
- The hospital worked with local clinical commissioning groups to develop services for NHS patients.
- The services responded to individual patient needs by offering appointments outside of core business hours.
- The outpatient department was meeting its referral to treatment time (non-admitted) pathway and 100% of patients were seen within 18 weeks.
- We saw there was very little issues relating to waiting times and access to appointments and treatments.However, there was only one area where slight delays were seen for patients waiting for x-ray due to there being one x-ray room and, as radiographers were undertaking analogue imaging which took 90 seconds as opposed to digital which were processed immediately.
- There was very little exposure for staff to people living with dementia or a learning disability within the service. The patients attending this hospital were cared for in rooms rather than wards, as this would present an elevated risk for vulnerable people.At the referral stage risk assessments were undertaken to identify people requiring additional support and recommended for NHS care.
- Translation services were available to support patients whose first language was not English.Printed information was available on request in other languages and in large font, braille or audio. The numbers of complaints were very low.In outpatients and diagnostic imaging there had not been any complaints for over a year.Complaints were appropriately recorded and responded to. Staff felt empowered to respond to verbal complaints by acting on them quickly to resolve them and thus prevent them from escalation to formal complaints. Between October 2014 and September 2015 the hospital received 33 formal complaints related to slow discharge process, surgical outcomes or charges, and poor food.

Are services well led at this hospital

- There was a vision and strategy for the hospital; we noted that staff were committed to their areas of work. During induction, staff were introduced to the BMI brand promise to be “serious about health, passionate about care”.

Summary of findings

- The Edgbaston and a nearby BMI hospital provided similar services.The two hospitals were looking at ways to collaborate and support each other.Executive and corporate managers were considering options to site individual specialist services at one or other of the hospitals.
- Records were not always available on site in outpatients as some consultants removed notes or saw patients both on and off site, this was for some private patients only.This was the same issue for analogue x-rays which were also removed from the premises.
- The Executive Director (ED) from the nearby BMI hospital oversaw the practicing privilege process.However, the ED from the Edgbaston attended each meeting.
- The Medical Advisory Committee (MAC) meetings took place and followed a set agenda.The format reflected a Verita report published March 2014 recommendations.This had been commissioned by another independent healthcare group but had implications for all independent health hospitals.We saw that the MAC meeting were run largely in line with the recommendations within that report.The hospital had representation in another regular meeting with other local NHS and independent hospitals as they shared a consultant body.This enabled them to share information, which may be a trigger and enable them to start preliminary investigations / discussions with a consultant, if there was cause for concern relating to their practice.
- The governance structure was robust in the most part, having a committee structure in place.Meetings took place to share information such as daily 'Comm-Cells' which hospital staff attended.Each department held regular meetings, which were minuted.We noted that regular agenda items included incidents and complaints.
- When investigations took place, the appropriate committees including the Medical Advisory Committee (MAC) reviewed them.We noted where incidents or complaints involved a consultant they were supported by the chair of the MAC.Either consultants were interviewed or they undertook a period of reflection.
- Learning from incident investigations had action plans associated with them and we saw these were completed.They included the sharing of learning mechanisms required to share the learning with appropriate staff.
- The hospital risk register held both clinical and risks associated with the fabric of the building.We noted that some of these were for escalation; however, the mitigation in place appeared reasonable to control the risk.
- There was a risk associated with carpet in clinical areas.There was a programme for refurbishment in place and housekeeping were maintaining the carpet including access to spill kits.
- One consultant insisted on using analogue x-rays rather than digital, they thought the images were better.This was despite all other consultants move over to digital and the Royal College of Radiographers recommending this practice.
- The leadership was very stable, the Executive Director had worked in a number of different roles so knew the hospital and the staff very well.Staff we spoke with were very complimentary of the leadership.There was a Director of Clinical Services in post, who at the time was an allied health professional.Nursing specific support was available from both BMI Head of Nursing and a team of clinical specialists who supported the Directors of Clinical Services.
- Within the core services staff felt supported by the management within their service.We saw this role required someone who could hold both consultants and staff to account to ensure policies are followed appropriately.At the time of the inspection, this was not happening in full.
- We were not able to check the fit and proper persons regulations compliance, as all the senior management documents were held at BMI head office.

Our key findings were as follows:

Summary of findings

- Staff were not following the infection protection controls, not being bare below the elbows as per the company policy. Staff were using incorrect doors to enter and leave areas in the theatre suite.
- Care delivered was seen to be of a high standard.Patient complaints were very low.Staff felt empowered to deal with complaints initially before they became official complaints.
- We also observed that although the '5 steps to safer surgery' audits showed 100% compliance, our observation of practice was not in line with the results.
- Audit activity results were above (better) than the England average for national audits relating to surgery.
- Incident management was good.The culture was one of safety and learning.The investigation process was of a good standard.
- Medications kept in refrigerators were not always maintained at the correct temperatures to maintain drug efficacy.
- Outpatient and diagnostic imaging was rated good for all the domains.
- Some patient records and x-rays were removed from outpatients and diagnostic imaging, which was not meeting regulations.

However, there were also areas of poor practice where the provider needs to make improvements.

- The hospital was not meeting the regulations relating to the duty of candour.An apology was being given verbally, but the rest of the regulation practice was inconsistently applied.
- The surgery checklist appeared to be more of a tick box exercise, as our observations did not match the audit results.

Importantly, the provider must:

- The hospital must ensure that governance systems were in place, which ensures safe practices were followed in theatres, and the 'five steps to safer surgery' are complied with.
- Theatre staff must comply with hospital policy and be bare below the elbow, which is considered best practice in preventing and controlling infections.In addition, staff must wear facemasks when undertaking tasks for which it is required.
- Medicines storage records indicated that the refrigerators were not being maintained within the recommended range.

In addition the provider should:

- Compliance with the surgical safety checklist should be improved with attention to detail and auditing to ensure attention to detail in order to ensure patient safety.
- Duty of Candour is regulatory duty that requires providers of health and social care services to notify patients (or relevant persons) of safety incidents involving their care. The hospital should ensure that that it is consistently applied.
  - All patients should have pre-operative assessments undertaken prior to surgery.
  - Ensure that when the NEWS tool is used when scores meet the escalation point they are raised appropriately.
  - The hospital should ensure that they meet and can demonstrate all parts of the regulations is met consistently.
- The hospital must ensure that all patients notes and diagnostic results are kept securely on the premises.
- People were not given the choice to self –administer their own medication if they wished to do so. We did see some people continuing to take their own medicines but there was no self-administration policy in place.

Summary of findings

Professor Sir Mike Richards
Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Surgery	Requires improvement 	We rated surgical services overall as requires improvement. We rated the safe and well –led domain as requires improvement. We rated the service good in the domains of effective, caring, and responsive domains. • Incident management was mostly good, but there had been some failures seen in processes which enabled some incidents to occur.In addition to this, these incidents were not recognised as reportable in each case. • We saw issues in theatres and in the Harborne suite with compliance with infection prevention and control. Whilst the hospital had not experienced any infection outbreaks, we found clinical practise increased the risk of infection due to complacency of some staff. • The 'Five steps to safer surgery' checklists completion was inconsistent.Missing data from the checklists included signatures, dates and times.Observation of theatre practice during operations demonstrated that some staff were complacent and showed poor theatre practice. • The service participated in national audits to record patient outcomes; outcomes demonstrated that patients received effective care and treatment.All patients were seen in a timely manner and exceeded 18-week national targets. • We observed good multidisciplinary working between nursing staff, medical staff and allied health professionals. • Staff were caring and supportive of patients, protecting their privacy and dignity. • Patients received individualised care based on their personal needs. • Supervisors and managers understood their staff and supported them to provide good

Summary of findings

care.However, the senior management in theatres was acting up in the role at the time, which meant some poor practice went unchallenged.

Outpatients and diagnostic imaging

Good

We rated safe as 'good.'

- Staff were aware of their responsibility to report incidents and received feedback from incidents. All areas and clinical rooms were visibly clean and tidy. Cleaning schedules for all areas were seen and had been fully completed. Staff gave good examples of what Duty of Candour meant and what their roles and responsibilities were The environment, equipment and management of Medicine ensured patient safety. Staff in outpatients were clear about how to respond to patients who became unwell and how to obtain additional help from colleagues in caring for a deteriorating patient. Staffing levels were sufficient to keep people safe. However senior management told us that only patients that hadn't received any kind of treatment in the outpatient department would not have records. Although the number of patient this related to was low this was a breach of a legal requirement.

We inspected but did not rate 'effective' as we do not currently collate sufficient evidence to rate this**.**

- Staff in all outpatient areas followed national or local guidelines and standards to ensure patients received effective and safe care. Options for pain relief were discussed with patients prior to any procedure being performed. We observed effective team working, with particularly strong working relationships between consultants, nursing staff and radiographers. However, there was a lack of up to date and clear guidance for radiographers to authorise medical exposures.

We rated 'caring' as good.

- All patients were positive about the care they had received. All the patients we spoke with

Summary of findings

told us they had been provided with relevant verbal and written information to enable them to make informed decisions about their care and treatment.During our conversations with staff it was clear they were passionate about caring for patients and put the patient's needs first.

We rated 'responsive' as good.

- Services were well planned and the facilities appropriate to support the running of clinics.All patients told us they felt the availability of appointments was good and appointments were provided at times that fitted in with their needs. The outpatient and diagnostic imaging teams had not received any written complaints during the year preceding our inspection.However, there weredelays to patients waiting for x-ray due to there being one x-ray room and as radiographers wereundertaking analogue imaging which took slightly longer to process.

We rated 'well-led' as good.

- Staff had a clear vision for the service and were aware of the overall vision for the hospital. The outpatient department had its own risk folder, which identified risks, the people who could be affected by the risk, assessment of risk and controls to reduce the level of risk. Front line staff were very positive about the leadership at departmental and senior management level.However concerns raised by staff regarding the continued used of analogy plain film x-rays on the request of one consultant were not addressed.

Summary of findings

Contents

Requires improvement

The Edgbaston Hospital

Services we looked at:
Surgery with medicine; Outpatients and diagnostic imaging;

Summary of this inspection

Background to BMI The Edgbaston Hospital

This location is part of BMI Healthcare Limited.

The hospital is a purpose built facility in the suburb of Edgbaston near the city centre. It is a mile away from a sister BMI hospital and shares some functions and staff with it.

The work undertaken is mostly elective. We inspected as a core service Surgery with some medicine reported within it and Outpatients & diagnostic imaging. We inspected the hospital as part of our commitment to inspect all independent health providers. We undertook this as a comprehensive inspection.

There were 4,733 visits to the theatre between Oct 14 and Sep 15. The five most common procedures performed were; Multiple arthroscopic operations on knee including meniscectomy (183), Primary total hip replacement with or without cement (166), Hysteroscopy including biopsy, dilatation, curettage and polypectomy (140), Total prosthesis replacement knee joint, with/without cement (138), Metal on metal hip resurfacing arthroplasty (133).

Medical procedures for the same time period within the endoscopy unit were; 433 bladder examinations, 403 diagnostic oesophagus-gastro-duodenoscopy (OGD), 332 diagnostic colonoscopy including forceps biopsy, 106 sigmoidoscopy including forceps biopsy and proctoscopy and 35 functional endoscopic sinus surgery (FESS).

In the same period, the outpatient department at the hospital conducted 7,544 new patient appointments and 9,524 follow up appointments. 279 first outpatient attendees were children aged 3-15 year old. 13 young people aged 16-17 were treated as in patients. All the children and young people seen at the hospital were self-funded.

There are:

- 56% of all patients are NHS funded.
- 55 registered beds. 20 beds on Forelands suite were not in use.
- Three theatres
- The Registered Manager is Clare Louise Austin and has been in post for one year and eight months.

Our inspection team

Our inspection team was led by:

Donna Sammons, Inspection Manager, Care Quality Commission

The team included CQC inspectors and a variety of specialists: a theatre co-ordinator, a consultant general surgeon, a matron on an independent hospital, a consultant in trauma and orthopaedics, a head of outpatients, a lead radiographer and a managing director/non-executive director.

How we carried out this inspection

We carried out this inspection by conducting focus groups for different levels of staff including consultants prior to commencing the inspection.

We requested and reviewed information about the hospital which was supplied both by the head office function and the hospital itself. Both during and after the inspection we requested further data to be analysed.

We spoke with staff and interviewed senior staff including the medical advisory chair and the executive director. We spoke with patients attending; we also collected comment cards, which had been available for people to complete in the run up to our inspection. We reviewed records maintained as part of the running of the regulated activities and observed care being delivered.

Summary of this inspection

We did not conduct any listening events as patients came from a wide geographic area, so in addition to the comment cards, posters were placed prominently within the hospital with all our contact details so people could share their experiences.

Information about BMI The Edgbaston Hospital

Birmingham is an ethnically and culturally diverse city and is the most populous city within the UK after London. 58% White, 27% Asian 9% Black, mixed 4% and other 2%. Eighty-five percent of Birmingham's population speak English. The most common other spoken languages are Urdu (3%), Punjabi (2%), Bengali (1.4%) and Pakistani (1%)

The health of people in Birmingham is varied compared with the England average. Deprivation is higher than average and about 29.9% (73,000) children live in poverty. Life expectancy for both men and women is lower than the England average. The life expectancy for males is 77.6 compared to the England average of 79.4. The life expectancy for females is 82.2 compared to the England average of 83.1.

Smoking prevalence is 19% compared to the England average of 18%. Twenty-three percent of Birmingham's adult population is classified as obese, which is equal to the England average. Twenty-four percent of Birmingham's children (up to year 6) are obese compared to the England average of 19%. Infant mortality is 7.1 per 1000 births compared the England average of 4.0 per 1000 births.

The accountable office for controlled drugs is Clare Louise Austin (registered manager).

- 214 doctors with practising privileges at this hospital
- 20.9 whole time equivalent (WTE) registered nurses
- 2.8 WTE operating practitioners
- 16.1 WTE healthcare assistants
- 7.5 WTE allied health professionals
- 33.9 WTE support staff

Core services provided at this hospital include, diagnostic imaging, endoscopy, medical care, surgery and physiotherapy.

Detailed findings from this inspection

Overview of ratings

Our ratings for this location are:

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

Notes

Notes:

1. We are currently not confident that we are collecting sufficient evidence to rate effectiveness for Outpatients & Diagnostic Imaging.

Requires improvement

Surgery

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

Information about the service

BMI Edgbaston Hospital is part of BMI Healthcare. The group has a nationwide network of private hospitals including its sister hospital, which is also based in the Edgbaston area. Some administrative and managerial functions are shared between the two hospitals. The group sets policies and procedures.

The Edgbaston hospital has 55 inpatient beds on two wards. Please note, the hospital refer to their wards as suites, Harborne having 32 beds and Forelands having 20 beds. At the time of our inspection, Forelands suite was not in use. All beds have private rooms and on-suite facilities.

This report covers both surgical and medical provision at the hospital. This is due to the small number of patients who were treated solely for medical conditions.

The site has three theatres and a dedicated endoscopy/ minor operations suite.

Theatres are available between 8am and 8pm Monday to Saturday.

From October 2014 to September 2015 there were 4,733 surgical procedures completed at the hospital. The most common surgical procedures being; multiple arthroscopic surgery – knee (183 procedures), primary total hip replacement (166 procedures), hysteroscopy including biopsy, dilatation, curettage and polypectomy (140), total prosthesis replacement knee joint (138 procedures), metal on metal hip resurfacing arthroplasty (133 procedures).

The hospital does not employ any doctors. 56% of patients seen were NHS. There were 214 consultants with practising privileges at the hospital. The administration and governance of practising privileges was conducted at the nearby BMI hospital.

A resident medical officer (RMO) provides clinical support under contract from a second company. RMO's provide medical cover 24 hours a day, for patients admitted to the suites. Nurses, healthcare workers and theatre staff were employed by the hospital.

During the inspection we visited a number of suites, treatment areas theatres and recovery areas. We spoke with 22 patients, relatives and carers about their experiences at the hospital. We spoke with 17 staff and reviewed documentation in relation to the general running of the services, maintenance of equipment and buildings. We also reviewed six patient records and reviewed information provided to us prior to and during the inspection.

Please note where we found evidence of medical practice, which differed from that within surgery we have listed the additional findings at the end of each section for clarity. At the time of our inspection there were four medical patients receiving care via the Endoscopy suite, plus one patient on a ward for discharge that day.

In relation to medical services:

We spoke with 6 staff members, including nurses, doctors, managers and healthcare assistance. We spoke with three patients and followed them pre and post operatively during their endoscopy pathway. We reviewed one medical record on the suite and looked at three on the endoscopy

suite. We observed interactions between staff and patients'. We attended a handover and held staff focus groups, which were attended by staff treating patients with medical conditions.

Summary of findings

We rated surgical services overall as requires improvement. We rated the safe and well –led domain as requires improvement. We rated the service good in the domains of effective, caring, and responsive domains.

- Incident management was mostly good, but there had been some failures seen in processes which enabled some incidents to occur.In addition to this, these incidents were not recognised as reportable in each case.
- We saw issues in theatres and in the Harborne suite with compliance with infection prevention and control. Whilst the hospital had not experienced any infection outbreaks, we found clinical practise increased the risk of infection due to complacency of some staff.
- The 'Five steps to safer surgery' checklists completion was inconsistent.Missing data from the checklists included signatures, dates and times.Observation of theatre practice during operations demonstrated that some staff were complacent and showed poor theatre practice.
- The service participated in national audits to record patient outcomes; outcomes demonstrated that patients received effective care and treatment.All patients were seen in a timely manner and exceeded 18-week national targets.
- We observed good multidisciplinary working between nursing staff, medical staff and allied health professionals.
- Staff were caring and supportive of patients, protecting their privacy and dignity.
- Patients received individualised care based on their personal needs.
- Supervisors and managers understood their staff and supported them to provide good care.However, the senior management in theatres was acting up in the role at the time, which meant some poor practice went unchallenged.

Requires improvement

Surgery

Are surgery services safe?

Requires improvement

We rated this service as requires improvement for safe, this was because;

- Infection control practices needed to improve; we saw that recognised processes were not followed in theatres in particular. For example, staff were not always arms 'bare below the elbows', or used face masks appropriately.
- We saw that compliance with the surgical safety checklist was inconsistent in theatres.
- Although staff understood how to raise incidents, we did note two significant issues which were of concern for which no incidents were raised. These related to a patient who had deteriorated and no escalation had been sought at the time. This had not been raised as an incident. The other related to the practice of an operating practitioner undertaking a role for which the anaesthetist was required to do. This meant that the hospital lost learning opportunities
- Duty of candour was understood by staff but not each element of the regulation was being met in full.
- Agency health care staff failed to identify a deteriorating patient when completing the National Early Warning Score tool (NEWS) score. Nursing staff who delegated the task did not check the score.
- We saw a day case patient operated on without evidence in their notes of any pre-operative assessment having been completed.
- Medications reconciliation was not being undertaken consistently. There was no direct pharmacy support unless nurses identified a problem and sought advice.

However we also saw;

- Harm free care information was displayed on the suites for patients, staff and visitors to see.
- Emergency resuscitation trolleys were checked regularly and recorded.

In relation to medical services;

- Sufficient equipment was available to the staff to meet patients' needs.
- Appropriate storage facilities for medicines were in place.
- The suites were clean and there were appropriate systems in place to minimise the risk of cross infection.
- Patient's records were mostly complete and legible.

Incidents

- The hospital had an incident reporting policy, which was in paper format. In the event of an incident, all employees were to report it to their line manager and record all facts on the incident report form, which was passed to the patient safety team. The team, led by the Director of Clinical Services, participated in appropriate investigation to ensure that learning and improvement was identified and disseminated across the hospital. The team was also required to provide assurance to the governance committee that the reporting arrangements were robust and appropriate.
- Staff confirmed that they were made aware of hospital wide incidents in various formats, for example, through team meetings, governance meetings and emails from line managers.
- Policies were available to staff to enable them to identify when they needed to report incidents, and how to do so. Incidents were graded according to their severity and impact on individuals or services.
- Staff understood the incident reporting process. They were able to describe instances where they had completed incidents forms. Staff told us that feedback was provided during handovers and formal team meetings, and on display boards which meant learning was shared.
- We observed one incident of an operating department practitioner (ODP) carrying out a procedure, which should be done by an anaesthetist. The ODP placed a Laryngeal Mask Airway on the patient. Laryngeal mask airways are used by anesthetist's to channel oxygen or anesthetic gas to a patient's lungs during surgery in unconscious patients. The anesthetist was not present supervising at the time, the Royal College of Anesthetists to confirmed the ODP should be supervised for this procedure.
- During the inspection whilst reviewing documents, we noted a patient had deteriorated and no escalation had been sought. When shared with local management it was also noted that no adverse incident report had been raised.

- We escalated this to the suite manager. It was identified that the entries had been completed by bank healthcare assistant. The ward manager told us that an adverse incident report had not been completed. We requested that an incident be recorded, which was then done.
- Never events are serious, wholly preventable patient safety incidents that should not occur if the available preventative measures had been implemented. There had been no never events at the hospital during the reporting period October 2014 to February 2016.
- 427 incidents had been reported during the period, two of which were classified as serious incidents.
- The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support to that person. We found that staff were aware of the need to be open and honest with patients, but not all staff understood when duty of candour procedures were actually required.

Safety thermometer

- The NHS Safety Thermometer provides a quick and simple method for surveying patient harms and analysing results so that providers can measure and monitor local improvement and harm free care. The system is designed to monitor the number of pressure ulcers, falls, catheter acquired urinary tract infections (UTI's) and venous thromboembolism (VTE).
- Harm free care information was displayed on boards at the entry to suites and departments and information in relation to NHS patients was submitted as part of the national NHS safety thermometer audit.
- From October 2014 to September 2015, figures showed that there had been no hospital acquired pressure ulcers. However, there had been five cases of VTE.
- All patients were screened to assess their risk of acquiring a VTE whilst in the hospital.
- Staff identified patients at high risk of pressure ulcers, falls or VTE and when necessary actions were taken to reduce the risk. We saw documentations on their medical care pathway forms to score the patient if they were high, medium or low risk.

Cleanliness, infection control and hygiene

- We saw that the hospital looked visibly clean and uncluttered.
- Infection control practices were monitored by the infection prevention and control lead. They attended departmental meetings and infection control action plans were produced for each department, displaying their performance and what areas should be focussed on to improve performance.
- We observed staff in many locations washing their hands and making use of hand gel. However not all staff in the theatres complied with 'arms bare below the elbow' which is considered to be best practice in preventing and controlling infections. We observed one procedure in the orthopaedic theatre where facemasks were not being worn by some staff.
- January 2016 audits of hand hygiene, Infection prevention and control were all 100% on the suites.
- We saw staff in theatres opening instrument sets without wearing facemasks, which meant that instruments might not be sterile.
- Some staff did not wash their hands after picking or moving things on the theatre floor.
- We saw poor theatre discipline with staff entering and leaving theatre by the wrong doors.
- Hand gel was available at the entrance to all suites, however signage was poor and we saw that very few patients or visitors used the gel.
- We saw that personal protective equipment was available to staff in the form of aprons and gloves.
- No cases of clostridium difficile (C.diff) or Methicillin-resistant Staphylococcus aureus **(**MRSA**)** for over 16 months. The infection control lead had a programme in place which included further investigation if a surgical site infection took place. From October 2015 to September 2015 there were 12 surgical site infection.
- All patients were screened for MRSA during the pre-assessment process or on admission.
- We saw cleaning schedules and audits of cleaning which showed how senior housekeepers completed 'white glove' rounds where they accompanied cleaning staff and ensured that areas they had cleaned met standards.
- The provider has employed their own dedicated infection control lead nurse and no longer shares this resource. Following feedback, the provider instigated spot checks in theatres, undertook staff awareness activities and increased the hand gel provision.

Environment and equipment

- Emergency resuscitation equipment, for use in operating theatres and suite areas, were regularly checked, and documented as complete and ready for use. Resuscitation trolleys were secured with tags, which were removed daily to check the trolley, and contents were in date.
- January 2016 audits demonstrated that resuscitation trolley checks were completed 100% of the time.
- We saw that there was insufficient protection for staff in theatres when x-ray equipment was in use due to the doors not being of the correct specification to provide protection.
- There were systems to maintain and service equipment as required. Equipment had safety check stickers which identified they had been tested.
- We did identify one piece of equipment which appeared not to have been serviced for a number of years. When we queried this, we were provided with evidence to show the equipment had been regularly serviced and maintained. The service date tag had become detached from the machine and no action had been taken to address it.
- There was good management and segregation of waste. All bins were labelled to indicate the type of waste to be disposed. Staff described how porters emptied bins regularly throughout the day.
- Hospital buildings were maintained such that patients, visitors and staff were safe.

Medicines

- Medicines were stored safely and securely including those requiring extra controls (controlled drugs). Room temperatures were monitored to ensure medicines did not become too warm. Medicines requiring cold storage were kept in refrigerators. Refrigerators had the capacity to be centrally monitored but currently this was not working and individual areas were required to monitor the refrigerators themselves. This had not been done adequately and there were records indicating that the refrigerators were not being maintained within the recommended range and there were no indications of what actions had been taken to ensure that the medicines kept within the refrigerator were still suitable for use. Following feedback the central monitoring fault was rectified enabling temperature recordings to be completed.
- We saw a good working relationship with nursing staff and the pharmacy team, there were good processes in place to obtain medicines and weekly checks by an appropriate member of staff to ensure medicines remained safe to use. All medicines were within date and items supplied for individuals to take home were appropriately labelled.
- Medicine recalls and alerts were dealt with appropriately.
- Emergency medications were available on the resuscitation trolley for the treatment of cardiac arrest and anaphylaxis. The resuscitation trolley was checked daily.
- People were not given the choice to self –administer their own medication if they wished to do so. We did see some people continuing to do their own medicines. Documents supplied by the provider demonstrated there was a local policy in place. This is important to make sure that people were assessed appropriately and risks were minimised when people were allowed to self-administer their own medicines. However, senior ward based staff were not aware of the policy. We were told that no such local arrangement existed. This meant there was a risk to patients with no universal process followed.
- Nursing staff undertook the procedure of medications reconciliation as outlined by the BMI policy. Medications reconciliation is the process of verifying the most accurate list possible of all medications a patient is taking. There was some documented evidence that nursing staff didn't always complete this.
- Critical medicines had been identified as recommended by the NPSA/2010/RRR09. This list identifies medicines where the timeliness of administration is crucial. The provider did undertake regular audit activity in line with the recommendations and the results were positive.
- Up to date reference materials for staff to use regarding the use of medicines such as British National Formulary were available either in hard copy or online.
- There was a system in place to report medicines incidents and following investigation to share learning amongst staff.

In relation to medical services;

- Where required, patients were sent pre-bowel prep medication, before they attended their endoscopy procedure. The process was discussed with patients in pre-assessment telephone calls.

Records

Requires improvement

Surgery

- We examined six sets of patient medical and nursing records, which included assessments for patients treated in operating theatres. We found that five sets of notes had omissions including one set where no pre-operative assessment was present.
- Records included details of the patient's admission, risk assessments, treatment plans and records of therapies provided. We looked at preoperative records, including completed preoperative assessment forms. Records were legible, accurate and up to date.
- When not being used by staff, medical records were secured which prevented tampering and ensured privacy and confidentiality.
- The 'Five steps to safer surgery' surgical safety checklist was launched in June 2008 based on the World Health Organisation version. The checklist should be used for every patient undergoing a surgical procedure. We saw that the guidance was followed in the theatres however in checking records for the period of our inspection and for a similar period in November 2015, we saw that the checklists contained a significant number of omissions. Most of the omissions related to the time of different aspects of procedures. It is important that all aspects of the checklists were completed accurately which enables better analysis and learning if procedures go wrong.
- We reviewed 35 records from 17, 18 and 19 November 2015; we saw a total of 129 errors or omissions. These included 42 signatures missing; 43 dates missing, and 44 times omitted. Records for 16, 17 and 18 February 2016 showed that of the 33 records reviewed we found a total of 153 errors or omissions; 38 signatures, 46 dates and 69 times omitted.
- During our inspection we observed the completion of different aspects of the surgical checklist during eight individual operations. Five of the procedures we observed were seen to follow good practice. We saw that three of the lists appeared to be completed as a 'tick box' exercise. Following feedback, the provider undertook training with staff to improve engagement with this safety process.
- The hospital had as process for reviewing the surgical safety checklist, the hospitals own audit demonstrated 100% compliance for all of 2015. This meant the process used was not robust enough to identify shortfalls. Following feedback the provider upgraded how they sought assurance regarding the checklist.
- Monthly health records checks showed a compliance rate of 85% for completion, this was being targeted to raise compliance to 100%.

In relation to medical services:

- We saw endoscopy pathways were available; we were able to review the process for three patients during our inspection.
- During the review of notes we saw that within endoscopy the surgical safety checklist was used appropriately.

Safeguarding

- The hospital had safeguarding policies and procedures available to staff on the intranet, including out of hours contact details.
- Consultants were required to evidence their safeguarding training as part of their practising privileges.
- The hospital safeguarding lead for adults and children's was the Director Of Clinical Services.
- No safeguarding issues had been reported at the hospital between October 2014 and September 2015.
- However, we found for adult level two the hospital attainment rate was 28% . The hospital had delivered level two training to 10 staff. We reviewed documents sent by the provider that identified 36 staff had professional registrations employed by the hospital (October 2015). This meant they were involved in clinical and assessment work, which would require them to be trained to level 2. We noted that the policy in place did not identify the staff that were required to be trained to level two. The hospital has since changed the training matrix which means that all clinical staff will be trained to level 2.
- Level 3 adult and children safeguarding training was held by the Director of Clinical services.

Mandatory training

- Staff had access to both on-line and face-to-face training. We saw records which showed compliance with mandatory training for nursing and care assistants on the suites averaged 91%. Many staff had achieved 100% compliance, however overall compliance was reduced as a result of some staff falling behind due to sickness or other absence. We saw that in January 2016 theatre staff had achieved 100% for mandatory training compliance.

- Staff had individual training programmes relative to their role. We saw that there were between 17 and 22 mandatory subjects dependent upon role. Senior staff were able to review which subjects individual staff had attended and which were outstanding.
- Induction processes ensured that new staff or temporary staff understood their role and were supported.
- Nursing staff had a 95% compliance rate against a hospital target of 85%.

In relation to medical services;

- 85% of staff had completed their mandatory training on the suite with 95%

of staff in theatre (endoscopy) who had completed their mandatory training.

- Staff had a learning training tracker which informed the staff when they were due for their next training sessions and in what area.

Assessing and responding to patient risk

- Staff engagement prior to surgery was not consistent, some staff did not follow the required 'stop' whilst important information was checked within the team, and they continued to complete their own tasks. Following surgery the check-out was completed without all theatre staff being present, and with some staff continuing to complete their own tasks instead of stopping to engage with the process. We saw one occasion where instruments checks were agreed and the checklist marked up when there had not been an instrument check. Questions about the patient's health, allergies and proposed procedure were not asked in the order they appeared on the list or not at all.
- Patients were assessed in line with the American Society of Anaesthesiologists (ASA) physical status classification system. ASA scores range from 1 to 6. ASA1 is a normal healthy patient; health and wellbeing reduce as the ASA number increases. Consultants did not use the hospitals services if patients ASA level was above ASA3.
- We saw from records that comprehensive pre assessments had been completed prior to patients being admitted. These included a health questionnaire which all patients were required to complete. This was used as part of a risk assessment. Documents received from the provider demonstrated that the vast majority of patients received both face to face and telephone pre surgery assessments prior to admission. We were also provided assurance that all NHS patients were pre-assessed in advance of their admission date and their assessments included screening for MSRA and VTE.
- We saw evidence of good local audit procedures on the suites; schedules and outcomes were recorded electronically and included: falls assessments – audit results showed that there was 91% compliance rate.
- The hospital had provision to support patients who became ill or whose recovery did not follow anticipated pathways. Transfer arrangements were in place with the sister hospital where full intensive care facilities were available. Hospital policy also included use of the 999 system to request emergency ambulance transfer to neighbouring NHS hospitals if this was required.
- The National Early Warning Score tool (NEWS) which demonstrated whether a patient's condition was deteriorating was used in all surgical suites. The NEWS tool shows whether observations were recorded upon patient admission to the suite, the frequency of observations post admission and any actions taken by staff for patients identified as a risk following observations.
- We identified a patient who's NEWS score increased to a level which should have resulted in increased observations and escalation to senior nursing staff. Neither intervention had been undertaken, which meant that the patient's health had not been effectively monitored.
- We saw that NEWS audits were completed each month on the suites. The audits identified that other discrepancies such as missed checks had been found, but they did not show how learning had been shared to prevent re-occurrences. Managers told us that results were displayed on the information boards and if individual staff were identified they would be spoken to and given advice. The information notice boards were information boards in the staff rooms which had notices and information displaced and had plastic holders or cells where documents could be placed for staff to review.
- Risk assessments were undertaken in areas such as venous thromboembolism (VTE), falls, malnutrition and pressure sores. These were documented in the patient's records and included actions to mitigate the risks identified.

- A theatre communications meeting took place each morning at 7.30am where any issues were discussed which might impact on the proposed procedures that day.
- The policy for transferring patients between suites and theatres stated that a qualified member of staff should accompany patients between theatres and suites. However, we saw that practice was that staff who were not qualified were completing the transfers.

In relation to medical services;

- We spoke with the pre-assessment lead who said that endoscopy patients were being pre-assessed via telephone. On the telephone they discussed about MRSA via a questionnaire, if the patient had MRSA screening that was positive in the past patient would be sent out ' hydrex washing product.

Nursing staffing

- We saw that staffing levels in theatres and on the individual suites were good.
- Theatre staffing consisted of 3.8 whole time equivalent (WTE) nurse team leaders, four nurses and nine care assistants, and 2.8 WTE operating department practitioners (ODP's).
- Harborne suite nursing establishment was 15.6 WTE registered nurses and four health care assistants (HCA's). They had 1.5 WTE nurse vacancies and 0.2 WTE HCA vacancies at the time of our inspection.
- During the inspection we reviewed the rota on site for the preceding three months. Actual staffing levels on Harborne suite met their planned levels with four nurses and two (HCA's) on early shift, four nurses and two HCA's on late shift and two nurses and one HCA on nights during our inspections.
- Agency staff were used on occasions to cover vacancies for annual leave or training. Theatres had an arrangement with the agency which ensured that any staff used were 'critical care unit' trained, managers explained that this ensured agency staff could deal with any eventuality they might face.
- The Dietician and speech and language therapist worked on the bank and as such worked only when requested.

Medical Staffing

- Individual consultants made their own arrangements to visit patients at the hospital. Staff told us that surgeons with inpatients attended the suites at least once per day to meet with and review their patients; some attended twice per day.
- Consultants were available to attend within 30 minutes of being made aware of a deteriorating patient.
- Nursing staff explained that consultants also left contact details and requested that they be contacted if any of their patients were unwell. They were also happy to be contacted for advice.
- In the absence of consultants medical cover was provided through a contract between the hospital and a private firm which provided an on-site Resident Medical Officer (RMO) on a 24/7 basis.
- We spoke with a RMO during the inspection. They described their role and told us they felt supported by the hospital staff and felt able to approach individual consultants for advice or guidance if this was required.
- RMO's worked a rota of one week on and one week off. The RMO was resident on site during their week on, and in addition to regular ward rounds during the day and evening, they were on call throughout the night.
- RMO appraisal and training was provided by their own organisation.
- We were told that RMO's who were new to the hospital arrived three days prior to their duty week for induction and shadowing of the duty RMO which ensured that they were familiar with the hospital processes and practices prior to undertaking the role.

Major incident awareness and training

- Emergency plans and evacuation procedures were in place and arrangements were displayed on noticeboards. Staff were trained in how to respond to fire and evacuation procedures.
- The provider had an service level agreement with a local NHs Hospital to transfer deteriorating patients to.

Are surgery services effective?

Good

Surgical services were rated good for effective because;

- Performance was reasonable compared to other hospitals.

- Pain levels were assessed and monitored using nationally recognised tools. Medication was administered and adjusted where required to keep patients as comfortable as possible.
- Nutrition and hydration met people's needs, Help was available for patients who could not manage to feed themselves. Recognised tools were used to monitor people who were at risk. The hospital staff sought appropriate interventions such as the use of a dietician to support them.
- Pre assessment provided carbohydrate loaded drinks, which helped patients, recover following surgery.
- The hospital engaged with national audits for its NHS patients. Audits showed that the hospital was performing to a reasonable standard when compared to other private and NHS hospitals. These results demonstrated good outcomes following surgery for patients.
- The hospital held group sessions for patients, who had undergone joint surgery, feedback from the sessions had led to improved patient involvement in pain management.

However;

- Endoscopy suite did not have JAG accreditation, although the unit was working towards it.

Evidence-based care and treatment

- BMI Edgbaston did not admit emergency patients. All surgical procedures were elective, which meant that patients had chosen to have an operation to deal with their condition.
- Policies and guidelines were readily available for staff on the hospital's intranet. These were seen to be up to date. Policies followed guidance with National Institute for Health and Care Excellence (NICE) and other professional associations.
- One anticoagulant was prescribed outside of the NICE guidelines. An anti-coagulant is a medication which thins the blood.) The consultant undertaking this practice had reported the doses as more therapeutic. The BMI Medical Director had agreed this practice and patients gave informed consent.
- The hospital took part in national audits to demonstrate the effectiveness of evidence based care.
- The hospital had a quality improvement programme agreed with a local CCG . One area related to the completion of a vascular care bundle, along with evidence of environmental and patient experience audits. The others related to patient experience. Results for 2014/15 demonstrated that the hospital achieved 100% compliance against a target 95%.

Pain relief

- Patients' pain was assessed and managed effectively in most cases. The NEWS chart was used to record patient pain score and medication was given as prescribed.
- We asked four people about their experiences regarding their medicines and pain relief, everyone said they were well informed, had adequate pain relief and were kept quite comfortable. They told us how doctors had amended their medication when this had been required.
- Some patients prior to surgery had had input from the physiotherapists specifically around pain management. This had resulted in better controlled pain for patients.
- The hospital staff used nationally recognised tools to identify and measure pain.

Nutrition and hydration

- We saw that the Malnutrition Universal Screening Tool (MUST) was used to assess and record patient's nutrition and hydration. The MUST tool is a five step screening tool to help identify patients who were underweight and at risk of malnutrition. We saw that where scores indicated patients were at risk, additional interventions were introduced.
- During pre-assessment for surgical patients, there was a good system in operation to allow for the timely provision of carbohydrate–rich drinks to aid recovery.
- Support was available for patients who required assistance to eat or drink. Relatives and carers were able to attend and assist patients if they wished and were able to do so.
- Specialist support from dieticians and therapists was available where appropriate or required.

Patient outcomes

- The hospital engaged with national Patient Recorded Outcome Measures (PROMs) audit for its NHS patients. PROMs data measures the general health and wellbeing of patients before certain operations and again at intervals after the operation to assess any positive or negative effect.
- PROMs data is submitted to the Health and Social Care Information Centre. Eligible procedures are; groin

hernia, hip replacement, knee replacement and varicose vein operations. In order to protect the anonymity of patients and ensure accurate analysis PROMs data is not published on numbers below 30 in each category.

- Health and Social Care Information Centre (HSCIC) data showed that during the reporting period April 2014 and March 2015, the BMI Edgbaston hospital had 103 eligible procedures consisting of; Groin Hernia – 23, Hip Replacement – 35, Knee Replacement – 44.
- We saw PROMs outcome data for knee replacement patients. PROMs outcomes were listed under two headings EQ-5D which is calculated based on the patients response to five questions and EQ-VAS which is the patients estimate of wellbeing based on a single sliding scale.
- The results for the hospital were better than the England average for patients satisfaction with their quality of life following their procedures;
  - EQ- 5D results for groin hernia patients showed that 13 (56.5%) of the 23 eligible patients had seen improvements in health. The England average was 81.1%.
  - EQ-5D results for hip replacements showed that all 35 (100%) patients had experienced an improvement after surgery.
  - EQ-5D results for Knee surgery showed that all 46 (100%) patients improved.
- The National Joint Registry (NJR) collects information on all hip, knee, ankle, elbow and shoulder replacement operations. The latest published data from the NJR is the 2015 report, which relates to operations completed during 2014. Data in the report showed that, 24 consultants completed 527 qualifying operations at BMI Edgbaston Hospital.
  - The data showed that the average ASA level for patients was 1.9.
  - 98% of patients had evidence of confirmed consent.
  - 88% of patients had an identifiable link to their NHS patient number.
- The register identifies providers which have been classified as outliers since 2003, and 2010 for hip or knee revisions (re-do operations) and for mortality within 90 days of surgery. BMI Edgbaston had not been an outlier in any of the recorded categories which indicated that the service was performing within acceptable levels.

In relation to medical services;

- The Joint Advisory Group (JAG) on gastrointestinal endoscopy is a quality improvement and service accreditation programme for gastrointestinal endoscopy. The group support and assess endoscopy units to meet and maintain the JAG standards.
- The scheme is a patient centred and workforce focused scheme based on the principle of independent assessment against recognised standards.
- Edgbaston was not JAG accredited but they are working towards becoming JAG accredited. . Part of the JAG accreditation included having separate waiting room facilities for patients, this meant they did not need to be admitted on to a separate suite, patients could attend theatre with a 'walk in' and 'walk out' service.

Competent staff

- Staff were competent to undertake their roles, having the professional qualifications to do so.
- We reviewed documentation and records which showed the process the hospital used to ensure that consultants requesting or renewing their practising privileges were properly assessed. This included evidence from the consultants NHS hospital. Where consultants did not have an NHS practice we saw that comprehensive validation processes were in place within BMI which ensured they had maintained their level of competence and completed all appropriate training.
- Nursing staff that we spoke with stated they were supported by senior staff and managers to undertake training and were able to request funding for additional training.
- Nursing staff appraisal rates on the suites was 90%.
- A competency programme was in use for scrub staff. We saw a copy of the assessment and competency document, which appeared comprehensive. The document did not have references so we could not see if it was aligned to the Perioperative Care Collaborative RCN, which is also a competency-based training for advanced scrub practitioners. Following the inspection, we did receive documentation, which demonstrated that the provider aligned the competency programme to the Perioperative Care Collaborative, surgical first assistant.
- Agency staff received induction when new to the hospital.

Multidisciplinary working

Requires improvement

Surgery

- Multidisciplinary working took place between nursing staff and allied health professionals. Consultant input was less obvious as most clinical decisions had been completed prior to patients being admitted to the hospital.
- We observed good working relationships between the residential medical officer (RMO)'s, nursing staff and theatres staff.
- Patients who undergo hip or knee replacement surgery automatically received pre-operative input from occupational therapists and post-operative physiotherapy. Patients also receive a follow-up phone call within 48 hours of discharge.
- There were three handover held , which occurred each morning, for late shift and evening to the night shift. All staff coming on to shift were expected to attend the hand-overs.

Seven-day services

- Nursing and care assistant staff worked 24/7 and were supported by the resident medical officer (RMO).
- The majority of operations were conducted on weekdays between 8am and 8pm, 8am to 5pm on Saturdays.
- Services were provided to support the demands of consultants. At the time of our inspection we were told that there was no demand from consultants for extended hours or additional days.
- There was a Monday to Friday service provided by the pharmacy department and a provision for supply of medicines out of hours in an emergency. At the weekend, there was no pharmacy service at Edgbaston, if required medicines could be obtained from the nearby BMI hospital.
- Discharge letters were completed electronically and populated by the pharmacy team to make sure the list of medicines supplied was clear and accurate.

In relation to medical services:

- The hospital had a dedicated Endoscopy unit within theatre which was open for elective surgery Monday to Friday 8am to 8pm and Saturdays 8am to 5pm. Types of cases undertaken within the suite included urology, gastroscopy, colo-rectal, gynaecology and dermatology procedures.

Access to information

- Staff all had access to the hospitals computer systems. Guidelines and protocols and policies were all accessible. Staff were able to demonstrate how they accessed information on the electronic system.
- The policies on the intranet were numerous and to support staff the senior management had produced a booklet with a quick guide to identify the policies, to make it easier for staff to search for what they needed online.
- Patient notes were available to staff and kept securely when not in use.
- All theatres were equipped with picture archiving and communication system (PACS) which enabled staff to access digital x-ray and scan images whilst in theatre.
- Discharge letters were written for the patients GP detailing the treatment and medication prescribed.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- All staff had received training in the mental capacity act and mental health act; however understanding of the acts was very fragmented. Managers explained that although training had been given, the methods employed by consultants and the choose and book system used by GP's meant that it was very rare for patients who did not have capacity to be treated at the hospital.
- Admission criteria meant that consultants were unlikely to use the hospital services for patients who were unable to make informed decisions or lacked capacity. Decisions such as consent to surgery or care pathways were only discussed when patients were not affected by anaesthesia or other medication.
- Patients we spoke with told us that they had been informed of the risks associated with their surgery before they signed the consent form. Staff discussed their treatment with them before commencing care. We saw that consent forms were completed, signed and available for staff to check prior to treatment being commenced.

Are surgery services caring?

Good

We found that staff were caring and rated the domain as good because;

Requires improvement

Surgery

- We observed good interactions between staff and patients and their family members. Staff were friendly, polite and professional. Patient's privacy and dignity were respected and protected.
- Patients told us that staff were attentive and had involved them in decisions about their care.
- Family and Friends test were audited and results were displayed. This showed that satisfaction levels were good.

Compassionate care

- Patient's privacy and dignity were maintained when personal care was given or when any procedure or treatment was undertaken.
- We saw that patients in theatre were treated with respect at all times.
- We observed many instances of staff talking with patients, and laughing and joking with them. Staff remained professional and took their lead from the particular patient they were dealing with.
- We overheard nursing staff asking patients if they needed assistance during meal times.
- Patient satisfaction survey results indicated that 98.2% of patients were satisfied with the care they received. NHS friends and family test results showed that 90% of patients would recommend the hospital to their friends and family members.

In relation to medical services:

- Friends and Family Test (FFT) from the NHS patients' were high (above 85%) FFT scores in the reporting period Apr 15 to Sep 15. Moderate (31% - 60%) response rates in the reporting period (Apr 15 to Sep 15) with the exception of Sep 15 when there was low response rate.

Understanding and involvement of patients and those close to them

- Patients told us that they had been able to discuss their care and treatment with their consultant and with nursing staff and were given different options about their care and treatment. Some patients described how they had been provided leaflets describing their procedure so they understood what to expect which had helped to reduce their anxiety.
- Patients told us that their relative or carer had been able to attend meetings and consultation's and had been able to take a full part, asking and answering questions.
- Private patients were provided with information regarding cost of services, most of which were agreed with or specified by insurance providers. Information about costs and potential additional costs were also on the hospital website.

In relation to medical services:

- We saw patient were given feedback about their procedure within endoscopy soon as the procedure was completed.

Emotional support

- Nursing staff explained that consultants usually dealt with patients and their relatives if bad news had to be given. Occasionally nurses had to speak with relatives or friends who visited when consultants were not on site. Quiet rooms were available for staff to speak with relatives.
- There was a chaplaincy service available for patients' religious or spiritual needs.

Are surgery services responsive?

Good

Surgical services were responsive to people's needs and rated good.

- Surgery at BMI Edgbaston was all elective planned procedures, so very few procedures were cancelled. Referral to treatment times were very good.
- Referral systems meant that very few patients who were vulnerable or with complex needs were treated in the hospital. This was done to ensure that those patients who required additional support were cared for in hospitals with more appropriate facilities. Where patients with additional needs were able to be treated in the hospital, systems were in place to support them.

In relation to medical services:

- Waiting times, delays and cancellations were minimal and were managed appropriately. People were kept informed of any disruption to their care or treatment.
- Facilities and premises were appropriate for the services being delivered. Endoscopy had rooms available on the suites to care for patients who required that extra input.

Requires improvement

Surgery

Service planning and delivery to meet the needs of local people

- The hospital worked with consultants to provide them with the equipment, facilities and support they required in order to provide surgical services. Patients who preferred to pay for their treatment or patients who had chosen to have their NHS procedure carried out at the hospital through the NHS e-Referral Service were able to use the facilities.
- Services were planned to meet clinical need of the procedures carried out rather than local population needs although BMI Edgbaston hospital had a much higher proportion of NHS patients than its sister hospital. NHS patients were able to choose the hospital through the GP referral system choose and book. 47% of patients who used the hospital were NHS patients.
- E-referral patients were allocated hospitals by the BMI central facility in Manchester. This meant that wherever possible patients were treated in a hospital as close as possible to their home which meant access for relatives and friends was made as easy as possible.

In relation to medical services:

- Late endoscopy theatre times throughout the week and on Saturdays enabled patients to attend around their working patterns.
- There were private rooms for endoscopy patients' they walked to theatre and were transferred to recovery then back to the suites until they felt ready to go home.

Access and flow

- Referral to treatment times for all groups of patients between October 2014 and September 2015 averaged 98.4% against national targets of 90%.
- Average length of stay for patients following surgery who had undergone hip or knee procedures were better than England averages. We did note that it was slightly higher for private patients. Staff felt that many private patients had different expectations of how they should be treated and when they felt well enough to take control of their own recovery.We asked the hospital for data in relation to this. Between August 2015 and January 2016, 32 NHS patients underwent hip procedures and they had an average length of stay of 3.5 days. During the same period 38 privately funded patients underwent hip procedures and they had an average stay of 3.7 days. NHS patients for knee procedures totalled 35 with an average stay of 3.5 days while 24 private patients averaged 4 days. Whilst it was difficult to see why there were any differences between the two groups undergoing the same clinical procedures and pathways, we did not feel the differences were significant. During August 2015 and January 2016, the NHS knee patient's length of stay was actually longer than that of private patients.
- Between August 2015 and January 2016 the hospital had only one patient who required an unplanned readmission within 28 days of discharge.

Meeting people's individual needs

- The provider met the needs of both patients and the consultants. The availability of the consultants determined the times of treatments. However, the availability was such that this did not present an issue for patients. We saw that the consultants and the hospital were responding to the needs of individual patients. Patients had individual personalised care during their procedure and stay.
- Between August 2015 and February 2016, a total of 1,421 patients underwent pre-assessment; 438 (30.7%) were completed on the day of admission. Assessing patients on the day of admission can lead to cancellation of planned operations and inconvenience to patients.
- We did see how patients with learning disabilities were accommodated and patients with mild memory problems. Nursing staff were able to provide details of how they supported a patient with a learning disability and how provision had been made for their relative to help support the person whilst they were in the hospital. Although the majority of patients who used the services had been selected by their consultants because they did not require extensive support.
- There were facilities available for relatives or carers to remain on the suites if they needed to.
- We did not see but on one suite staff were able to describe adjustments which had been made to accommodate a patient with a learning disability. We observed access for those with a physical disability to the hospital was well managed with slopes and lifts available.
- Translation services were arranged if required and as patients were all elective, such issues were identified in advance of the patient attending.

- The pharmacy lead introduced an initiative to talk to people about their expectations for pain relief during pre-assessment for joint surgery. This issue was identified from the patient satisfaction survey.

In relation to medical services:

- The Endoscopy unit provided a 'Walk in Walk out' service. Patients were following an ambulatory care pathway that included single sex waiting areas. Private rooms were also available on the suite post-operative recovery.
- The environment on each suite was visibly clean and comfortable, and the furnishings and decoration were in good condition throughout.

Learning from complaints and concerns

- The hospital followed the BMI complaints policy when formal complaints were made. The complaints process was promoted to patients via leaflets in around the hospital.
- Staff understood how to support people who complained. They told us that the majority of issues patients raised were dealt with at the time, preventing issues escalating to formal complaints. These issues were recorded in individual patients care records. Following our inspection the provider informed us they used a query tracker and trends were discussed monthly at the staff patient satisfaction meeting. We were also told that some minor complaints were discussed informally in team meetings or at handovers.
- Learning from formal complaints was shared locally to staff at team meetings, which was evidenced through minutes of meetings. Minutes were available to staff on the suite's information noticeboard.
- Information was available to patients regarding the complaints process and the Hospital website included information on how to complain.

Are surgery services well-led?

Requires improvement

We found that services required improvement in respect of being well led because;

- Governance systems were not sufficiently robust to ensure that practice in theatres was reflected in the information shared with senior management.
- We saw strong local leadership on the suites. Within theatres the lead was acting manager at the time and was very competent but we saw that some staff failed to follow procedures and good practice.
- Some practice was not challenged which impacted on the services provided.

However we also saw;

- Senior managers were visible and approachable.
- Systems were in place to ensure that consultant's performance was monitored and reviewed through the Medical Advisory Committee.

In relation to medical services;

- There were no plans for JAG accreditation of the endoscopy service at the hospital.

Vision and strategy for this service

- BMI Edgbaston Hospital is part of the BMI Healthcare group which had 59 hospitals throughout the UK. All locations share the BMI corporate identity and the company vision of Serious about health, Passionate about care
- Edgbaston hospital is based in Birmingham and is geographically close to and shares some administrative and managerial roles with the nearby sister BMI hospital.

In relation to medical services;

- At the time of the inspection Joint Advisory Group (JAG) accreditation of the endoscopy service at the hospital was not in place but staff were working towards it.

Governance, risk management and quality measurement

- Systems were in place, which were designed to monitor performance and feed back to board level. However, there appeared to be an overreliance on paper-based reviews as opposed to physical checks of systems. For example the reviews of the World Health Organisation safer surgery checklists, identified that the checklists were completed correctly, when our observations suggested that in many cases the lists were inaccurate, and not completed in full accordance with guidance in relation to staff presence and procedure 'stops'.
- The service had a Medical Advisory Committee (MAC), which oversaw governance of consultants working in the hospital. The committee met every four to six weeks.

We saw minutes of the MAC meetings which showed how issues were debated and information shared between consultants, the committee and the executives of the hospital. We met with the Chair of the MAC who was able to describe the governance process and gave examples of how the committee had been effective in management of adverse incidents and management of consultant performance. This committee was jointly run with the nearby BMI hospital.

- We saw minutes of team meetings, which contained feedback on incidents, complaints and compliments.
- Medical alerts and information of note was shared during meetings in addition to being published on the hospital intranet site for staff to access.
- There was good collaboration with pharmacy managers across the BMI group to enable shared learning to take place.
- The pharmacy lead felt very well supported by the Senior Management Team and had a good working relationship and discussed medicine audits that had taken place within the hospital.

Leadership of service

- Supervisors and managers on the suites understood the skills and abilities of individual members of their team. Managers and supervisors treated staff with respect and supported them in their work. In theatres at Edgbaston we found that there was no substantive theatre manager. There was no one of sufficiently seniority and gravitas available to ensure that theatre practice and procedures were maintained.
- Staff did not challenge each other when breaches occurred.
- Consultants were complimentary of the theatre staff, who were described as first class. Consultants believed the MAC process supported them and protected them and the hospital.

Culture within the service

- There was an open culture within the staff and management teams at the hospital. During our inspection we found staff of all levels to be approachable and polite.
- We found complacency had been allowed to develop amongst some staff. We saw poor theatre discipline with staff entering and leaving through the wrong doors without being stopped or prompted to use correct procedure. Staff were not challenged when they were not bare below the elbow. There was a lack of attention to detail when completing '5 steps to safer surgery' checklists.

Public engagement

- BMI Healthcare had a comprehensive website which enabled patients to review the Edgbaston Hospital. Details of the services available and the consultants registered with the hospital were all available.
- A patient newsletter was published on the website with news items and general information.
- We did not hear call bells being used; patients told us that staff were always calling in so they didn't need to call them. The suites operated a 'You said – We did' system and we saw that in response to patients comments nursing comfort rounds had been increased to hourly visits which meant that patients knew they would be visited regularly. Patients told us that that this meant they didn't need to call staff unless they had a particular need. They told us that when they had needed to call for assistance, staff were prompt and they were not kept waiting.

Staff engagement

- Staff had access to the hospital intranet system with emails, news feeds and access to policies procedures and working practice.
- The staff felt engaged, as they knew the leadership well. The executive director knew all staff by name.

Innovation, improvement and sustainability

- The hospital were reviewing services provided at BMI Edgbaston and the nearby sister BMI hospital with a view to providing specialist treatments at individual sites . This may lead to more advanced services; the ability to provide more intensive treatments; attract additional and more specialist consultants.
- The hospital shared some management and governance systems with the nearby sister BMI hospital, which reduced costs and improve liaison between the sites. For example, all consultants practising privileges were filed the sister hospital and the Medical Advisory Committee covered both sites.
- The pharmacy lead had introduced an initiative to talk to people about their expectations for pain relief during pre-assessment for joint surgery. This issue was identified from the patient satisfaction survey.

Good

Outpatients and diagnostic imaging

Safe	Good
Effective	
Caring	Good
Responsive	Good
Well-led	Good

Information about the service

The outpatient department at The Edgbaston Hospital provides a wide range of speciality appointments including cosmetics, dermatology, ENT (ear, nose and throat), gastroenterology, general surgery, gynaecology, immunology, neurology, neurophysiology and ophthalmology.

The diagnostic imaging department comprises of a computed radiography x-ray room, an ultrasound room, mobile x-ray units and image intensifiers for theatre imaging and an outsourced MRI scanner.

October 2014 to September 2015, the outpatient department at the hospital conducted 7,544 new patient appointments and 9,524 follow up appointments. The vast majority of patients seen were adults however children aged 3-15 years were seen in outpatients. For the same time period 279 were outpatient first attendees.

The outpatient department consists of 10 consulting rooms and one treatment room, supported by an onsite pharmacy, X-ray and physiotherapy. Another provider offered a MRI scanner on site. These facilities, combined with the hospital's on-site support services, enable consultants to undertake a wide range of procedures from routine investigations to surgery.

The physiotherapy service consists of two individual consulting rooms and one dedicated physiotherapy gym. Outpatient clinics for musculoskeletal, orthopaedics, women's health, and hands. Classes for post-surgical patients are conducted which include Pilates.

The outpatient department operates between 8.00am and 8.00pm Monday to Friday, 8-1 Saturday

During the inspection we visited the outpatient department and diagnostic imaging services. We spoke with six patients and 10 members of staff including nurses, consultants, radiographers, health care assistants, radiography department assistants, administrators and managers.

Throughout our inspection we reviewed hospital policies and procedures, staff training records, audits and performance data. We looked at computerised records and patient care records in addition to the environment and equipment being used. We observed care being provided

Good

Outpatients and diagnostic imaging

Summary of findings

We rated safe as 'good.'

- Staff were aware of their responsibility to report incidents and received feedback from incidents. All areas and clinical rooms were visibly clean and tidy. Cleaning schedules for all areas were seen and had been fully completed. Staff gave good examples of what Duty of Candour meant and what their roles and responsibilities were The environment, equipment and management of Medicine ensured patient safety. Staff in outpatients were clear about how to respond to patients who became unwell and how to obtain additional help from colleagues in caring for a deteriorating patient. Staffing levels were sufficient to keep people safe. However senior management told us that only patients that hadn't received any kind of treatment in the outpatient department would not have records. Although the number of patient this related to was low this was a breach of a legal requirement.

We inspected but did not rate 'effective' as we do not currently collate sufficient evidence to rate this**.**

- Staff in all outpatient areas followed national or local guidelines and standards to ensure patients received effective and safe care. Options for pain relief were discussed with patients prior to any procedure being performed. We observed effective team working, with particularly strong working relationships between consultants, nursing staff and radiographers. However, there was a lack of up to date and clear guidance for radiographers to authorise medical exposures.

We rated 'caring' as good.

- All patients were positive about the care they had received. All the patients we spoke with told us they had been provided with relevant verbal and written information to enable them to make informed decisions about their care and treatment.During our conversations with staff it was clear they were passionate about caring for patients and put the patient's needs first.

We rated 'responsive' as good.

- Services were well planned and the facilities appropriate to support the running of clinics.All patients told us they felt the availability of appointments was good and appointments were provided at times that fitted in with their needs. The outpatient and diagnostic imaging teams had not received any written complaints during the year preceding our inspection.However, there weredelays to patients waiting for x-ray due to there being one x-ray room and as radiographers wereundertaking analogue imaging which took slightly longer to process.

We rated 'well-led' as good.

- Staff had a clear vision for the service and were aware of the overall vision for the hospital. The outpatient department had its own risk folder, which identified risks, the people who could be affected by the risk, assessment of risk and controls to reduce the level of risk. Front line staff were very positive about the leadership at departmental and senior management level.However concerns raised by staff regarding the continued used of analogy plain film x-rays on the request of one consultant were not addressed.

Good

Outpatients and diagnostic imaging

Are outpatients and diagnostic imaging services safe?

Good

Patients in the outpatients and diagnostic imaging departments were protected from the risk of abuse and avoidable harm.

We rated safe as good because

- Staff were aware of their responsibility to report incidents and received feedback from incidents.
- All areas and clinical rooms were visibly clean and tidy. Cleaning schedules for all areas were seen and had been fully completed.
- Staff gave good examples of what Duty of Candour meant and what their roles and responsibilities were.
- The environment, equipment and management of medicines ensured patient safety.
- Staff in outpatients were clear about how to respond to patients who became unwell and how to obtain additional help from colleagues in caring for a deteriorating patient.
- Staffing levels achieved their plan to keep people safe..

However we also saw;

- Senior management told us that only patients that hadn't received any kind of treatment in the outpatient department would not have records. Although the number of patient this related to was low this was a breach of a legal requirement.

Incidents

- Staff were aware of their responsibility to report incidents. These were raised initially in paper format. They were then uploaded to an electronic reporting system. All of the staff we spoke to were confident in reporting incidents.
- There were 15 incidents raised for the area (2014-2015). Most related to clinical concerns, the next category was from equipment.
- Staff received feedback on outcomes from incidents. A staff member described the learning she had been supported with following an incident.
- Outcomes of incidents were discussed during team meetings and learning was shared at these meetings to improve patient outcomes. We saw minutes of team meetings where incidents had been discussed and changes in practice made as a result.
- There was a monthly update of all incidents within the hospital and a bi-monthly clinical governance meeting.
- The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support to that person. Organisations have a duty to provide patients and their families with information and support when a reportable incident has, or may have occurred. All staff told us they had received information and training about the Duty of Candour. We observed signed training logs that confirmed this. Staff gave good examples of what Duty of Candour meant and what their roles and responsibilities were.

Diagnostic Imaging

- There had been no serious incidents within the outpatient or diagnostic imaging department in the 12 months prior to our inspection.
- There have been no never events in radiology. 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.
- Incident reporting in diagnostic imaging was a paper-based system which fed into an electronic corporate register. The Radiology Services Manager (RSM) informed us they investigated the incident locally and submitted all paper documentation to the executive director's clinical governance team for population onto the electronic system. Feedback from incidents came through the clinical governance forum.
- Staff were aware of how to report incidents and there was a culture of openness when errors occurred.
- Staff were aware of the Duty of Candour policy. We saw posters displayed which demonstrated the policy. The Radiology Service Manager either verbally at the time of the error or via a letter as part of the departmental incident processes communicated all errors to the patient.

Good

Outpatients and diagnostic imaging

Cleanliness, infection control and hygiene

- The outpatient waiting areas and clinical rooms were visibly clean and tidy. Cleaning schedules for all areas were seen and had been fully completed.
- Hand sanitizer points were available to encourage good hand hygiene practice. We observed staff adhered to the 'bare below the elbow' guidance, which enabled thorough hand washing, and to prevent the spread of infection between staff and patients.
- Personal protective equipment (PPE) such as gloves and aprons, were readily available for staff in all clinical areas, to ensure their safety when performing procedures. We saw staff used them appropriately.
- Infection control practices were monitored by the infection prevention and control lead. They attended departmental meetings and infection control action plans were produced for each department, displaying their performance and what areas should be focussed on to improve performance. In outpatient clinics regular infection control audits were conducted and a recent hand hygiene audit showed 96% compliance. Staff told us they were aware of the outcomes from audits.
- In-line with current best practice the outpatient department had a 0% Methicillin-resistant Staphylococcus aureus rate (October 2014 to September 2015).
- Consulting rooms, hallways and stairs were carpeted throughout. Senior management told us that this was on the capital expenditure programme to replace over the next two years. The department had spill kits available to deal with any fluids that were spilled on the floor. The carpets were visibly clean, without any staining. Department of Health guidance for 'all providers of NHS care' states "if carpets are to be considered for non-clinical areas (for example, interview rooms, counselling suites, consulting rooms), it is essential that a documented local risk assessment is carried out with IPC involvement and a clearly defined pre-planned preventative maintenance and cleaning programme is put in place." We saw the hospital had carried out an IPC risk assessment for the carpeted areas.
- Flooring in the diagnostic imaging rooms was wipe-clean, and spill kits were available.

Diagnostic Imaging

- In diagnostic imaging the waiting and imaging areas were visibly clean and robust cleaning rotas were in place and completed appropriately.
- The protective lead vests were regularly cleaned, checked and recorded.

Environment and equipment

- Equipment was visibly clean. During inspection, we looked at equipment and all the electrical equipment had been safety checked and was up-to-date. Staff were clear on the procedure to follow if they identified faulty or broken equipment and whom to report this to. They ensured the item was removed from the clinical area to prevent further use until it had been repaired.
- There was a central log of all equipment to ensure annual testing was completed for all equipment.
- Availability and access to equipment met patient needs. We saw a new couch that had recently been purchased for the treatment room to support gynaecological examinations. Senior management were supportive to requests for new equipment if it improved patients experience and outcomes.
- There was a rolling equipment replacement programme in place for the outpatient department which demonstrated risk assessments and timely replacement of out-dated equipment.
- In the outpatient treatment and consultation rooms, single use items were stored in clearly labelled drawers and were well stocked. All items observed were seen to be in date.
- Rubbish disposal was well managed by the housekeeping team and nursing staff to ensure that bins never overflowed. All items were clearly separated into domestic and clinical waste bins.
- All sharps disposal bins were in date and not overfilled.
- Emergency call bells were situated in the clinical rooms.
- Resuscitation equipment was well maintained, in order and ready for use in an emergency. Trolleys were checked daily and records kept demonstrating that checks had been completed. All contents in the trolley were checked once a month and any items due to expire that month were thrown away and replaced. The trolleys were secured with tamper evident seals.
- The physiotherapy department had a non-slip floor surface and all of the equipment we inspected had been appropriately tested and maintained.
- All equipment requested from the physiotherapy management had been granted in a timely way.

Good

Outpatients and diagnostic imaging

Diagnostic imaging

- In diagnostic imaging rooms, Ionising Radiation (Medical Exposure) Regulations 2000 (IR(ME)R) local rules were displayed and up to date.
- The department was supported by a medical physics team contracted to the hospital for the provision of radiation protection services. The provider had a contractual agreement for the provision of a Radiation Protection Advisor (RPA) and medical physics experts (MPE).
- All x-ray equipment was regularly serviced and we saw evidence of service records, maintenance handover forms and medical physics checks after servicing.
- The lead radiographer was in the process of training to undertake the quality assurance (QA) of the equipment.
- We saw evidence of robust quality assurance of all equipment.
- Analogue imaging took place on the insistence of one consultant. They wanted to use this process as they felt the picture quality was better. The activity was having a negative impact on staff, in so much that staff were at risk due to exposure to chemicals required to develop and fix the images. However, following the inspection the provider informed us they had undertaken risk assessments to identify and implement mitigations against this risk. This included some of the images now being completed as digital. Also, the reports and analogue images were digitally copied so the hospital had electronic images on site and accessible. We have also been informed the consultant in question is transitioning to digital images.

Medicines

- Medicines were stored safely. All medicines cupboards were locked and the keys held by the Lead Nurse on duty. Fridges were locked and temperatures were checked and logged daily to ensure medicines were stored at the correct temperature. During our inspection the temperature of one fridge was noted to be above the recommended range, staff had reported this equipment issue in the appropriate way and the equipment was fixed before the end of our inspection.
- In the outpatients department, prescription pads were stored in lockable drawers within the nurse's office. There was a record of every prescription serial number, which doctor and patient it had been allocated to.
- The medication cupboard was temperature controlled. Up-to-date records were seen and temperatures were within the correct range.

Records

- We saw patient personal information and medical records were managed safely and securely. Patient records were transferred to the locked consultation rooms ready for when the clinic commenced. Staff told us that they had no difficulty in retrieving patient notes for clinic appointments.
- Patient records were held securely on site in the medical records room. There was an archive facility for patient notes that was located off site.
- The majority of consultation records were kept by the hospital; senior management told us that only patients that hadn't received any kind of treatment in the outpatient department would not have records. Although the number of patients this related to was low this was a breach of a legal requirement.
- The outpatient department was working towards a standardisation of outpatient notes; staff felt their opinions were being taken into consideration as these notes were developed.
- We reviewed 12 sets of patient notes: six for NHS funded patients and six privately funded patients. All records were legible, dated and signed appropriately. The expected sets of document were present in every set which included: referral letter, consultations discussion, images where appropriate and a follow up plan.

Diagnostic Imaging

- The department used a radiology information system (RIS) and picture archiving and communication system (PACS). The PACS System (PACS) is a nationally recognised system used to report and store patient images. This system was available and used across the hospital.
- All IT systems were password protected and records of patient's appointments, examinations and reports were stored securely.

Safeguarding

- Safeguarding training for vulnerable adults was mandatory for all staff. All the staff we spoke to were aware when to raise a concern and the process they

should follow, but had not had to raise any recent concerns. Compliance with safeguarding level one and two for adults and children training was 100% in both diagnostic imaging and within the outpatients department. However, we found for adult level two the hospital attainment rate was 28%. The hospital had delivered level two training to 10 staff. We reviewed documents sent by the provider that identified 36 staff had professional registrations employed by the hospital (October 2015). This meant they were involved in clinical and assessment work, which would require them to be trained to level 2. We noted that the policy in place did not identify the staff that were required to be trained to level two. The hospital has since changed the training matrix which means that all clinical staff will be trained to level 2.

- Staff knew how to locate the safeguarding flow chart, which was available as guidance for all staff and was seen by the inspection team.
- Children over the age of three were seen in the hospital outpatient department but procedures were not carried out at this hospital. Staff were aware of who the safeguarding level 3 lead was and how to contact them. They worked jointly at another local hospital.

Mandatory training

- Staff completed a number of mandatory training modules as part of their induction, and updated them in line with hospital and corporate policy. This included infection prevention and control, fire safety and basic or intermediate life support. The training was mainly via e-learning packages, with practical sessions for basic/ intermediate life support and manual handling.
- Outpatient department compliance rate for mandatory training was 96% for January 2016.
- None of the staff we spoke with reported any difficulty in finding time to complete their mandatory training.

Diagnostic Imaging

- Mandatory training in diagnostic imaging was 100% compliant .

Assessing and responding to patient risk.

- Staff in outpatients were clear about how to respond to patients who became unwell and how to obtain additional help from colleagues in caring for a deteriorating patient. All radiographers and registered nurses in the outpatients and diagnostic imaging had received training in intermediate life support, with all other staff trained in basic life support.
- There was always a Registered Medical Officer (RMO) on duty, who was trained in advanced life support to assist if a patient became unwell. Patients who became medically unwell could be transferred to the local acute NHS Trust by ambulance if required.
- The outpatient department had a detailed minor procedure pathway for treatments conducted in the department. This included a patient risk assessment, a specific outpatient consent forms, operation/treatment notes and histology request forms.
- Emergency resuscitation equipment was available throughout the outpatient and physiotherapy areas.
- Systems to promote safety were in place and well managed for example alarm systems, key coding access to consulting corridors, fire alarm procedures and checked fire extinguishers.
- The physiotherapy department conducted risk assessments on patients before they could use the equipment.
- Designated staff from the physiotherapy department were on call in the evenings and at the weekends in order to provide post-operative assessments such as for falls.

Diagnostic Imaging

- There was an appointed and trained Radiation Protection Supervisor (RPS) within the diagnostic imaging departments. RPSs are appointed under the ionising radiation regulations 1999 (IRR). They locally oversee radiation protection under the ionising radiation (medical exposure) regulations (IRMER). Their role was to ensure that equipment safety, quality checks and ionising radiation procedures were carried out in accordance with national guidance and local procedures. Evidence was seen that these checks and procedures were being completed correctly.
- There is an established radiation protection committee (RPC) which meet annually. The principal function of the Radiation Safety Committee is to ensure that clinical radiation procedures and supporting activities are undertaken in compliance with ionising and non-ionising radiation legislation. Actions and recommendations from this group were fed into the provider's clinical governance forum.

Good

Outpatients and diagnostic imaging

- The RPC committee and the medical advisory committee (MAC) approve procedures, local rules and employer's procedures and this was last undertaken in February 2016.
- There was clear radiation hazard signage outside the x-ray rooms for staff and patients.

Nursing and radiography staffing

- Nursing and radiography cover was sufficient in outpatient and diagnostic imaging areas.
- The outpatient department required the equivalent for one whole time equivalent (WTE) lead nurse, 3 WTE nurses and 4 WTE health care assistants This staffing level was calculated according to patient need and would be adapted if necessary to meet additional requirements.
- At the time of our inspection the lead nurse role was vacant due to a recent reconfigure of leadership responsibility. The vacancy was being recruited to at the time of our inspection.
- There were no agency staff used within outpatients. Bank staff were used to support the outpatient's department staffing requirements to cover absences such as annual leave and sickness. The bank staff were regular members of staff that were familiar with the environment and provider; bank staff contributed 20% of the nurse work force in the outpatient department.

Diagnostic Imaging

- In Diagnostic imaging there was one radiographer and there were no vacancies .

Medical staffing

- Within the outpatient department, consultants covered all specialities for all clinics. There were no concerns raised about the availability of consultants to cover their clinics.
- Practising privileges is an authority granted to a doctor by a hospital board, to provide patient care within the hospital. The practising privileges for the outpatient doctors were checked during inspection and were all up-to-date.
- There was a Resident Medical Officer (RMO) based within the hospital that could be called upon by diagnostic imaging and outpatients when required. Staff reported no concerns in being able to reach the RMO when necessary.

Major incident awareness and training

- There was a member of the senior management team on duty each day responsible operationally for any major incident affecting the hospital. Staff were aware who to contact if an incident should arise.
- The provider had up to date policies and procedures for: the event of fire, bomb threat and major incidents.
- Staff could recall a fire drill training session that occurred the previous year and they received feedback on their performance.
- There was a picture archiving and communication system (PACS) and radiology information system (RIS) downtime contingency arrangement which extends across the hospital group. There was an escalation policy and a service line agreement with the IT providers should issues arise.

Are outpatients and diagnostic imaging services effective?

We inspected but did not rate 'effective' as we do not currently collate sufficient evidence to rate this.

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.

- Staff in all outpatient areas followed national or local guidelines and standards to ensure patients received effective and safe care.
- Options for pain relief were discussed with patients prior to any procedure being performed.
- We observed effective team working, with particularly strong working relationships between consultants, nursing staff and radiographers.

However

- There was a lack of up to date and clear guidance for radiographers to authorise medical exposures. Examination protocols at the time of the inspection were out of date and required review. The authorisations included staff who no longer worked at the hospital. The Royal college of Radiologists annually update guidance for imaging examinations and techniques and radiology departments should review their own procedures against these.

Evidence-based care and treatment

- Staff in all outpatient areas followed national or local guidelines and standards to ensure patients received effective and safe care. We saw policies' that reflected evidence based guidelines.
- Clinical care pathways had been developed in line with best practise and were put into action, for example physiotherapy pathways.
- The physiotherapy department used an electronic exercise prescription programme which ensured consistency between practitioners.

Diagnostic Imaging

- IR(ME)R audits were undertaken in line with regulatory responsibility, copies of these audits, outcomes, actions and results were seen during our inspection.
- Local rules as required under IRR were observed and these had been recently reviewed and signed by the majority of staff bound by them.
- The IR(ME)R employers procedures, standard operating procedures and examination protocols for individual examinations had not been sufficiently reviewed and a mix of current and historical paper documents dating back to 1999 were found in the IR(ME)R folders. There was a lack of up to date and clear guidance for radiographers to authorise medical exposures.
- The provider had a radiation safety policy but although recently reviewed, historic and current documentation were stored in paper folders together which made it difficult to ascertain the most up to date information.
- Staff were aware of their responsibilities and there was good understanding, specifically relating to dose awareness and diagnostic reference levels (DRL's) as required under IR(ME)R.
- A number of dose audits had been conducted in conjunction with the medical physics service and the department had adopted a number of national diagnostic reference levels. The provider must be able to determine radiation doses for specific patients and procedures. Patient dose information is then compared to diagnostic reference levels (DRLs) in order to determine if the dose levels are appropriate at a particular facility. DRLs are typical doses for examinations commonly performed in Radiology departments. They are set at a level so that roughly 75% of examinations will be lower than the relevant DRL.
- Recent dose audits with data sourced from radiology information systems had been undertaken, resulting in the adoption of local diagnostic reference levels which reflect more accurately local practice. There is an ongoing commitment to a dose audit programme to further develop local diagnostic reference levels.
- All medico-legal and research exposures are easily identifiable and staff followed the employers procedures under IR(ME)R for this imaging. Medico-legal exposures are x-rays taken or procedures performed for insurance or legal purposes where there is no medical indication or benefit.
- Research exposures are x-rays taken as part of a research trial. Referrers made make use of i-Refer which are the Royal College of Radiologists guidelines for referrals for medical exposures. However, the up to date referral criteria and examinations were not available within radiology when requested.
- There was a register of non-medical referrers including information around training and entitlement however, a number of staff were identified as having left or were no longer acting in the capacity of a non-medical referrer and the register required updating to reflect current practice.

Pain relief

- Options for pain relief were discussed with patients prior to any procedure being performed. Many procedures were undertaken with the use of local anaesthetic, which enabled patients to go home the same day. Patients were given written advice on any pain relief medications they may need to use during their recovery at home.
- Complimentary pain relief therapies were also available via the physiotherapists such as acupuncture, Pilates and massage.

Patient outcomes

- The physiotherapy department took part in a national audit for perceived patient improvement following physiotherapy treatment. For upper limb conditions a 23% change in quality of life was demonstrated, lower limb demonstrated a 22% increase and spinal treatment an 18% increase.
- The physiotherapy department used a survey which measured pain on a scale of one to 10 before and after treatment and included areas such as mobility, anxiety and self-care.

Diagnostic Imaging

Good

Outpatients and diagnostic imaging

- The hospital required consultant radiologists to participate in discrepancy audits. Reviewing and learning from reporting discrepancies can provide evidence of reflective practice and can provide a learning opportunity to enhance patient safety. The most recent radiology report discrepancy audit figures were between 2-5% which is within the Royal College of Radiologists recommendations of 5% by 2018. If a discrepancy is found this is raised directly with the original reporting radiologist and this is documented on an audit form and retained locally.

Competent staff

- Patients told us they felt staff were appropriately trained and competent to provide the care they needed. This was confirmed by staff who felt well supported to maintain and further develop their professional skills and experience. One member of staff described how she was fully encouraged and supported to complete her NVQ level 3 for healthcare.
- In the period November 2014 to October 2015, 100% of outpatient nursing staff and healthcare assistants had received an appraisal. In the same period, 100% of radiographers and radiography department assistants had received an appraisal.
- Practicing privileges is authority granted to a physician by a hospital governing board to allow them to provide patient care within that hospital. There were appropriate systems in place to ensure that all consultants practising privileges were kept up-to-date. Evidence of this was seen during the inspection.

Diagnostic Imaging

- Continuous professional development (CPD) was self-directed with all records being kept by individuals. Staff were encouraged to undergo CPD.
- Radiologists undertook CPD but primarily at their NHS base.
- NHS appraisals for radiologists were provided to the hospital annually.

Multidisciplinary working (related to this core service)

- We observed effective team working, with particularly strong working relationships between consultants, nursing staff and radiographers.
- There was effective multidisciplinary team working involving the physiotherapy team. They would attend consultant appointments where required to discuss rehabilitation and to follow up patients.
- Referral to follow up services after treatment such a GP's and community rehabilitations teams was effective.
- The physiotherapists demonstrated effective MDT with the local NHS rapid orthopaedic community services for knee replacement patients.

Diagnostic Imaging

- Communication between radiology and the wider hospital was effective and services were easily accessible when required.
- We spoke with a number of staff throughout the hospital and received feedback regarding diagnostic imaging.

Seven-day services

- The majority of outpatient clinics were held Monday to Friday, with clinics running from 8.30am to 8.00pm Monday to Fridays. Clinics were also held on Saturdays as required.
- The physiotherapy department provided services five days a week with times to suit the patients. The physiotherapists were on call at the weekend to assist the ward areas for any assessments or to assist with discharge if required.

Diagnostic imaging

- In diagnostic imaging services were available between 9.00am and 9.00pm Monday to Friday. During the weekend and overnight, radiographers were on call from home. There was support from radiologists out of hours if required. There was an on call service for general and mobile and theatre radiography for urgent night and weekend imaging. All radiographers participate in the on call service.

Access to information

- Staff reported timely access to blood test results and diagnostic imaging. This enabled prompt discussion with the patient on the findings and treatment plan.
- Diagnostic imaging results were available electronically and were accessible by the clinician during clinic appointments.

Good

Outpatients and diagnostic imaging

- There were appropriate systems in place to ensure safe transfer and accessibility of patient records if a patient needed to be transferred to another provider for their treatment.
- IT systems in radiology integrated with the hospital system so staff had access to patient information.
- All referrals were paper based via an imaging request or a referral letter

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Outpatient specific consent forms were used for minor treatments in the department.
- All staff were aware of the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS). Staff knew what their responsibilities were in relation to the MCA and DoLS and how to apply this within everyday practice. Staff received mandatory training in relation to this.

Are outpatients and diagnostic imaging 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;

- All patients were positive about the care they had received.
- All the patients we spoke with, told us they had been provided with relevant verbal and written information to enable them to make an informed decision about their care and treatment
- During our conversations with staff it was clear they were passionate about caring for patients and put the patient's needs first.

Compassionate care

- All patients were positive about the care they had received. We received comments such as: 'very good service', 'polite caring staff', 'friendly and approachable ', 'great service from start to end.' There were no negative comments from any patients within outpatients and diagnostic imaging.
- The main outpatient reception desk was close to the waiting areas so patients conversations may be overheard when speaking confidentially. The hospital mitigation was there was an office behind main reception where patients can utilise if they have confidential details to discuss.
- We observed all clinical activity was provided in individual consulting rooms and doors were always closed to maintain privacy and confidentiality. There was signage on the door to signal if the room was engaged or available, to ensure no inappropriate interruptions.
- All clinics provided chaperones for clinics. Nursing staff would ask patients if they would like a chaperone. This was then clearly documented in the patient notes.
- Throughout the inspection, staff spoke in a calm and relaxed way to patients. All the patients we spoke with told us staff were friendly, helpful and caring. They told us staff always showed concern and understanding for their situation and were sensitive to any needs or worries they had.

Understanding and involvement of patients and those close to them

- All the patients we spoke with, told us they had been provided with relevant verbal and written information to enable them to make an informed decision about their care and treatment. There had been sufficient time at their appointment for them to discuss any concerns they had.
- The hospital participated in the Friends and Family Test for the period of April 2015 to September 2015. 100% of NHS patients would recommend the hospital to friends or family. The response rate for this feedback was on average 38% of patients.

Emotional support

- Patients commented that they had been emotionally well supported by staff, particularly if they had received upsetting or difficult news at their appointment.
- During our conversations with staff it was clear they were passionate about caring for patients and put the patient's needs first.

Are outpatients and diagnostic imaging services responsive?

Good

Outpatients and diagnostic imaging

Good

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

We rated responsive as good because;

- Services were well planned and the facilities appropriate to support the running of clinics.
- All patients told us they felt the availability of appointments was good and appointments were provided at times that fitted in with their needs.
- The outpatient and diagnostic imaging teams had not received any written complaints during the year preceding our inspection.

However we also saw;

- There were delays to patients waiting for x-ray due to there being one x-ray room and as radiographers were undertaking analogue imaging which took slightly longer to process. This is because one consultant is acting outside of the provider and Royal College requirements and was impacting negatively on other staff and patients.

Service planning and delivery to meet the needs of local people

- Services were well planned and the facilities appropriate to support the running of clinics. Clinics were held Monday to Friday until 8.00pm in the evening and some weekends to accommodate patients with commitments during the working week.

Access and flow

- The patients seen at the hospital consisted of an equal amount of NHS patients and self-funded patients or patients funded by other means. NHS patients were seen within the hospital using the 'choose and book' system. Patients could either book their appointment online, visit or ring the booking office which enabled them to choose an appointment time which suited their needs.
- All patients told us they felt the availability of appointments was good and appointments were provided at times that fitted in with their needs. The majority of patients left with their next appointment date or if appropriate, an admission date for surgery. Patients were very complimentary about the efficiency of the service as a whole.
- The clinics we observed mostly ran to schedule. Staff told us if there were delays, they would speak to patients and keep them informed
- Patients could be given an outpatient appointment on the same day, but generally appointments were given within a week of contacting the hospital.
- The outpatient department was meeting its referral to treatment time (non-admitted) pathway and 100% of patients were seen within 18 weeks.
- The physiotherapy department told us they could offer an appointment within 48 hours of referral if appropriate for the patient or the same day for emergency referrals.

Diagnostic Imaging

- There were some delays to patients waiting for x-ray due to there being one x-ray room and as radiographers were undertaking analogue imaging took 90 seconds to process as opposed to digital ones which are instant. As a result, the waiting area could become crowded but there was another waiting area available.
- There were no delays to reporting and all radiologist reports were undertaken in real time.
- There were no appointment waiting times for services that were offered.
- The outsourced magnetic resonance imaging (MRI) scanner was on site 2 days per week running over an extended day from 8am until 8pm to undertake musculoskeletal imaging. The images are reported by the hospitals radiologists and there were no delays in the reporting of these images.

Meeting people's individual needs

- There was ample seating in waiting areas. All consulting rooms and communal spaces were wheelchair accessible.
- There was complimentary refreshment facilities provided in the waiting areas.
- All written information and signage, including pre-appointment information was provided in English only. There was a telephone interpreting service provided all staff were aware of it.

Good

Outpatients and diagnostic imaging

- Information leaflets were not provided in easy-read format. There was no information on display to advise patients how to access information in large font, braille or audio, nor was this printed on any leaflets.

Diagnostic imaging

- There was no multilingual information available and all appointments and pre and post examination care was written in English. There was access to translation services.
- Patients were sent appropriate information prior to their first attendance, this contained information such as the consultant or clinic they were to see, length of time for the appointment and written information on any procedures which may be performed at the first appointment, including the cost of the appointment and subsequent procedures (for self-funding patients).

Learning from complaints and concerns

- Complaints leaflets were available in the waiting areas for patients who wished to make a formal complaint.
- If a patient wanted to make a complaint, staff told us they would ask their immediate line manager/service manager to speak to the patient. Most complaints were resolved locally. The outpatient and diagnostic imaging teams had not received any written complaints during the year preceding our inspection.

Are outpatients and diagnostic imaging services well-led?

Good

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

We rated well-led as good because;

- Staff had a clear vision for the service and were aware of the overall vision for the hospital.
- The outpatient department had its own risk folder, which identified risks, the people who could be affected by the risk, assessment of risk and controls to reduce the level of risk.
- Front line staff were very positive about the leadership at departmental and senior management level.

However we also saw;

- Concerns raised by staff regarding the continued used of analogy plain film x-rays on the request of one consultant were not addressed.

Vision and strategy for this core service

- Staff spoke enthusiastically about the service they provided and were proud of the facilities they worked in and the care they could offer to patients.
- Staff had a clear vision for the service and were aware of the overall vision for the hospital. The vision was to provide high quality care in a timely and effective way.

Governance, risk management and quality measurement for this core service

- There was a hospital wide risk register which reflected the hospitals environmental risks. The outpatient department had its own risk folder the risks were managed locally. Although they were reviewed by the Health and safety committee so could be escalated to the hospital wide risk document if needed. It included details such as, the people who could be affected by the risk, assessment of risk and controls to reduce the level of risk. These risks did not appear on the hospital risk register, but the departmental leads were clear about their key risks and how to mitigate the risks to patients.
- The departments provided the senior management team (SMT) with a weekly report, which effectively updated them with operational information from that week. This included any risk issues.
- We saw minutes of the Medical Advisory Committee (MAC) meeting which covered areas of good practice and risk and included outpatients. Minutes from the MAC meeting were circulated to all the consultants for information.

Diagnostic Imaging

- The risk register for diagnostic imaging was held both locally and at provider level and radiology fed into this overarching document. However, at the time of the inspection, radiology did not have any items on the risk register.
- The Lead Radiographer was an integral part of all management meetings and regularly attended the

clinical governance, clinical leads, patient satisfaction, infection control and business continuity meetings. Evidence of these meetings in the form of minutes were provided.

- The department converted analogue plain film imaging to computed radiography and digital storage a number of years ago and analogue films were removed from the department. The radiology services manager (RSM) communicated to all referrers the timescale for this and how images would subsequently be acquired and stored digitally. One consultant insisted on the continued production of analogue x-ray. Analogue hard copy Images were produced for one consultant and the subsequent x-ray films were removed from the hospital and stored off site. The radiographers found this way of working cumbersome and it slowed the department down considerably during busy clinics.
- The RSM had escalated their concerns to the leadership of the hospital including the MAC and to provider level but has not been able to get the practice stopped.
- The provision of analogue images precludes digital image capture, and exposes the hospital staff to increased risk in regard to COSHH issues associated with the chemistry required to develop and fix the images. In addition, there is an increased risk of untoward radiation doses to patients should repeat imaging be necessary due to lost hard copy films.
- Nationally both the NHS and independent sectors have moved away from analogue imaging to achieve the dual benefits of digital image capture in terms of safe storage and readily available image transfer. Digital capture negates the need for repeat Imaging in the event of loss and the associated radiation risks to the patient.
- The diagnostic imaging lead has raised these issues with senior management at the hospital but no action has been taken.

Leadership / culture of service

- Front line staff were very positive about the leadership at departmental and senior management. They told us the leadership team were visible and approachable and if they had any concerns, these were listened to and were acted upon. Staff felt their immediate manager had the appropriate skills to lead and run their department and was supportive.
- Staff reported an open and transparent culture which was apparent during our inspection.

Diagnostic imaging

- The senior management were supportive and the Executive Director was seen daily by the radiographic staff. There was an open door policy and staff felt well supported and well led by the management team.
- The two radiographers worked well together and were supportive of one another.
- There were concerns around the provision of the MRI service through a third party provider. There were concerns relating to staff professionalism, continuity of the workforce, patient care, chaperoning and a lack of cohesion with local hospital staff and arrangements and requirements.
- The RSM has indicated their concerns regarding the outsourced MRI company to BMI but feels that not enough was being undertaken to address these issues. They felt that the company and provision of service was impacting on the reputation of the hospital. Following the inspection the hospital made us aware that agreement with the outsource MRI providers was in place. Quarterly meetings and monthly calls occurred, with the RSM and a representative for the MRI company. We noted a document supplied by the provider which identified areas of discussion and action agreed which included complaint response times and the requirement to inform the provider in the event that two male radiographers were running the unit.

Public and staff engagement

- Patients were regularly asked to complete satisfaction surveys on the quality of care and service provided. The results of the survey were used by departments to improve the service. However, although outcomes were displayed in waiting areas, actions for making improvements were not available for patients to read.
- The outpatient and diagnostic imaging departments sought staff engagement through monthly meetings between where staff opinions were discussed and updates given. Meeting minutes were seen during our inspection.
- Radiology managers held regional meetings in an attempt to get to know each other's department and to share information and move towards more standardised radiological practices.

Innovation, improvement and sustainability

Good

Outpatients and diagnostic imaging

- The diagnostic imaging department worked towards the imaging service accreditation scheme (ISAS). ISAS is a nationally recognized accreditation scheme available for diagnostic imaging services in the UK.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

- The hospital must ensure that governance systems were in place which ensure safe practices were followed in theatres and the five steps to safer surgery are complied with.
- Theatre staff must comply with hospital policy and be bare below the elbow which is considered to be best practice in preventing and controlling infections.Also staff must wear facemasks when undertaking tasks for which it is required.
- Medicines storage records indicated that the refrigerators were not being maintained within the recommended range.
- The hospital must comply with the Royal College recommendations to use digital imaging rather than analogue imaging. As this has negatively impacted on staff.

Action the provider SHOULD take to improve

- Compliance with the surgical checklist should be improved with attention to detail and auditing to ensure attention to detail in order to ensure patient safety.
- Duty of Candour is regulatory duty that requires providers of health and social care services to notify patients (or relevant persons) of safety incidents involving their care. The hospital should ensure that that it is consistently applied.
- All patients should have pre-operative assessments undertaken prior to surgery.
- Ensure that when the NEWS tool is used when scores meet the escalation point they are raised appropriately.
- The hospital should ensure that they meet and can demonstrate all parts of the regulations is met consistently.
- The hospital must ensure that all patients notes and diagnostic results are kept securely on the premises.
- People were not given the choice to self –administer their own medication if they wished to do so. We did see some people continuing to take their own medicines but there was no self-administration policy in place.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment 12.—(1) Care and treatment must be provided in a safe way for service users. (2) Without limiting paragraph (1), the things which a registered person must do to comply with that paragraph include— (a) assessing the risks to the health and safety of service users of receiving the care or treatment; (b) doing all that is reasonably practicable to mitigate any such risks; (g) the proper and safe management of medicines; (h) assessing the risk of, and preventing, detecting and controlling the spread of, infections, including those that are health care associated; **How the regulation was not being met:** Theatre staff were completing the five steps to safer surgery but as a tick box exercise. Staff were not following the infection control policy fully in theatres. Medicines were not being kept at the correct temperatures to ensure efficacy. Imaging staff were undertaking analogue imaging for one consultant which was negatively impacting on staff.

This section is primarily information for the provider

Requirement notices

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance 17.—(1) Systems or processes must be established and operated effectively to ensure compliance with the requirements in this Part. (2) Without limiting paragraph (1), such systems or processes must enable the registered person, in particular, to— (b) assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk which arise from the carrying on of the regulated activity; **How the regulation was not being met:** The continued use of analogue imaging put patients and staff at unacceptable risk. The use of this system was contrary to the corporate decision to move to digital imaging, which was in use for the vast majority of patients receiving imaging.

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

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