BMI St Edmunds Hospital

Quality Report

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

Ratings

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

Summary of findings

Letter from the Chief Inspector of Hospitals

BMI St Edmunds is operated by BMI Healthcare and is situated in Bury St Edmunds, Suffolk. The hospital provides surgery, outpatient and imaging services to adults only.

On 16 and 20 March 2017, we inspected surgery, which included the ward, operating theatres, endoscopy and the outpatients and diagnostic imaging departments.

We inspected this service using our comprehensive inspection methodology. We carried out the announced part of the inspection on 16 March 2017, along with an unannounced visit to the hospital on 20 March 2017.

To get to the heart of patients' experiences of care and treatment, we ask the same five questions of all services: are they safe, effective, caring, responsive to people's needs, and well-led? Where we have a legal duty to do so we rate services' performance against each key question as outstanding, good, requires improvement or inadequate.

Throughout the inspection, we took account of what people told us and how the provider understood and complied with the Mental Capacity Act 2005.

The main service provided by this hospital was surgery. Where our findings on surgery for example, management arrangements – also apply to other services, we do not repeat the information but cross-refer to the surgery core service.

We rated this hospital as requires improvement overall.

We found areas of practice that require improvement in outpatient and diagnostic imaging:

- We found a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, specifically Regulation 17: Good governance.
- We found a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, specifically Regulation 18 Staffing. Within radiology, we found not all bank staff received required levels of support and competency assessment to enable them to carry out their role safely.
- Consultants did not make copies of patient records to be stored at the hospital.
- Consultants did not make complete, contemporaneous notes on each patient, including a record of the care and treatment provided and of decisions taken in relation to the care and treatment provided.
- Not all imaging staff had completed all of the required competencies and training to operate the radiology equipment. The Ionising Radiation (Medical Exposure) Regulations (IR(ME)R) 2000 requires staff to be trained in the safe use of equipment.
- We found five of the eight outpatient consulting rooms to have carpeted floors. The use of carpets within treatment areas was not in line with the Department of Health, Health Building Note 00:10, which independent healthcare providers should take account of when designing and planning buildings.
- Senior staff within outpatient and diagnostic imaging did not routinely or consistently engage with clinical governance meetings or heads of department meetings.
- Not all managers submitted audit data as required for three months in 2016, and required prompting to submit data since.

We found areas of practice that required improvement in surgery:

- We found a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, specifically Regulation 17 Good governance. Within theatres, senior staff did not have up to date competency records for staff, and did not know which staff were currently competent to undertake specific tasks.
- We found a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, specifically Regulation 18 Staffing. Within theatres, we found staff had not received an appraisal in the last twelve months.

Summary of findings

- Staff lacked required competencies within theatres, and staff records were filed in a chaotic manner making retrieval of current competencies difficult. In addition, theatre staff had not undergone an appraisal.
- Overview of risk, particular within theatres, was limited. For example, there was no plan in place to improve compliance with staff competencies in theatre.
- We found staff from across the service had mixed engagement with clinical governance meetings and heads of department meetings.

However, we also found the following good areas of practice in relation to surgery:

- We found detailed and accurate documentation within patient's ward records, from medical, nursing and therapy staff.
- Equipment was serviced and in date across all departments, and emergency equipment (such as resuscitation and difficult intubation equipment) was readily available and routinely checked.
- Staffing within the ward and theatres was sufficient to meet the needs of patients, and the heads of department used recognised staffing tools to review staff numbers routinely.

We found areas of good practice in relation to outpatients and diagnostic imaging:

- We found good standards of infection prevention and control, including hand hygiene and staffing complying with the 'bare below the elbows' guidance.
- Staff treated patients with dignity, respect and compassion throughout their treatment.
- The service had regard for the needs of patients in line with the Equality Act 2010. For example, reception desks had been lowered to allow wheelchair users access, and staff utilised translation services for patients whose first language was not spoken English.

Following this inspection, we told the provider that it must take some actions to comply with the regulations, as they had been breached and that it should make other improvements, even though a regulation had not been breached, to help the service improve. We also issued the provider with three requirement notices that affected surgery and outpatients and diagnostic imaging. Details are at the end of the report.

Heidi Smoult

Deputy 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 	Surgery was the main activity of the hospital. Where our findings on surgery also apply to other services, we do not repeat the information but cross-refer to the surgery section. The same consultant group and resident medical officer worked in both inpatient and outpatient departments. We rated this service as requires improvement because: • We found a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, specifically Regulation 17 Good governance. Within theatres, senior staff did not have up to competency records for staff, and did not know which staff were currently competent to undertake specific tasks. • We found a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, specifically Regulation 18 Staffing. We found not all staff within theatres received regular appraisals or reviews of their training and development needs. • We found staff from across the service had mixed engagement with clinical governance meetings and heads of department meetings. However: • We found detailed and accurate documentation within patient's records, from medical, nursing and therapy staff. • Equipment was serviced and in date across all departments, and emergency equipment (such as resuscitation and difficult intubation equipment) was readily available and routinely checked. • Staffing within the ward and theatres reflected activity and patients' acuity. The heads of department used recognised staffing tools to review staff numbers routinely.

Summary of findings

- Staff treated patients with respect, dignity and compassion.
- Patients had access to therapy, nursing and medical services when required, including at weekends and out of hours.

Outpatients and diagnostic imaging

Requires improvement

We rated this service requires improvement because:

- We found a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, specifically Regulation 17: Good governance. Medical staff did not record treatment and care offered and given within patient's records in outpatients.
- We found a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, specifically Regulation 18 Staffing. Within radiology, we found not all bank staff received required levels of supervision and competency assessment to enable them to carry out their role safely.
- Not all imaging staff had completed the required competencies to operate the imaging equipment, in line with the Ionising Radiation (Medical Exposure) Regulations (IR(ME)R) 2000.
- We found that some managers did not routinely and consistently engage in clinical governance and heads of department meetings.
- We found carpeted treatment rooms within the outpatient department, which were not in line with the Department of Health, Health Building Note 00:10, which independent healthcare providers should take account of. However, this had been recognised and was on the hospital risk register.

However:

- There was compliance with good practice with regards to infection prevention and control amongst staff, including hand hygiene and staffing complying with the 'bare below the elbows' guidance.
- Staff treated patients with dignity, respect and compassion throughout their treatment.

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- The service had regard for the needs of patients in line with the Equality Act 2010. For example, reception desks had been lowered to allow wheelchair users access, and staff utilised translation services for patients whose first language was not spoken English.

Summary of findings

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BMI St Edmunds

Services we looked at
Surgery; Outpatients and diagnostic imaging.

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Background to BMI St Edmunds Hospital

BMI St Edmunds is operated by BMI Healthcare Ltd and has been operated by BMI since 2008, although the hospital has been on the site, in the middle of Bury St Edmund's since 1980. The building has two floors and 26 beds all with ensuite facilities. The ward also has an ambulatory care room.

There are two operating theatres, one of which has laminar flow. In addition, there is an adjacent endoscopy suite.

The outpatient department on the ground floor consists of seven consulting rooms, and a treatment room. The imaging department is also located on the ground floor, containing ultrasound and general x-ray. A separate provider undertakes MRI and CT off site.

There is a Resident Medical Officer (RMO) on duty 24 hours a day.

A range of elective surgeries are provided, which include, but not limited to, orthopaedics, general surgery, urology, ophthalmology, ENT, gynaecology and cosmetic surgery.

The hospital has had the present registered manager in post since September 2009.

Our inspection team

The team that inspected the service comprised a CQC lead inspection manager, Kim Handel, four other CQC inspectors, an assistant inspector, and two specialist advisors with expertise in surgery.

Information about BMI St Edmunds Hospital

The hospital has one ward and was registered to provide the following regulated activities:

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

During the inspection, we visited the ward, operating theatres, outpatients, imaging, endoscopy and physiotherapy. We spoke with 24 staff, including registered nurses, health care assistants, administrative staff, medical staff, operating department practitioners, support staff and senior managers. We spoke with seven patients and three relatives. We also received 34, 'tell us about your care' comment cards, which patients had completed prior to our inspection. During our inspection, we reviewed 50 sets of patient records, 31 from outpatients and 19 from admitted or surgical patients.

There were no special reviews or investigations of the hospital ongoing by the CQC at any time during the 12 months before this inspection. CQC had previously inspected the hospital three times, and the most recent inspections took place in July 2014 and December 2013, which found that the hospital was meeting all standards of quality and safety it was inspected against.

Between October 2015 and September 2016, the hospital had 680 inpatients and 2152 patients undergoing day-care procedures, of these 45% were NHS funded with the remainder funded by other means; (for example insurance companies or were self-funding).

During the same period, there were 11,787 outpatient attendances, 25% of whom were funded by the NHS, mostly through the NHS referrals system.

There were 86 surgeons, physicians, anaesthetists and radiologists who worked at the hospital under a

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practising privileges agreement. There was a resident medical officer (RMO) working on a seven day (24 hours a day) on, seven days off rota and was employed through an agency under a BMI contract.

The hospital employed 63.3 whole time equivalent staff which included, registered nurses, care assistants, operating department practitioners, physiotherapists, a radiographer and support staff, as well as having its own bank staff. The accountable officer for controlled drugs (CDs) was the registered manager.

Track record on safety:

Between October 2015 and September 2016, there were184 incidents. This is a higher rate per 100 bed days than other hospitals we hold data for. Of all incidents, 109 caused no harm, 60 low harm, 15 moderate harm, zero severe harm and there had been no deaths arising from incidents.

- Zero incidences of hospital acquired MRSA.
- Zero incidences of hospital acquired Methicillin-sensitive staphylococcus aureus (MSSA)
- Zero incidences of hospital acquired Clostridium difficile
- Zero incidences of hospital acquired Escherichia coli (E-Coli)

During the same period, the hospital received 44 complaints, one of which was referred to the Independent Sector Complaints Adjudication Service for resolution.

Services accredited by a national body:

The hospital has no national accreditations.

Services provided at the hospital under service level agreement:

- Clinical, non-clinical, general and confidential waste removal
- Decontamination of surgical instruments
- Interpreting services
- Grounds Maintenance
- Laundry
- Maintenance of medical equipment
- Pathology and histology
- Blood transfusion
- RMO provision
- Car park management
- Catering
- Resuscitation training

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

Requires improvement

We rated safe as requires improvement because:

- We found a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, specifically Regulation 17: Good governance.
- Care and treatment delivered to patients, or the decisions made in accordance with that care and treatment, was not consistently documented by consultants within the outpatients department.
- Not all outpatient consultants routinely stored copies of patients' medical records at the hospital, removing all outpatient notes.
- Of the eight outpatient consulting rooms, five had carpeted flooring. This was not in line with the Department of Health, Health Building Note 00:10, which independent health care providers must take account of when designing and refurbishing healthcare premises. However, this risk was on the hospital's risk register.
- Medication management within theatres did not always follow best practice, with staff reporting anaesthetists leaving anaesthetic medicines unattended in operating theatres.
- There was poor compliance with best practice when inserting intravenous cannulas. Despite an action plan, very little improvement had been made.

However:

- Staff were aware of incident reporting procedures and we found evidence of learning from incidents.
- Staff were knowledgeable about safeguarding procedures. The majority of staff had completed safeguarding training at the correct level.
- Staff compliance with mandatory training was as good as or better than the BMI target across all areas inspected.

Are services effective?

Requires improvement

We rated effective as requires improvement because:

- We found a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, specifically Regulation 18 Staffing. Within theatres, we found staff had not received an appraisal in the last twelve months. Within radiology, support, competency assessment and professional supervision were not routinely undertaken.

Summary of this inspection

- The senior management team did not check the skills and competence of staff routinely, or monitor the scope of practice of consultants in line with the requirements of BMIs practicing privileges policy.
- Senior theatre staff did not have an oversight of staff competencies.
- The completion of staff appraisals was inconsistent across the hospital. Senior staff told us that no staff member in theatre had received an appraisal in the last year.
- Surgical services had a mixed picture with regards to the latest Patient Reported Outcome Measures (PROMS) data. Some results were the same as and some slightly worse overall than the national average.
- The number of unplanned transfers of care to another hospital or provider was higher than the national average.
- Access to information, such as pre admission assessment in outpatients and some NHS records, was inconsistent across all areas.
- The hospital provided no evidence of staff receiving clinical supervision within their roles.
- Surgical services had a higher than national average of unplanned transfers of care.
- Staff did not monitor or audit the preoperative fasting of patients to ensure they were not starved for longer than necessary.

However:

- Staff delivered care in a way that followed current evidence based best practice and national standards.
- We found good multidisciplinary working across all departments.
- Staff were knowledgeable about the use of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards 2010 across all departments.
- Consent was taken in line with current best practice, including allowing a 'cooling off period' for those patients undergoing a cosmetic procedure.
- Patients had access to consultants, therapists and radiology services seven days a week where required.

Are services caring?

Good

We rated caring as good because:

- Patient feedback from all departments was very positive.
- We observed staff treating patients with dignity, respect and patience.

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- Staff gave patients sufficient time to ask questions and involve their friends and family within discussions relating to their care.

Are services responsive?

Good

We rated responsive as good because:

- The hospital met national targets for 'referral to treatment' (RTT) in the majority of cases, for example, the national 18 week target for non-urgent surgery and the 42 day target for non-obstetric diagnostic ultrasound scans.
- Surgical services had a very low rate of cancelled procedures.
- Patients had access to physiotherapists within 24 hours of surgery.
- The hospital took account of the Equality Act 2010 when planning services. For example, the reception desk had been lowered to allow wheelchair access, and all staff asked knew how to access interpreters for patients whose first language was not spoken English.
- We received positive feedback from patients regarding access to services and wait times for clinics.
- The hospital responded to or acknowledged complaints in a systematic and timely way and we found evidence of learning from complaints.

However:

- Not all verbal complaints were recorded.

Are services well-led?

Requires improvement

We rated well-led as requires improvement because:

- We found a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, specifically Regulation 17 Good governance. Within theatres, senior staff did not have up to competency records for staff, and did not know which staff were currently competent to undertake specific tasks.
- We found mixed engagement with clinical governance from the heads of department.
- Senior outpatients and diagnostic imaging staff had a limited understanding of the risks within their departments.
- Senior theatre staff did not have oversight of the department, for example they did not know the number of staff vacancies when asked, or which staff were competent to undertake which skills.
- The senior management team had knowledge of breaches of hospital policy by consultants within outpatients (such as the

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lack of documentation within patient's medical records.) However, despite their attendance at medical advisory committees, the senior management team and medical advisory committee had not identified this as a risk.

However:

- The hospital risk registers were up to date and were reviewed regularly.
- We found a clear corporate vision and strategy for the hospital, which staff understood.
- Staff told us they felt supported and encouraged by their local line managers.

Detailed findings from this inspection

Overview of ratings

Our ratings for this location are:

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

Requires improvement

Surgery

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

Are surgery services safe?

Good

We rated safe in surgery as good.

Incidents

- The hospital had an established process through an electronic incident reporting system for staff to report clinical and non-clinical incidents.
- Between October 2015 and September 2016, the hospital reported no never events. Never events are wholly preventable, where guidance or safety recommendations that provide strong systemic protective barriers are available at a national level, and should have been implemented by all healthcare providers.
- The hospital reported 184 clinical incidents between October 2015 and September 2016, with 151 (82%) within theatres and the ward. Of the 184 incidents, 59.2% where categorised as 'causing no harm', 32.6% as 'low harm' and 8.2% as 'moderate harm'. The hospital recorded no incidents resulting in 'serious harm' or 'death'. At the time of the inspection, eight records were 'open' and had met the criteria for and were awaiting investigation. Three of these had been entered two or more months prior to the inspection.
- The hospital reported an average of 11.5 clinical incidents per 100 bed days between October 2015 and September 2016, which was higher, compared to the national average of five. The number of clinical incidents had been falling at BMI St Edmunds over this period, reducing from 19.6 per 100 bed days between October and December 2015, to 11.5 per 100 bed days between July 2016 and September 2016. However, this could have been due to a good reporting culture.
- The hospital reported 39 non-clinical incidents between October 2015 and September 2016. None of these incidents occurred within theatres or the inpatient ward. The rate of non-clinical incidents was slightly higher than the national average and had shown a trend of increasing, from 2.9 per 100 bed days between October 2015 and December 2015 to 3.5 per 100 bed days between July 2016 and September 2016. Again, this could have been due to a good reporting culture.
- We found nursing staff had a good understanding of how to report incidents, and provided appropriate examples of when this might be done. However, one resident medical officer (doctor) did not know how to report an incident, as they had not had to do so during their time at the hospital.
- We considered a random selection of seven incidents, one of which was serious. We found that all had been graded appropriately and investigated thoroughly. Where it was found lessons could be learnt from an incident we saw this discussed at governance meetings, departmental meetings, the medical advisory committee meeting and the daily 'comms cell' meeting. This included the serious incident and learning following its investigation.
- We found evidence of learning from incidents. Staff told us that following incidents, managers would provide feedback on a one-to-one basis and the whole team at team meetings. The theatre manager gave an example of a recent incident where an incorrect medicine had

been administered during surgery. Staff sought advice from a specialist, recorded this as an incident on the internal electronic reporting system, and feedback was due to be given to the team at the next team meeting.
- There was evidence of learning from corporate incidents. Any that had been rated red, on a red, amber and green rating, were shared from BMI's head office so that any learning could be shared throughout the group. We saw evidence of these being discussed at governance meetings.
- Staff understood the principles of the duty of candour regulation. 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' andprovide reasonable support to that person.
- The theatre manager gave an appropriate example of the use of duty of candour by a surgeon.

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

- The NHS Safety Thermometer measures six areas of clinical care, including the rates of catheter acquired urinary tract infection (CAUTI), falls with harm, harm free care and venous thromboembolisms (VTE). The hospital participated in the NHS Safety Thermometer, submitting the required data for NHS patients.
- BMI St Edmunds scored better than the national average in all areas of care measured by the NHS Safety Thermometer. Between October 2015 and September 2016, the hospital recorded no new pressure ulcers, no falls, no falls with harm, and no new VTEs. During the same period, 100% of patients had received a VTE risk assessment and appropriate VTE prophylactic (preventative) measures, and all patients received harm free care, according to the Safety Thermometer parameters.
- The hospital used a clinical dashboard to monitor the safety and quality of care for all patients. The dashboard measured multiple areas including surgical site infection (SSI) rates, unplanned readmissions to theatre, mortality rates, falls rates, complaints, serious incidents and never events.
- We reviewed dashboard data between October 2015 and September 2016 and found good results across all areas. For example, the hospital reported no surgical site infections, MRSA or clostridium difficile, scored 98% or above from patient feedback about the quality of care delivered and had recorded no serious incidents or never events.

Cleanliness, infection control and hygiene

- All clinical areas appeared to be clean. In addition, all corridors, bedrooms, treatment rooms and dirty utility areas were visibly clean and tidy.
- The hospital worked to multiple infection control policies and procedures, including hand hygiene policy, patient isolation policy, waste management policy and infection prevention and control in the theatre department policy. We reviewed the hand hygiene and standard infection control precautions policies and found they referenced national best practice and guidance. Staff were aware of these policies and where to find them on the hospital's intranet.
- We found infection control arrangements in place to ensure the environment, including treatment areas with carpeted flooring, kept people safe. For example, following a body fluid spillage on a carpeted floor, staff 'closed' that area until a deep clean could be undertaken.
- We observed staff complying with current best practice national guidance in relation to hand hygiene. We saw staff utilising hand sanitising gel after patient contact and washing their hands when appropriate (for example after touching a patient). This was in line with the World Health Organisation Five Moments of Hand Hygiene.
- Departmental hand hygiene audits had been undertaken monthly and we found the audits we considered, which took place between January 2016 and October 2016, showed a high level of compliance with good hand hygiene practice.
- We observed all staff complying with best practice in relation to having arms 'bare below the elbows'. This helps reduce the risk of cross contamination when staff move between patients.
- The hospital issued nursing, therapy and support staff with uniforms, which could be laundered at high temperatures. We observed all staff complying with BMI uniform guidance, and all uniforms seen, appeared visibly clean.
- All staff, including surgeons, wore recognised theatre attire within theatres. The hospital had a contract with an external company to launder all theatre attire and this was done daily.

- The hospital had recorded no surgical site infections in 2016. However, we found poor performance in relation to good infection control standards for the insertion of peripheral lines between October 2016 and May 2017. Between October 2016 and May 2017, the hospital scored an average of 55% for compliance with infection control precautions when inserting peripheral lines. This was worse than the preceding 12 months, as between October 2015 and September 2016; the hospital scored an average of 70% for compliance with infection control precautions. Senior theatre staff had implemented monthly actions to address this, which focussed on re-educating anaesthetists and discussing at the medical advisory committee. However, we found these to be ineffective as compliance continued to decrease.
- The hospital followed current Department of Health guidance Who to Screen for MRSA August 2014 on the taking of MRSA swabs prior to admission. The hospital had reported no MRSA, clostridium difficile or MSSA between January 2016 and February 2017.
- BMI Healthcare undertook decontamination of surgical instruments at its facility in Kent. The hospital previously decontaminated endoscopes on site; however, since December 2016 these were also sent to the facility in Kent to be cleaned and re-sterilised.
- Staff undertook deep cleans of theatres monthly, and where required between scheduled deep cleans, to ensure safety and reduce the risk of cross infection and contamination.
- We inspected the endoscopy department, where we saw that some remodelling was required if the hospital wanted to attain a national accreditation. However, it did have an acceptable clean/dirty workflow, despite the compromises posed by the environment.
- Endoscopes were sent off site to a BMI decontamination hub for cleaning. They were transported in a bespoke trolley and vacuum sealed when decontaminated, until they were ready to use.

Environment and equipment

- We found the ward environment to be suitable for the level and type of care delivered. Each patient had an individual room with ensuite bathroom and toilet facilities.
- We checked five pieces of equipment on the ward and found all to be within their required service dates. Theatre staff kept a detailed log of all equipment, with service dates.
- In the operating theatre, we saw lists that evidenced that anaesthetic equipment was checked before each list to ensure it was safe.
- The onsite engineering team had a comprehensive record of all equipment across the hospital, with current service history, and when the next service was needed. In addition, all pieces of equipment had a laminated tag attached to it, which showed when it had been purchased and when the next service was required. This initiative was being 'rolled out' to all BMI hospitals.
- The ward had a resuscitation trolley, which staff checked daily to ensure equipment stored outside of sealed drawers was correct, and all internal equipment on a weekly basis. We reviewed records between October 2016 and February 2017 and found staff had completed this every day.
- Theatres had a resuscitation trolley and a separate difficult intubation trolley. We reviewed records and found the daily and weekly checks completed as required.
- We checked medication fridges on the ward and medication and blood fridges within theatres. We found staff checked temperatures routinely and recorded these. Staff would report any temperatures outside the permitted rages to a pharmacist for advice. There were two units of O blood, should it be required, for urgent transfusion.
- We found all theatre areas and the majority of patient bedrooms to have suitable hard flooring. This complied with the Department of Health, Health Building Note 00:10, which independent providers of healthcare must take account of when planning services. All non-clinical areas (corridors and offices) had carpets within them.
- The hospital had an upgrade programme ongoing at the time of the inspection to replace all carpeted floors in clinical areas.
- During the period February 2016 to June 2016, BMI St Edmunds achieved a site score of 85% in the PLACE assessment for condition, appearance and maintenance of the environment. This was below the England average of 93%.
- Staff used sharps bins appropriately for the safe disposal of waste. All sharps bins were visibly clean and correctly assembled, within safe fill limits, signed and dated.
- There were arrangements in place for managing waste and clinical specimens. This included the use of

colour-coded bags to dispose of clinical and infected waste. There was a contract in place with an external supplier to dispose of clinical waste, which was stored securely until collected.

Medicines

- There were arrangements in place for managing medicines. This included obtaining, prescribing, recording, handling, storage and security, dispensing, safe administration and disposal.
- The hospital purchased pharmacy services from a local trust. There was an up to date policy how medicines should be delivered to each department, reconciled and stored safely.
- We found medicines management within the ward to follow best practice guidance. All medication rooms, trolleys and fridges were secure and access restricted, by either a coded keypad or traditional key system.
- There was a small amount of take home medicines available in the ward. These consisted of antibiotics and analgesia. These were dispensed by the RMO.
- The hospital used the local Trust's antimicrobial policy in order that there was consistency with antibiotic prescribing.
- We checked controlled drugs on the ward and found these matched the register. Two registered nurses checked controlled drugs each night and staff had consistently done this throughout December 2016 and January, February and up to 15 March 2017.
- Within theatres, we found fluid and blood fridges to be secure. However, senior theatre staff told us anaesthetists often prepared by drawing up controlled drugs ahead of the patient's arrival in theatre, and then left these unattended in anaesthetic rooms. This is not considered to be best practice, as these medicines should always be locked in a controlled environment. However, we did not observe this happening during the inspection.
- We reviewed medicine management audit results from February, May and August 2016, and found a 96% and 97% compliance in February and May 2016. However, in August, staff compliance with medicine management had dropped to 42%. There was no action plan in place to effect improvements.

Records

- Individual care records were written and managed to ensure that they were accurate, complete, legible, up to date and stored securely.
- We reviewed 19 medical records of patients who had been treated between January and March 2017. We found documentation from all staff was completed thoroughly, with risk assessments, treatment plans and medication charts completed as required.
- Of the 19 records looked at, 12 were for patients who had undergone a procedure and one for a patient who had surgery planned. Of those 12, all had completed consent forms, with copies stored in the records, completed risk assessments as required and completed medication charts, which had all been reviewed by a pharmacist. All nine sets of notes for theatre contained a completed World Health Organisation (WHO), five steps to safer surgery checklist.
- We found staff had completed a pre-operative checklist for all 12 patients that underwent a procedure. However, we found two of the 12 patients had no operation or procedure notes within their medical records. This meant ward and therapy staff did not know exactly what procedures had been undertaken.
- The hospital provided results of a health record audit from October 2016, which looked at 15 sets of records of patients that had attended theatre. The audit showed compliance against all outcomes, including (but not limited to) early warning score documentation, pain scores, falls risk assessment and WHO checklist completion. However, one record out of the nine did not have the 'time out' or 'sign out' sections completed within the WHO records.
- We found facilities for staff to dispose of confidential waste (such as handover sheets and appointment letters) in each clinical area. We observed staff disposing of confidential waste appropriately throughout the inspection.

Safeguarding

- There were arrangements in place to safeguard adults and children from abuse which reflected relevant legislation and local requirements, and staff understood their responsibilities and adhered to safeguarding policies and procedures. All staff underwent training in safeguarding adults and safeguarding children level one, with clinical staff undertaking safeguarding children level two. An average of 98.9% of ward staff had

completed their safeguarding training as of 27 March 2017. Within theatres, an average of 91.6% of staff had completed their required level of children and adult safeguarding training. This was against a target of 90%.
- Staff understood their responsibilities and adhered to safeguarding policies and procedures. The ward manager was the designated safeguarding lead nurse for the hospital and had undertaken adult safeguarding level three training. All staff asked knew who the safeguarding lead was and how to escalate concerns, with one resident medical officer (doctor) stating they would inform the ward manager if they had a concern.
- The safeguarding adult policy contained information on female genital mutilation and domestic violence.

Mandatory training

- Staff were trained in the hospital's safety systems, processes and practices.
- All staff, including temporary workers (bank), commencing employment at the hospital had completed mandatory training in line with hospital policy. This included, but was not limited to, information governance, conflict resolution, dementia awareness and manual handling.
- Staff undertook yearly mandatory training updates, in line with BMI and the hospital's mandatory training policy. Data supplied by the hospital stated that, on average, 90.8% of ward staff had up to date mandatory training as of 27 March 2017. Within theatres, 83.8% of staff were compliant with their mandatory training. This was against a hospital target of 90%.

Assessing and responding to patient risk (theatres, ward care and post-operative care)

- Comprehensive risk assessments were carried out for people who used services and risk management plans were developed in line with national guidance. Staff were able to identify and respond appropriately to changing risks to patients, including deteriorating health and well-being and medical emergencies.
- The hospital used a national early warning score (NEWS) to assess and monitor patients pre and post operatively. This allowed staff to monitor patient's blood pressure, pulse, respiratory rate and temperature, amongst other vital signs, to recognise and intervene where a patient was deteriorating.
- The hospital had a sepsis screening tool in use for when patients had a NEWS score above four. The tool was in line with current best practice principles from The UK Sepsis Trust. The hospital provided evidence of training provided to staff in relation to sepsis. The hospital told us that 75% of staff had undertaken sepsis training as part of acute illness management (AIM) training.
- All patients due for admission were pre-assessed. In addition, the week prior to admission, all records for those due for admission were checked to ensure essential equipment had been ordered.
- We found no formalised or specific risk assessment process for patients undergoing elective cosmetic procedures. Senior staff told us staff use the 'generic surgical pathway' booklet for all surgical patients. This included generic assessments of health and wellbeing and covered areas such as medication and pain control. However, this did not formally assess the patient's psychological health and the implications of cosmetic surgery on the patient's wellbeing post-surgery.
- We reviewed 19 records and found NEWS scores completed in all cases. Staff reviewed patients in accordance with the escalation policy where vital signs fell outside the expected parameters.
- All registered nurses and operating department practitioners within theatres received intermediate life support training. All other clinical staff received basic life support training.
- Staff had access to an internal emergency number in the event of a cardiac arrest and all staff asked knew this number and how to summon help in an emergency. We found an established system in place should a patient require transfer to a critical care environment in an emergency.
- We observed theatre staff using the World Health Organisation Five Steps to Safer Surgery guidance, which is a structured approach to ensure the safety of patient before, during and after their operation.
- The hospital had immediate access to blood products, if required to stabilise patients with life threatening haemorrhage prior to transfer to a local emergency department.
- Staff had the ability and there was equipment available, to stabilise patients with compromised airways following surgery within recovery or operating theatre, prior to transfer to an intensive care facility.
- The hospital had a service level agreement with the local NHS trust to transfer any patients that deteriorated

unexpectedly, for example post-surgery. The RMO, theatre and ward managers were aware of the process to refer patients to an emergency department or intensive care unit.

- The hospital had an onsite resident medical officer (RMO), who was available 24 hours a day to review patients. Physicians, surgeons and anaesthetists were available by phone and in person when they had a patient in the hospital for advice or to review a patient that had deteriorated. Theatre staff told us a full list of personal numbers was held on the ward and that there was a quick response made when needed.
- Patient safety alerts from the National Patient Safety Alert (NPSA) were circulated for local action. New safety alerts were also discussed during departmental meetings and at governance and MAC committee. In addition, they were displayed on the staff notice board, which was situated in an open corridor where the 'comms cell' took place, by the staff dining room.

Nursing and support staffing

- Staffing levels were appropriate according to activity and patient dependency and acuity. The ward manager used an acuity tool, called the labour tool, to assess and review nurse staffing. Any shortages in staffing were discussed at the daily 'comms cell,' which was attended by a representative from all hospital departments.
- At the time of inspection, the ward had three registered nurse vacancies; however, one of these had recently been appointed to, but the staff member had not commenced employment. One staff member told us that the ward relied heavily on agency staff particularly overnight and at weekends when the hospital remained open for patients who had not been fit for discharge.
- The inpatient ward employed 8.2 whole time equivalent (WTE) registered nurses and 3.6WTE healthcare assistants (HCA) at the time of inspection, with a ratio of 2.3 registered nurses to one HCA. The ward used a high proportion of agency and bank staff to fill registered nurse shifts, and this had been on an upward trend between October 2015 and September 2016, rising from 12% use in October 2015 to 36% in September 2016. This was higher than the national average of 15%-20%, in the same period, for similar independent hospitals. However, the difficulty recruiting suitable staff was listed as a weakness in the hospital business plan and was recorded on the risk register.
- The ward had a low use of HCA bank and agency staff, with an average use of 1.5% between October 2015 and September 2016. This was below the national average for similar independent hospitals.
- Within theatres, staff used the Association of Perioperative Practice (AFPP) guidance to establish staffing requirements.
- Theatre's use of bank and agency HCA and registered staff was below the national average for similar types of independent hospitals between October 2015 and September 2016. The average registered nurse bank and agency use was 15.3% over the period, and HCA bank and agency use was 6.5%.
- Within theatres, planned staffing consisted of one or two scrub nurses, one 'runner', an operating department assistant and a recovery nurse.
- Theatres utilised bank staff to fill any outstanding shifts, and was in the process of building a bank of staff (from across BMI and externally) to fill empty shifts.
- Staff undertook handover between each shift (day shift to night shift, and vice versa), which included an update on all patients currently admitted and highlighted any specific concerns (such as infection risks or safeguarding concerns) to all staff.

Medical staffing

- Patient care and surgery was consultant led. The hospital had a database of consultants, which included anaesthetists, who had been granted practising privileges, in line with BMI's practising privileges policy. Compliance with this policy was monitored centrally as well as locally. This included the status of each consultant concerning their indemnity, appraisal, General Medical Council registration and Disclosure and a Barring Service (DBS) check. DBS assists employers make safer recruitment decisions and prevents unsuitable or unqualified people from working with vulnerable groups, including children. However, not all checks had been completed for all consultants. There was work underway to remedy this, which is described in the well led section of this report.
- There was a resident medical officer (RMO), in the hospital 24 hours a day, who supported the surgical service and wider hospital. The RMOs worked set shift patterns of one week on duty, followed by a minimum of one week off.

Requires improvement

Surgery

- RMOs had a designated room in which to sleep overnight; however, nursing staff would wake the RMO should a patient deteriorate.
- Handovers between RMOs took place on a weekly basis. Nursing staff supported the RMO in planning the handover to ensure all relevant patient information was shared between the two doctors. This took place in a private room to maintain confidentiality of patient information.
- One RMO told us that the handover process worked well, and the nursing staff were supportive of the RMOs during these times. The provider of RMOs, worked closely with its clients to maintain safe working rotations and arranged appropriate holiday cover.
- Individual consultants remained responsible for the overall care of their admitted patients. The RMO and nurses told us that consultants could easily be contacted 'out of hours' (such as at night or over a weekend) should staff be concerned with a patient's condition. The practising privileges agreement stated that consultants should be available to be in the hospital to respond to any concerns within 30 minutes.

Emergency awareness and training

- There were arrangements in place to respond to emergencies and major incidents.
- The hospital had a robust major incident policy in place, which senior staff reviewed routinely and we saw evidence of updates and version control of the document. The major incident policy contained 'flash cards' that informed staff of what action to take in a variety of situations. For example, the policy contained 'flash cards' for loss of drainage and sewage systems, loss of medical gas supply and passenger lift failure. Each 'flash card' contained the actions that staff should take and useful contacts, such as the company responsible for servicing the equipment (such as the lift) and local and national companies (such as electricity suppliers).
- We spoke with the hospital's engineering team during the inspection. The hospital had embedded procedures for dealing with emergencies.
- The hospital had established processes in the event of a fire. The hospital had fire extinguishers present in each area, and staff we asked knew their role in the event of a fire.
- The engineering team conducted fire alarm tests weekly and full evacuation tests a couple of times a year. Staff undertook fire training as part of their mandatory training on a yearly basis.
- The hospital had 'backup' generators in the event of the hospital losing electrical power. Critical pieces of equipment ran from separate electrical power supplies to ensure continuous power. These included all plug sockets and electrical equipment within operating theatres. This ensured patients remained safe whilst undergoing operations should a power failure occur.
- The engineering team tested the backup power generators weekly and changed the hospital over onto full emergency power several times a year to ensure the system's resilience in the event of an electrical incident.

Are surgery services effective?

Requires improvement

We rated effective as requires improvement.

Evidence-based care and treatment

- Relevant and current evidence-based guidance, standards, best practice and legislation identified were used to develop how services, care and treatment were delivered.
- Hospital and BMI policies were version controlled. This evidenced the hospital reviewed and updated policies as required. We noted that policies contained a table to highlight what additions had been made to the policy and when. For example, the hand hygiene policy had been updated in February 2016 when new national guidelines from the Department of Health had been issued. Most policies and procedures were well referenced to national guidance and requirements.
- All policies were on the hospital's electronic system. We asked to review specific policies and staff were able to locate these easily within the intranet.
- The National Institute of Health and Care Excellence (NICE) guidelines were reviewed centrally by BMI and were cascaded to the individual hospitals and shared with staff. Policies based on best practice and clinical guidelines were developed nationally and cascaded to the hospitals for implementation.

- Patients had their needs assessed, their care goals identified and their care planned and delivered in line with evidence-based, guidance, standards and best practice.
- Staff completed corporately set audits on a monthly basis, according to the BMI audit calendar on the ward, including medical records, consent, venous thromboembolism, the World Health Organisation safer surgery checklists, (in theatres).
- Hospital specific audits included the Edmonton (or frailty) tool for all patients over the age of 75 years, pregnancy testing for all females undergoing gynaecological surgery who were of childbearing age, high intervention audits such as surgical site, cannula and catheter infections, group and save audits (blood transfusion) and second stage consent audits.
- We found compliance with audits across all surgical areas. The World Health Organisation safer surgery checklist audit showed an average compliance of 98.4% between January and October 2016. The theatre audit (which looked at compliance across multiple areas within theatres) showed an average compliance of 96.5% between January and October 2016.
- Critical care protocols were clearly displayed in recovery for staff to refer to as required, if a patient became unwell. We found these supported by the BMI critical care policy, which were well referenced to current best practice guidance, for example from the Critical Care Society Standards and Guidelines, Guidelines for the Provision of Critical Care Services (GPICS) 2015 and Guidelines for the Provision of Anaesthetic Services (GPAS) 2015.

Pain relief

- Staff assessed patient's pain and documented this within their medical records. An internal audit of nine health records from October 2016 showed that staff had recorded patient's pain each time they documented the patient vital signs (blood pressure, temperature and respiratory rate). We saw that regular pain relief was given according to the patient's individual treatment plan.
- All patients spoken with were satisfied with how their consultant and the nursing staff had managed their pain and all reported being pain free when we spoke with them.
- Pain audits took place yearly, according to the BMI audit calendar. The latest audit had taken place in August 2016 and was 72% compliant against a BMI target of 100%. We requested an action plan for improvement from the hospital; however, the hospital did not submit this. The hospital did submit a further pain audit, undertaken in February, which showed an improvement; however, we were unable to verify the year in which this audit took place.
- The hospital did not have a dedicated pain team or nurse specialist. However, there were pain management consultants who had practising privileges in the hospital, whom patients could be referred to.
- We requested information from the hospital on how they managed patients with nausea or vomiting following surgery. However, the hospital provided information on how they monitor and record the degree of nausea and vomiting, but did not state how this was managed and treated. We were not assured that the hospital had a robust nausea and vomiting management plan in place.

Nutrition and hydration

- Patients' nutrition and hydration needs were assessed and met. Staff completed a malnutrition universal screening tool (MUST) assessment for each patient to ensure those patients at greatest risk were highlighted.
- The hospital had a fasting before anaesthesia policy in place, that was implemented in November 2016 and due for review in June 2019. The policy set out specific details of fasting times and what patients could consume. However, the policy lacked clinical references, for example, it did not reference the Royal College of Anaesthetists Guidelines for the Provision of Anaesthesia Service 2016 or 2017 (GPAS) or the Royal College of Nursing Perioperative Fasting in Adults and Children 2005.
- There were no audits in place to ascertain compliance with best practice with regards to preoperative starving. Therefore the hospital had no evidence to demonstrate that patients were not starved for unnecessarily long periods of time.
- The hospital's February 2016 to June 2016 patient-led assessments of the care environment (PLACE) scores were better than the England average for food (94%), ward food (93%).
- A dietician had practising privileges at the hospital and was available on request.

Patient outcomes

- The hospital submitted data to a variety of national audit programmes, including the patient reported outcomes measures (PROMS) and the national joint registry (NJR). The hospital director was unaware of the Private Hospitals' Information Network (PHIN) when we asked them; however, later confirmed that the hospital was contributing to this database, which, once there is enough information, will compare different hospital's outcomes. Minutes of the MAC meeting evidenced that this was discussed by the Executive Director
- The latest PROMS data, published by NHS Digital in November 2016, shows that BMI St Edmunds patients had, overall an average health gain following knee and hip surgery, compared to the national average.
- The Oxford score, which asked condition specific questions, and the EQ-5D score, which asked about patient's general health, both scored worse than the national average for primary hip and knee surgery. However, the EQVAS score, which looked at different aspects of patient's general health, scored the same as the national average for primary hip and knee operations.
- BMI St Edmunds did not perform enough hernia operations to be included in the hernia PROMS data.
- The latest National Joint Registry annual report, published December 2015, showed that BMI St Edmunds performed at or above the national average in all areas measured. This included a consent form for each patient (achieving 99% out of 207 patients) and the ability to link patient records by including an NHS Number (achieved in 97% of cases).
- Surgical services had 10 cases of unplanned transfer of an inpatient to another hospital for care between October 2015 and September 2016. This was higher than the national average (around 0.4 per 100 attendances), with an average of 1.4 patients per 100 inpatient attendances having an unplanned transfer of their care. However, when we looked at the reasons for transfers, there were no trends and the patients had been transferred appropriately, at the right time, to ensure their ongoing care was carried out safely.
- The service reported three unplanned returns to theatre between October 2015 and September 2016. The hospital reported two unplanned readmission within 28 days of discharge between October 2015 and September 2016. This was below the national average.

Competent staff

- Staff had the right qualifications, skills, knowledge and experience to do their job. Training records for the end of March 2017 showed that the hospital exceeded BMI targets for training. However, 66% of theatre staff and 77% of ward staff had completed an intermediate life support (ILS). The only member of staff who had advanced life support training was the RMO, although whilst the operating theatre was working, many of the anaesthetists had this qualification.
- An external agency was used to recruit RMOs. The agency was responsible for their training. The RMO we spoke with was trained in ALS, European paediatric advanced life support (EPALS) and advanced trauma life support (ATLS). All RMOs who worked at the hospital were trained in ALS.
- The hospital provided an induction programme for new staff. We saw the induction training programme. We spoke with a new member of staff who told us that the hospital and local induction was relevant and useful.
- Staff were encouraged and given opportunities to develop. However, in theatre this was not organised in a way to support the service's needs and there was no strategy in place to manage this.
- Workshops had been held for nurses undergoing revalidation with their professional regulator. We were given examples of extra support put in place for newly qualified staff, to ensure that they felt comfortable and confident in undertaking their duties.
- Consultants worked on a practising privileges basis and all consultants were required to evidence current or recent work within the NHS.
- The MAC routinely reviewed the practising privileges of consultants and the executive director could suspend or revoke these privileges based on risk, outcomes and patient feedback. We saw evidence of such discussions in MAC minutes supplied by the hospital. However, as described under Governance and risk management section below, compliance with the hospital's practising privileges policy was low. This included inclusion of consultants' scope of practice. This meant that consultants were allowed to practise without having all their documentation in place. This was not in line with BMI practising privileges policy. An action plan had been put into place, but had not been fully implemented at the time of the inspection.
- Staff had a yearly appraisal, undertaken by the head of department (HoD) (ward manager or theatre manager). We found all ward staff had received an appraisal in the

year to the inspection. However, no theatre staff had an appraisal within the last year. The theatre manager was new in post (commenced December 2016) and had implemented an appraisal plan, which we saw during the inspection.

- One resident medical officer (RMO) was unaware that they had a designated mentor or supervisor whilst working at BMI St Edmunds. However, they were confident that all consultants would provide support where needed.
- The RMO told us they had undergone an appraisal within the last year.
- The HoDs monitored staff competence and kept written records of this. All ward staff had up to date competencies relevant to their roles. However, the theatre manager told us that they were currently updating the competency records of all staff, as these did not reflect staff current levels of competence and skill.
- The ward manager told us that they liaised with all agencies used to establish the competency needs of staff prior to them confirming shifts. The ward manager had assured themselves of their competence through agency staff completing four 'observed procedures' for each competency (such as cannulation) before they allowed them to do this independently. We saw a written induction checklist completed for agency staff.
- We found clinical and cleaning competencies in place for staff working within endoscopy. Staff had completed these competencies within the last twelve months and demonstrated a good understanding of their responsibilities.
- We requested information regarding clinical supervision for staff within theatres and on the ward. The hospital responded with confirmation of competencies undertaken by staff; however, did not provide any information in relation to structured clinical supervision for staff.

Multidisciplinary working

- Staff worked together to assess and plan ongoing care and treatment in a timely way. There was effective multidisciplinary team (MDT) working across the hospital, including from surgeons, theatre and ward staff and therapy staff, such as physiotherapists and radiologists.
- There was a daily 'comms cell' meeting, attended by a representative from each department. The comms cell whiteboard was updated at this time and could be seen by all staff entering and leaving the dining room, so that all could see the current status of the hospital. The meeting lasted 10 -15 minutes and covered activity, both patients and financial, any incidents, complaints, staff sickness any issues that may affect one or more departments. For example, a patient was being admitted who had been MRSA positive in the past. The infection control nurse took the opportunity to discuss that patient's particular needs with clinical staff after the meeting.
- The surgical service held weekly bed management meetings to review the patients attending for surgery in the coming week. A member of ward staff, theatres, therapy and administration staff attended the bed management meeting.
- Bed meetings reviewed patient test results, planned anticipated care (such as physiotherapy) and reviewed all admission administration had been completed, to reduce delays on admission. Staff we asked were positive about the bed management meetings and found them useful in planning forthcoming admissions.
- The hospital had a clear sepsis pathway, which included escalation from nursing staff to the RMO, and then to the consultant in charge of the patients care where required. Staff undertook sepsis training as part of an acute illness management (AIM) course.

Seven-day services

- The surgical service had capacity and capability to remain open seven days per week. Routine surgery occurred Monday to Friday, with only extra or urgent work happening at weekends.
- Senior staff planned surgical lists to ensure sufficient staff were available over night and at weekends where patients are expected to remain in hospital.
- There was an on call service for theatre staff.
- Staff and patients had access to pharmacy service Monday to Friday daytime, with an on call rota outside these hours. A radiographer provided a Monday to Friday service, with access to x-rays outside these hours in an emergency.

Access to information

- Relevant information was available to enable staff to make effective decisions about patients' care.
- Consultants had access to paper records for all patients. Consultants accessed x-rays and pathology test results

electronically. Professionals referred patients to the hospital through an electronic system, which staff used to triage and accept referrals. The system allowed staff to review and book next day appointments for patients whose referrals had been accepted.

- One staff nurse told us they found a delay in receiving NHS records for referred patients. The hospital told us that they were aware of this and an action plan was in place at the time of inspection to address the concerns. We did not ask for, or see this action plan.
- Arrangements for discharge were considered prior to elective surgery taking place. Discharge arrangements were discussed at pre-admission and confirmed following admission to ensure that any involvement from external organisations which were needed was finalised. We reviewed 15 patient records where a patient had been treated and discharged. Of those 15, six did not contain a discharge letter or summary, and no evidence of the hospital informing GPs of the patient's admission, treatment or discharge care.
- We reviewed 31 sets of medical records from outpatient clinics, and found 24 did not contain any outpatient records. This meant staff did not have any or all of the information required, where a patient had been seen in the clinic by a consultant.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- All staff received training in the Mental Capacity Act (MCA) 2005 and Deprivation of Liberty Safeguards 2010, which was included in the safeguarding adults training. At the time of inspection, 100% of ward staff and 85.7% of theatre staff had completed safeguarding adults training.
- The resident medical officer told us that they had received training from their agency and the hospital, and felt confident in the use of MCA.
- We found the consent process to comply with Department of Health best practice standards. The consultant responsible for the care of the patient took written consent either at pre-assessment (if face-to-face) or on admission to the ward. The surgeon reaffirmed this consent verbally in the anaesthetic room prior to surgery starting. Nursing staff confirmed to us that a patient would not be taken to the operating theatre without a valid consent being signed.
- Staff we spoke with were clear about the requirements of the MCA with regards to consent, but not as confident with Deprivation of Liberty Safeguards 2010. Those we spoke with said they would ask their manager or the director of clinical services.
- We observed nursing, therapy and medical staff gaining verbal consent before undertaking interventions, such as taking observations (for example blood pressure) or examinations.
- Where a patient was planned to undergo a cosmetic procedure, consultants observed the required two-week 'cooling off period' between the initial consultation and undergoing the procedure. This allowed patients the opportunity to consider the risks and benefits, and make an informed decision before agreeing to a cosmetic procedure.

Are surgery services caring?

Good

We rated caring as good.

Compassionate care

- We observed staff treated patients with compassion, kindness, dignity and respect throughout the inspection, for example, we observed they knocked on doors before entering and introduced themselves. The patients we spoke with were very positive about the care they had received.
- Patient Led Assessments of the Care Environment (PLACE) assessments are completed in hospitals providing NHS care. Patients were asked how the environment supports clinical care including dignity and respect. BMI St Edmunds achieved 88% site score for dignity and respect in the PLACE assessment during the period February 2016 to June 2016, which is above the national average of 83%.
- Patients told us they felt safe and valued by the frequent checks by care staff. Patients told us staff responded quickly when they used the call bells and always checked if they were comfortable or in pain. One patient told us "If I needed someone, I pressed the bell and they came".
- We observed reception staff greet patients and visitors in a friendly manner. Staff dealt with enquiries promptly and efficiently; patients and visitors were put at ease.

- The hospital was compliant with the government's requirement to eliminate mixed-sex accommodation. Patients were admitted to single rooms and shared facilities were only used when clinically necessary such as in the theatre recovery room. A member of staff was present on these occasions.
- We observed positive interactions between nurses, allied health professionals and patients. One patient told us that, from her first meeting with the consultant through to her treatment and post-operative care, all staff were accommodating and that they valued the time staff spent ensuring they were comfortable.
- Self-funding patients were given information about the cost of their operation prior to admission and in a sensitive way. Fixed priced packages were available that included pre-assessment, the procedure and aftercare costs. There was written information for patients to support this.
- We reviewed 39 patient feedback comment cards all contained positive comments regarding the provision of care. The comments included; 'all very caring and pleasant – I was treated with dignity and respect at all times', 'my needs were responded to with the right care and treatment at the right time', 'we were well informed before surgery and all questions answered', and 'I cannot fault the care and attention from the medical and non-medical staff'.
- However, one relative commented that 'although staff were generally caring, the room was cold, the heating was off, and the blankets were very thin'.
- The NHS 'Friends and Family Test' (FFT) is a survey measuring patient's satisfaction with the care they have received and asks if they would recommend the service to their friends and family. The scores related only to those patients seen and treated on behalf of the NHS. In the reporting period January 2016 to January 2017, 99% of NHS patients referred to BMI St Edmunds for inpatient care or treatment said they would recommend or highly recommend the service to family and friends. These scores were similar to the England average although there was an above average response rate to the survey.
- The BMI Health group used its own patient satisfaction survey where the results were compared against other BMI hospitals. All patients were actively encouraged to complete a feedback questionnaire that reflected on all aspects of their patient journey through the hospital and we saw feedback forms available in reception areas.
- The results were published on a monthly score report which could be broken down into patient group, speciality and department. The patient satisfaction dashboard was displayed on noticeboards and the results shared in monthly quality health meetings where staff representatives were present from each team. Actions were shared with staff, this demonstrated the reported patient experience of care and performance was transparent and available to all.
- We noted that the quality of care was rated as good, very good and excellent by 98% of self-funding and NHS inpatients who completed the survey during January 2017.

Understanding and involvement of patients and those close to them

- Staff communicated with patients and families in ways they could understand and patients felt they had been encouraged to make their own decisions. One patient told us she had a hearing difficulty and staff always checked she could understand what they had said.
- Patients told us they were satisfied with the written and verbal information provided about their care and treatment both at pre-assessment and on the day of surgery. Five patients we spoke with said they were happy with information received. One carer explained he was included in pre-operative discussions at the patient's request and was aware of the risks and discharge plan.
- Staff told us links were made with relatives and carers where appropriate and additional advice and support was made available to meet specific needs throughout a patient's care and treatment. One patient and her carer told us she was referred to a community occupational therapist that assessed and provided a raised toilet seat and walking frame to support her recovery at home.
- Staff assigned each patient a named nurse on admission who managed the admission process. The named nurse orientated patients in their room and provided an information pack. Patients and relatives were able to ask the named nurse questions and they kept them informed of what was happening.
- Staff shared discharge plans and information with the patient's relative or those close to them with their permission.
- The patient satisfaction feedback was analysed monthly and included questions related to how engaged the

patient felt with their treatment regime and pain management. Results were shared in monthly quality health report meetings and actions taken to make improvements if required.
- The patient satisfaction dashboard reported in January 2017, that 97% of inpatients were satisfied that the discharge pack contained all information required and 95% were satisfied with the instructions of their aftercare.

Emotional support

- Staff throughout the department understood the need for emotional support. Pre-admission assessments included consideration of a patient's emotional well-being. Staff told us there was signposting to local advisory groups to offer both practical advice and emotional support to both patients and carers.
- Staff demonstrated a good understanding of the emotional impact surgical treatment could have on patients' well-being. A member of nursing staff told us she spent longer with patients to support them and talk with family or carers with the patient's permission.
- We saw staff were passionate about working within the service and providing good quality care for patients. They demonstrated a good understanding of individual needs of patients and with ensuring the emotional impact of surgical treatment was minimised.
- All staff showed patience and understanding when interacting with patients. We saw and patients told us staff provided timely support and information to patients to cope emotionally with their care and treatment.
- There was a list of chaplains for staff to contact to meet patient's different spiritual needs when required.

Are surgery services responsive?

Good

We rated responsive as good.

Service planning and delivery to meet the needs of local people

- The service understood the different needs of the people it served and acted on these to plan, design and deliver services.
- The hospital worked in partnership with the NHS to respond to pressures within the local healthcare community. They gave the example of working with the local NHS trust to relieve some of the waiting list issues.
- The hospital used care pathways for surgical patients. These pathways promoted organised and efficient patient care based on evidence based practice. In addition, they provided flexibility to enable patients the option to stay an additional night according to need. One patient told us she stayed an additional night as she felt unwell and that it was 'totally her choice'. The hospital provided a flexible approach to older, self-funding patients who may not feel safe to return home after two nights. The hospital would, on a case by case basis, review the needs of older patients and consider offering a third night at no additional charge to the patient.
- The system to book in or day patient stays, was easy to use and supported patients to access dates and times that met their needs. Where possible, patients could select times and dates to suit their family and work commitments.
- Staff told us there was a flexible approach to working during busy times. BMI St Edmunds was periodically closed at weekends depending on activity levels. However, staff responded to patients' needs and the hospital was operational seven days a week when a patient required extended inpatient care.

Access and flow

- The hospital offered a patient centred, flexible service that included variable appointment times and choices regarding when patients would like their surgery, subject to consultant availability. Staff told us patients could request times between Monday to Friday to meet work and personal commitments.
- Patients had timely access to assessment, diagnosis and treatment; the hospital had no waiting lists for surgery for private patients. A cooling off period between booking and surgery allowed patients to cancel or postpone their surgery, should they wish.
- Operating theatre lists for elective surgery were planned with the operating theatre manager and bookings team and enabled effective use of operating times. All aspects of care and practical arrangements were considered

before booking to ensure a patient's safety and needs were met. For example, checks were completed to consider availability of specific equipment or staff such as radiographers.

- The wait times for the electronic referral NHS patients were controlled by the NHS referral to treatment time management system. Between October 2015 and September 2016, the hospital admitted 97% of patients for treatment within eight weeks of referral (target 18 weeks).
- In the reporting period October 2015 to September 2016, the provider cancelled three procedures for non-clinical funding reasons. Two of the patients were offered another appointment within 28 days in line with government guidance.
- The patients we spoke with told us the hospital was quick to respond. One patient funded by the NHS told us the initial operation date was postponed due to a NHS funding delay. However, the patient told us staff kept her fully informed and staff offered a new appointment within 18 weeks and she was pleased with the service.
- The hospital had a nurse led pre-operative assessment clinic. Following initial assessment the clinical pre-admissions team confirmed if pre-operative assessment was required in person or by telephone. This meant patients were identified as being safe for surgery and unnecessary cancellations were avoided where possible.
- Staff began planning the patient's discharge during the pre-admission process where they assessed a patient's specific home circumstances and likely needs following discharge.
- Positive practice was seen regarding the hospital's "Joint School" pre-operative assessment appointments. Patients requiring hip or knee surgery were seen by a multi-disciplinary team including a physiotherapist, a radiographer and nurse during the same appointment time. This allowed the hospital to carry out a thorough pre-assessment and commence discharge planning.
- The "Joint School" supported the hospital's enhanced recovery care pathway to promote the likelihood of a patient's early recovery. We saw in the patients' notes that this multi-disciplinary planning commenced pre-operatively. One patient told us a physiotherapist within "Joint School" provided clear pre-operative advice including a programme of exercises.
- Staff told us a physiotherapist assessed all patients on the day of, or the day after surgery.
- The hospital introduced an additional pre- admission stage during September 2016, a bed management meeting, where patient notes were analysed the week prior to admission with both clinical and non-clinical leads to ensure a holistic approach with individual patients. Staff told us this ensured all pre-operative tests and checks were completed and funding secured, as necessary, to minimise the risk of postponements or cancellations.
- Senior staff discussed bed capacity at daily communication cell (comms cell) meetings and addressed any identified risks.
- Arrangements were in place for unplanned surgery, for example if surgery was required more urgently, there was a dedicated on-call theatre team for emergency returns to theatre.
- During the reporting period October 2015 to September 2016 there were three unplanned returns to the operating theatre, one in each quarter. During the same period, there were two unplanned readmissions within 28 days of discharge, which is below the average when compared to a group of independent acute hospitals.
- We spoke with staff who told us they liaised with social services and the patient's GP, if required, in support of a safe discharge plan. A letter was sent to patient's GP's on the day of discharge, outlining the treatment given and any ongoing care that was required and we saw copies of the letters kept in patients' notes. Patients received a follow up call 24 hours following discharge to check on their progress.
- Patients were given a contact number where they could access clinical advice from the hospital if required. All advice was recorded in a ward log to allow staff to identify when to escalate concerns. For example, a staff nurse told us that the resident medical officer (RMO) had responded to a patient concern and had recommended the patient visit the GP for a pain management review.

Meeting people's individual needs

- BMI St Edmunds was able to meet patient's individual needs. Health beliefs, concerns and preferences were addressed within the patient's pathway.
- We saw staff had access to a translation service; the contact number was displayed at the nurse station. Staff told us the service was used recently to support a Polish patient to understand their care and treatment.

- The hospital had disabled access to all facilities and on all levels. This included a lift to the ward area.
- The provider acknowledged and had a plan in place to enhance the patients experience if outpatients was located close to pre-assessment clinic. In mitigation, we saw staff were available to support patients to move between the two areas.
- The hospital recognised the increase in the number of patients living with dementia. They told us they were beginning to address ways of assisting them and their relatives. Staff told us a dementia friendly toilet seat to improve safety and preserve independence was available in response to the patient satisfaction survey. A patient room close to the nurses' reception was used to ensure enhanced monitoring was provided.
- All patients over 75 years were assessed by using NHS guidelines and through the Edmonton Frailty tool which assesses 10 domains including cognitive impairment and balance and mobility. Care pathways addressed the risks of a hospital stay and subsequent discharge in order that these patients' needs were recognised and could be mitigated.
- Main meals were prepared off site and steamed in the ward pantry. Patients told us they had a choice of food and that they could have sandwiches and hot drinks on a flexible basis to meet their needs. One patient told us on admission they had ordered their meal and could have had this at any time after surgery.
- During our visit, we observed the pantry area, which was visibly clean and tidy. We spoke with a member of the catering staff who told us patients' individual dietary needs were catered for and a flexible service, with regards to snacks and drinks was provided throughout the day.

Learning from complaints and concerns

- There were systems in place to listen to patients' concerns and take appropriate action if required. This included the patient satisfaction survey, the hospital website enquiry form, written complaints and verbal complaints, the NHS choices website and social media. We saw the BMI information leaflet, "Please Tell Us" available in reception areas. This provided guidance on how to raise concerns and described the complaints procedure.
- Each patient admitted to the ward had a patient information folder and there was a section on, "How to Raise a Complaint" meaning there was a system of openness and transparency.
- All complaints were uploaded onto the incident reporting system that enabled the hospital to track complaints, to ensure they were responded to in a timely manner, generate reports and identify trends.
- BMI St Edmunds used the BMI complaints policy. It had a three stage process for dealing with complaints; local resolution; regional organisational review; and an independent review by the Independent Sector Complaints Adjudication Service (ISCAS). NHS patients had the option of writing to the Parliamentary and Health Service Ombudsman.
- Staff confirmed they encouraged patients to raise their concerns immediately with a member of staff, or their managers in the first instance, where the issue could be addressed without accessing the formal complaints process. However, not all verbal complaints were recorded which meant that opportunities to identify trends or learning opportunities had been missed.
- Staff we spoke with were knowledgeable about the complaints procedure. Reception staff told us how they would try to resolve concerns and ask patients and relatives if they needed support to fill in any forms, if appropriate.
- We noted that the hospital took overall responsibility for the management of complaints. The executive director's assistant acknowledged all complaints within two working days of them being received and entered them onto the incident reporting system. The operations manager led and investigated non-clinical complaints and the director of clinical services or a clinical lead assisted with clinical complaints.
- We saw that all complaints, except those that were complex were responded to within 20 working days, the industry standard. Those that were not because of their complexity or if there was a delay obtaining vital information, would be re-acknowledged.
- We saw a sample of the final response letters; all were checked and signed by the executive director. All the letters had been answered comprehensively and were sympathetic to the patient's concerns. Where a relative had complained about their loved one's care, we saw consent had been obtained from the patient to allow the hospital to communicate with them.

Requires improvement

Surgery

- In the reporting period October 2015 to September 2016 the hospital received 43 complaints. The rate of complaints (per 100 inpatient and day case attendances) was higher at 1.5 than the rate of other independent acute hospitals; 0.5, where data is available.
- One complaint had been referred to the Independent Healthcare Sector Complaints Adjudication Service (IHSCAS) in the same reporting period. This had not been upheld by IHSCAS. The CQC received one complaint in the same period.
- Senior staff reviewed complaints at leadership, quality health and governance meetings, where themes and patterns were identified. Complaints were discussed and lessons learnt were disseminated to departmental meetings. In addition, lessons learnt were displayed on the staff notice board. They were also discussed daily at the comms cell, attended by a representative from each department and the hospital's senior management team.

Are surgery services well-led?

Requires improvement

We rated well-led as requires improvement.

Leadership and culture of service related to this core service

- There was an executive director (ED) in post who had split his time between St Edmunds and another BMI Hospital, which was about 45 miles away. However, it had been recognised that this had affected leadership within the hospital and there was a recruitment process underway to appoint a manager for the other site, during our inspection. In addition, the director of clinical services, the ED's nominated deputy post had been vacant for some time, but a new director of clinical services had commenced employment a week before our inspection. The theatre manager had been in post for only three months.
- A senior management team (SMT) managed the hospital strategically, comprising of a director of clinical services, an operations manager and the ED. The ED had been in post since 2009, with the operations manager in post since March 2016.
- Heads of department (HoDs), which included a theatre manager, new in post and ward manager, managed the service on a day-to-day basis. This included allocation of staff, sickness management and quality assurance. The clinical HoDs reported directly to the director of clinical services, non-clinical HoDs to the ED.
- Concerns were raised at the medical advisory committee (MAC), who were responsible for advising the senior management team about clinical practice at the hospital. Therefore, from May 2016, the ward manager had been invited to the MAC meetings to promote cross profession working. The new director of clinical services was an operating department practitioner.

Vision and strategy for this core service

- The hospital had an overarching vision and strategy, which was outlined in its hospital business plan. However, neither the ward nor theatres had formalised and individualised visions or strategies.
- Staff we spoke with were aware of the hospital's, and wider (BMI) organisation's, vision and values.
- The hospital used BMI Healthcare Limited's vision, which was, 'We aspire to deliver the highest quality outcomes, the best patient care and the most convenient choice for our patients and partners as the UK leader in independent healthcare'. BMI St Edmunds local vision was "by delivering a consistent level of high patient care and optimum clinical outcomes, we will be the local hospital of choice."
- The hospital told us they aimed to achieve the vision by ensuring that "we have robust systems and processes in place that centre around delivering quality care through effective clinical governance".

Governance, risk management and quality measurement (core service and provider)

- We found a mixed approach to governance at the hospital.
- The hospital and service had an established governance structure. Where staff identified risk locally, HoDs discussed these at monthly HoD meetings, and at clinical governance meetings.
- We reviewed clinical governance meeting minutes from April and May 2016. Neither the theatre manager nor deputy theatre manager attended either meeting. However, the ward manager attended both clinical governance meetings. The infection prevention and

control lead nurse for BMI St Edmunds did not attend either meeting. In April, eight of the 16 invited staff attended the clinical governance meeting, and in May, six of the 17 invited staff attended.

- Clinical governance meeting minutes followed a standard agenda with clearly documented items and actions. The April meeting discussed Joint Advisory Group (JAG) accreditation (for endoscopy) and how the hospital would meet the standards within the next 18 months. We saw this followed through in the May 2016 meeting with further discussion.
- We reviewed minutes of the medical advisory committee (MAC), which met quarterly, from January and May 2016 and found a good mix of specialities attending, including an anaesthetist. This ensured the MAC represented all clinical specialities and provided specialist advice on specific concerns.
- The MAC minutes contained some detail and information, with actions allocated to individual persons and were reviewed at each meeting. The MAC meeting had regular agenda items, including practising privileges, health and safety and a review of recent clinical governance meeting minutes. However, consultants continued to practise at the hospital without the required checks being completed. Although there was evidence of some discussion, there had been no robust action taken by the MAC in conjunction with the ED to remedy this shortfall.
- We reviewed minutes from the heads of department (HoD) meetings in September, October and November 2016. We noted that the ward manager attended all three meetings. The theatre manager had attended in September and October. A new theatre manager had commenced in December 2016, however, no senior member of staff from theatres attended the November HoD meeting.
- The HoD meeting minutes showed updates given from each department manager. For example, the ward manager updated all HoDs in September around the implementation of new audits following an information governance breach. In addition, the September 2016 minutes demonstrated the theatre manager updating on staffing and the appointment of a new theatre manager.
- The HoD meeting minutes had standard agenda items, including complaints, risk register updates and significant audit results, plus corporate items such as financial updates and business development opportunities.
- BMI St Edmunds had a hospital wide risk register, which contained 60 risks. Of the 60 risks, 10 related to 'patient safety, including cross contamination from carpeted areas, non-compliance with Department of Health, Health Building Note 00:10 and damage to the flooring within one of the operating theatres. Other risk categories identified included governance, operational, reputational, workforce health and safety and information management.
- The highest risk reported on the hospitals risk register concerned falling masonry from the building. The SMT had categorised a further 20 risks as 'amber' (with a risk rating of eight or more), 35 'yellow' risks (with a risk score of between four and seven) and the remaining four risks as 'green' (scoring three or lower).
- Each risk identified had existing actions and further actions required clearly documented, plus an identified team and individual responsible for maintaining the risk. The risk register also contained a clear updates' section; however, the register did not contain the next planned review date.
- Not all departmental managers had oversight of concerns and risks within the department. For example some managers did not know how many staff vacancies there were within their departments.
- The theatre manager acknowledged that compliance with competencies was mixed across the staff; however, they had not developed a strategy or training plan to change or improve the lack of compliance.
- All Consultants, nursing and other healthcare professional registrations were current during the period inspected. Of the 56% of nursing staff whom required revalidation during the selected period 100% were complaint.
- At the time of inspection, we found the hospital had registered to carry on the regulated activity of family planning. However, the hospital director (who was the CQC registered manager for all other regulated activities) had submitted incomplete documentation to add family planning to their registered manager registration. We noted from the minutes of the MAC meeting in May 2016 that this was discussed, and the minutes stated the hospital director should resubmit

with all relevant information. However, this had not happened. We raised this with the hospital director following the inspection, who took immediate action and submitted the correct documentation to ensure they met the requirements of Regulation 15 of the Care Quality Commission (Registration) Regulations 2009.

Public and staff engagement (local and service level if this is the main core service)

- Staff participated in a yearly staff survey, last undertaken in April 2016. The results showed the 10 most positive areas included staff feeling supported by their manager, finding their job interesting, fulfilling, and being clear on what is expected of them.
- The 10 areas with the least positive feedback included change management, feeling valued as an employee and recommending BMI as an employer.
- Staff sought through patient feedback through feedback cards and ad hoc verbal feedback at the time of treatment. The hospital did not undertake any patient forums or focus groups to gage feedback.

Innovation, improvement and sustainability (local and service level if this is the main core service)

- When considering developments to services, the impact on quality and sustainability was assessed and monitored. This was evident in the hospital's business plan for 2017.
- The senior staff were adamant that there had never been an occasion where financial pressures had compromised patient care.
- The hospital utilised an ambulatory care model for patients who had been assessed as able to have their surgery and be safe to be discharged on an outpatient basis.
- A similar project in the administration departments, Project Optimum, was underway in the administration departments to ensure the patient's experience was aligned across the BMI group's hospitals.
- This hospital had several projects underway for 2017. The theatre and ward labour resource planning was a BMI wide project support hospitals to achieve the delivery of their key performance indicator targets for both the ward and theatre workforce. Best practice was shared across the group to ensure that safe, quality and financially appropriate clinical labour was deployed in the ward and theatre.
- Many of the staff we spoke with had started working at the hospital in junior positions, and had worked their way up to management roles.

Requires improvement

Outpatients and diagnostic imaging

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

Are outpatients and diagnostic imaging services safe?

Requires improvement

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

We rated safe as requires improvement.

Incidents

- Outpatients and diagnostic imaging had reported no never events or serious incidents between October 2015 and September 2016. Never events are wholly preventable, where guidance or safety recommendations that provide strong systemic protective barriers are available at a national level, and should have been implemented by all healthcare providers.
- The hospital had reported 13 clinical and zero non-clinical incidents within outpatient and diagnostic imaging services between October 2015 and September 2016. The assessed rate of clinical incidents is similar to the rate of other independent acute providers.
- Staff followed an incident reporting policy. This was up to date and outlined how to report incidents on the hospital's electronic reporting system. Senior staff stated that all staff had training and access. Staff we spoke to were able to demonstrate this process and felt confident that reported incidents would be investigated.
- Staff told us they were updated with the outcomes of these incidents, in person, through departmental meetings or the outpatients' communication book. We confirmed this by reviewing meeting minutes, containing evidence of investigations and lessons learnt. They gave an example of a recent incident involving two patients with similar names, and the improvements made to patient notes following this.
- We reviewed a root cause analysis (RCA) from a recent incident. It was well structured and there was evidence of a full investigation, lessons learnt and shared.
- Hospitals are required to report any unnecessary exposure of radiation to patients under the Ionising Radiation (Medical Exposure) Regulations 2000 (IR(ME)R). Diagnostic imaging services had procedures to report incidents on the electronic system and to a radiation protection advisor (RPA). There had been one reported IR(ME)R incident, concerning duplicate images being taken, between January 2015 and December 2016. We reviewed the RPA responses to this incident and confirmed they had been investigated. Senior staff had made Improvements in the department, following the RPA's advice such as adding additional checks prior to an examination taking place.
- Since 1 April 2015, all independent healthcare providers are required to comply with the Duty of Candour Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The Duty of Candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain notifiable safety incidents and provide reasonable support to that person.
- Staff were aware of duty of candour and when it should be used. Staff implemented duty of candour following the above detailed IR(ME)R incident.

Cleanliness, infection control and hygiene

Requires improvement

Outpatients and diagnostic imaging

- The hospital worked to multiple infection control policies and procedures, including hand hygiene policy, patient isolation policy, waste management policy and standard infection control precautions policy. We reviewed the hand hygiene and standard infection control precautions policies and found they referenced national best practice and guidance. Staff were aware of these policies and where to find them on the hospital's intranet.
- All areas we inspected throughout outpatients and diagnostic imaging departments were visibly clean. Cleaning schedules in clinical areas were completed daily and up to date. However, we noted that on days when the consultant rooms were not used, the records were blank. We escalated this to the senior team, who planned to note vacant days in the records to avoid confusion.
- We noted housekeeping staff cleaning and checking toilets regularly. Cleaning schedules for these rooms were also fully documented and up to date.
- The department had no incidents of MRSA, Escherichia coli or clostridium difficile in the reporting period October 2015 to September 2016.
- We reviewed the infection prevention and control policy, which referenced national guidance. We found that staff adhered to this policy and had good knowledge of infection control techniques. However, we noted that waste was not segregated into the correct coloured bin bags, as per hospital policy. The senior management team (SMT) addressed our concerns immediately and we saw new bags in use during our unannounced visit, in line with the hospital's waste management policy. We spoke to a member of staff who explained the training they had received in relation to infection control.
- Staff used sharps bins appropriately for the safe disposal of waste. All sharps bins were visibly clean and correctly assembled, within safe fill limits, signed and dated.
- All staff wore uniform and adhered to 'arms bare below the elbow' best practice. This enabled staff to effectively wash their hands and prevent spread of infection.
- Hand sanitiser was available at the reception desk and in the main hospital and staff carried portable hand sanitiser for their own personal use. Each consulting room also had hand sanitiser on the desks and a sink for handwashing. We witnessed staff using these and washing their hands between each patient. This was in line with National Institute for Health and Care Excellence (NICE) Quality Statement 61 guidance.
- Personal protective equipment (PPE), such as gloves and aprons were readily available in the clinical areas. We witnessed staff using these, and all available stock was within its expiry date.
- Infection prevention control formed part of staff's mandatory training and the hospital had a designated infection prevention lead nurse, whose role was to work with departmental links to ensure a safe, clean environment for patients. One member of outpatient staff confirmed they were helpful and described how they delivered training and worked with the team to improve the infection prevention guidance in each consultation room.
- There were further infection control measures in place to reduce the risk of infection. For example, staff cleaned couches and laid fresh paper sheeting between patients. If a patient had a communicable disease, staff described how the room would be closed and deep cleaned.
- The outpatient department has specialised chemical and biohazard spill kits to safely clean spillages within the department.
- The infection prevention lead nurse conducted unannounced infection prevention control audits. The hospital submitted hand hygiene audit results for February 2016, which showed 100% compliance across outpatients and imaging services. We reviewed the infection prevention control meeting minutes from July 2016 and October 2016, confirming audit results were on the set agenda.
- Staff talked us through the three part decontamination process for flexible endoscopes, and we confirmed that all staff had received this training. These were also packaged at the end of clinic to be sent away for maintenance checks and deep cleaning.

Environment and equipment

- The outpatients department consisted of seven consultation rooms and a treatment room. These, along with the corridor areas, were bright, well-lit and visibly clean. The hospital had clear signage to all departments.
- We noted that five consultation rooms were carpeted and three had hard flooring. We confirmed that no

treatments took place on a carpeted area, as per national guidance, and they were vacuumed daily as per policy. The hospital had plans to introduce hard flooring throughout the department.

- The use of carpets within clinical areas was not in line with the Department of Health: Health Building Note 00:10, which independent healthcare providers should take account of when designing and refurbishing buildings. However, we noted that this was on the hospital's risk register, discussed at clinical governance meetings and the senior management team had applied for funding to upgrade all treatment areas.
- Diagnostic imaging consisted of an x-ray room and an ultrasound room. Both of which were bright, well-lit and visibly clean.
- The hospital had access to a dual energy x-ray absorptiometry (DEXA) service that an external company provided. We confirmed that hospital patients could be transferred to this separate department safely.
- Waiting rooms were spacious, carpeted and had adequate seating, with complete oversight by the reception desk. This helped to protected patients from avoidable harm and ensured only patients and authorised personnel could enter this area. We noted that staff escorted patients when moving around the department.
- Staff told us they had sufficient equipment to meet the needs of their patients.
- The outpatient and radiology departments shared resuscitation equipment. We noted that this was securely tagged to ensure contents were kept safe and opening of the trolley could be audited. Records from 1 February 2017 showed that this tag and equipment on top of the trolley was checked every working day. Staff checked the contents of the resuscitation trolley, including medicines weekly and replaced the tag. This ensured the equipment on the trolley was complete, in date and safe to use.
- We confirmed that all resuscitation equipment was in working order and reviewed 23 pieces of single use equipment, all of which was in sealed packaging and within its expiry date. Staff we spoke to were aware of equipment reaching its expiry date and had a system of highlighting dates.
- We checked a further 30 pieces of single use equipment from store cupboards throughout outpatients and diagnostic imaging. All were within their expiry date and sealed.
- An external company serviced outpatient equipment. All equipment we checked was labelled, and within their service dates.
- An external company also tested and serviced imaging equipment, including the x-ray machine. We saw up to date service and maintenance records for equipment within outpatients and imaging, such as the x-ray machine. The on-site engineer confirmed that all equipment was within its required service date.
- Lead aprons were used for patients to reduce their exposure to radiation. These were visibly clean and in good working order. Radiology staff inspected lead aprons daily and an external contractor serviced them each year.
- The radiology department used a mobile medical imaging device, a C-arm, which was located within theatres. We reviewed the risk assessments and the equipment maintenance records, all were in date.
- The diagnostic imaging department held up to date records from the Health and Safety Executive. These confirmed they had registered their work with ionising radiations, a requirement of the Ionising Radiations Regulations 1999.

Medicines

- Controlled drugs were not stored or used within the outpatient or diagnostic imaging departments.
- Non-controlled medication was stored according to manufacturer's instructions, either in a refrigerator or at room temperature. We checked fridge temperature records and found these to be within acceptable limits for January, February and until the inspection in March. We checked six random medications within outpatients and a further three within imaging, and found all were within their use by dates and stored as per the manufacturer's guidance.
- Staff within the imaging department checked medication weekly and documented expiry dates and those that had been ordered. This prevented unnecessary ordering of medication by other members of staff.
- Nursing and imaging staff did not administer any medication during an imaging procedure. A consultant radiologist would administer any required medication. A

consultant surgeon within theatres administrated any required contrast (a substance used to enhance the contrast of structures or fluids within the body in medical imaging).

- Staff we spoke with explained the procedure for obtaining medication advice or reporting concerns to the pharmacy team. We heard of an example when a concern was raised when a fridge went out of temperature range. The pharmacy team reviewed all the medication to establish if it needed destroying. This ensured medication was safe to administer.
- The provider undertook medicine management audits every three months to ensure compliance in areas such as medication storage, accessibility and resuscitation trolleys. We found the outpatient department was 89% compliant overall in February 2016. Outpatients had improved compliance in May 2016, achieving 94%. The diagnostic imaging department had achieved 100% in both February and May 2016.
- Staff undertook further medicine management audits in August and November 2016; however, the hospital did not provide results for outpatients or diagnostic imaging.
- We were unable to establish and assess the quality of discussions between consultants and patients regarding medication due to the lack of documentation from consultants within medical records. The hospital provided no information, in addition to the standard manufacturer issued leaflets, to patients regarding medication.

Records

- The hospital used a system of paper records. We reviewed 12 sets of medical records relating to clinics in March 2017 during our announced inspection. We reviewed a further 19 medical records from clinics held in January 2017 during our unannounced inspection. All medical records reviewed were from a range of consultants and differing specialities.
- Of the 12 records from clinics in March 2017, none contained documentation from the consultant reviewing the patient. One set of records contained a referral letter and one contained an appointment letter.
- Of the 19 records from clinics in January 2017, 12 did not contain any documentation from a consultant and no referral or appointment letters. The remaining seven records were from two specific consultants and did contain contemporaneous documentation regarding the investigations undertaken and plan of care for the patient.
- We raised our concerns with the outpatient manager who told us that consultants had access to, and were encouraged to use, carbonated record sheets to enable a copy to be filed in patient notes. However, the outpatient manager told us that consultants did not routinely use them and were not receptive when challenged over it.
- We escalated our concerns to the hospital's senior management team who were aware consultants were not documenting within patient records and had encouraged consultants to do so. However, no action plan was in place to improve documentation from medical staff at the time of the inspection.
- When asked the procedure for obtaining consultants notes at short notice, two members of staff said they were unsure but would try to contact the consultant's secretary.
- An audit of the availability of medical records between December 2015 and February 2016 showed that all patients attending the outpatient department had a set of medical records at the time of their appointment. However, the audit did not review the content of these records.
- Data provided by the hospital showed that some consultants and medical secretaries removed and stored their own medical notes off site. These staff were registered with the Information Commissioner's Office and the hospital checked this as part of the admitting rights to the hospital. This ensured consultants and secretaries transported, stored securely and destroyed records in line with current legislation.

Safeguarding

- The service had raised no safeguarding concerns to either CQC or the local authority between October 2015 and September 2016.
- Safeguarding formed part of the hospital's mandatory training. Data provided by the hospital showed that, as of November 2016, one of the four bank radiographers employed at BMI St Edmunds had expired safeguarding

training (both adult and children). The remaining three bank and one substantive radiographer at the hospital had in date safeguarding training for children and adults.

- All outpatient staff, including registered nurses and healthcare assistants, had up to date safeguarding adults and children training, as of November 2016.
- The hospital had a reviewed safeguarding policy and staff were aware of this and how to access it. Staff could identified the safeguarding lead within the hospital and were able to explain the procedure should they have concerns regarding a patient or family.
- The safeguarding adult policy contained information on female genital mutilation and domestic violence.

Mandatory training

- All staff commencing employment at the hospital completed mandatory training in line with hospital policy. This included, but was not limited to, information governance, conflict resolution, dementia awareness and manual handling.
- Staff undertook yearly mandatory training updates, in line with the hospital's mandatory training policy. Data supplied by the hospital showed all outpatients and diagnostic imaging staff had in date mandatory training, or were booked onto an upcoming course, as of November 2016.
- Heads of departments for outpatient and imaging had up to date documentation to enable them to monitor compliance with mandatory training.

Assessing patient risk

- All areas had call bells to enable patients, visitors and staff to call for assistance. The 'crash team' attended all clinical emergencies and patients would be transferred to the nearest emergency department by ambulance where necessary.
- The hospital carried out resuscitation scenario sessions. We noted that clinical governance meeting minutes documented that these also included a scenario within the outpatients department.
- All outpatient and diagnostic imaging staff had received up to date basic life support (BLS) training.
- The outpatient department had a health and safety folder including risk assessments for the department and Control of Substances Hazardous to Health (COSHH) data sheets. This ensured staff could access information in the event of a chemical spillage or reaction.
- The hospital radiology department had introduced a 'pause check'; this allowed staff to do a double check on patients' name, address, date of birth, site of x-ray and previous imaging. This assured the correct patient and site of x-ray, as well as preventing any unnecessary exposure to radiation. We observed staff undertaking this during the inspection.
- Entrances to diagnostic imaging had light boxes that lit when the rooms were in use. These stated 'controlled area x-rays, do not enter'. This warned people to not enter the room and avoid unnecessary exposure to radiation.
- The radiology department had up to date risk assessments for the prevention of unnecessary exposure to radiation and the protection of both patients and staff.
- The radiology department also had access to an external radiation protection advisor (RPA) for advice, as well as performing yearly audits, in line with the Ionising Radiation (Medical Exposure) Regulations 2000. A member of senior staff described them as "accessible and responsive".
- The diagnostic imaging lead was the hospitals designated radiology protection supervisor (RPS), whose duties included ensuring staff were fully trained and followed the latest guidance and legislation.
- Staff called the resident medical officer to review any patient that became unwell during an imaging procedure.
- Pregnancy status of female patients of childbearing age was checked prior to receiving any diagnostic imaging. This was in line with the Royal College of Radiographers guidelines. Notices were also on the entrance to diagnostic imaging rooms, advising patients to notify the radiographers if there was a chance they might be pregnant.
- A consultant in theatre administered contrast and dyes for imaging purposes. The imaging department did not undertake any x-rays using contrast or dyes. See the surgery report for more information on anaphylaxis protocols within theatres.

Nursing and radiography staffing

Requires improvement

Outpatients and diagnostic imaging

- The hospital employed a mix of registered nurses (RN) and health care assistants (HCA). Data supplied by the hospital prior to the inspection showed the outpatients department employed one whole time equivalent (WTE) RN and 2.1 WTE HCA's. The diagnostic imaging department employed one radiographer for 28 hours per week.
- The hospital used agency and bank staff to fill outstanding shifts.
- Data submitted by the hospital confirmed that staffing and sickness levels within outpatients and diagnostic imaging were below the average for the industry, and there were no vacancies or unfilled shifts between July and September 2016.
- The diagnostic imaging service did not have a sufficient number of contracted staff, and relied upon bank members of staff for the service to run safely and efficiently.
- We escalated this to senior management, who had plans to use staff from a partner BMI hospital. They gave an example of this happening when the department lead was absent. At the time of our inspection, there were recruitment interviews for two radiology HCAs.
- The use of bank nurses in the outpatient department was higher than the average of other independent acute hospitals in the reporting period July 2016 to September 2016.
- Staff told us the same members of bank and agency staff were used wherever possible. This enabled continuity of care and familiarity with the hospital surroundings. One member of bank staff told us they felt part of the team.

Medical staffing

- The outpatients department was consultant led, with the hospital granting 86 consultants practising privileges.
- A consultant radiologist undertook two sessions per week (two half days) to review images and provide support within the diagnostic imaging department.
- Outpatients and diagnostic imaging also had access to the resident medical officer who was available in the hospital on 24 hours per day.
- The hospital was able to contact consultants outside of clinic hours through their secretaries. However, the outpatient department did not have access to phone numbers to contact the consultant's directly.

Emergency awareness and training

- The hospital had a business continuity management folder with policies and guidance in the event of an emergency. We reviewed this policy and found it to be well structured with a list of up to date emergency contacts. It contained procedures in events such as loss of water, loss of bleep system and failure of the passenger lift. It also stated that there was generator backup in the event of loss of electricity.
- We asked two members of outpatient's staff about this, but they were unable to locate the folder. We raised our concerns with senior managers who stated that the BMI policy was to have one folder that they kept on the ward. They planned to inform staff of its location and consider duplicate copies.
- All outpatients and diagnostic imaging staff had up to date training on emergency management and fire safety. Fire extinguishers were available throughout both departments and all had up to date maintenance.
- The outpatient manager was the fire marshal for the outpatient department, and they stated that staff participated in regular fire drill practice scenarios. For our detailed findings on emergency awareness, please see the safe section in the surgery report.

Are outpatients and diagnostic imaging services effective?

We do not currently rate effective for outpatient and diagnostic imaging services.

Evidence-based care and treatment

- Hospital policies were version controlled. This evidenced the hospital reviewed and updated policies as required. We noted that policies contained a table to highlight what additions had been made to the policy and when. For example, the hand hygiene policy had been updated in February 2016 when new national guidelines from the Department of Health had been issued. All reviewed policies and procedures were well referenced to national guidance and requirements.
- Assessments and advice on the outpatient's resuscitation trolley referenced good practice from the UK Resuscitation Council guidelines.
- Guidance for hand washing was based on the five moments of hand hygiene guidance from the World Health Organisation (WHO).

- Staff were updated on policies through email or departmental meetings.
- All policies were on the hospital's electronic system. We asked to review specific policies and staff were able to locate these easily within the intranet.
- The outpatient department also had a folder for some printed policies. The ward manager told us that these were the policies that the staff were required to read as they contained recent updates.
- The imaging manager told us they quality checked all diagnostic images before the patient left the department, as an additional quality assurance step.

Pain relief

- If a patient experienced pain during an appointment, the clinical team would assess the patient and appropriate pain relief was prescribed and administered. If pain relief was required, outpatient staff accessed the ward stock, as these medicines were so infrequently used within outpatients, they did not stock it within the department.
- Neither outpatients nor imaging had access to analgesic gas for pain relief. This is a form of pain relief that takes affect quickly and its effects are felt for a short period.
- Patients we spoke with had not needed pain relief during their attendance to the outpatient department.

Patient outcomes

- Provision of care was monitored with the use of local and national audits. During our visit, we saw an audit schedule for 2017.
- The National Diagnostic Reference Levels (NDRLs) conducted regular audits to compare the average dose of radiation used to national levels. Senior staff confirmed there had been no issues with the audit results and we saw the latest audit results during the inspection.
- For our detailed findings on patient outcomes, please see the effective section in the surgery report.

Competent staff

- All staff, including those on the bank, completed an induction and full training before commencing their role. All staff had core skill competencies alongside mandatory training requirements.
- The respective department manager, completed competencies for bank and agency staff. For example, staff underwent competency assessments to use the x-ray machine within imaging.
- The imaging manager told us they found it difficult to complete competencies for bank and agency staff, as they were not scheduled to work at the same time. The imaging manager had completed around half of all required competency assessments for bank and agency staff. The Ionising Radiation (Medical Exposure) Regulations (IR(ME)R) 2000 required staff to be trained in the safe use of equipment. At the time of inspection, the hospital had no action plan in place to ensure compliance with IR(ME)R Regulations in relation to training.
- The NHS trust that consultants with practising privileges worked for, completed their revalidation and appraisal process. There was a process in place to ensure all consultants were up to date with the revalidation and practising privileges process. However, this was not always effective. See the surgery report for details.
- All staff, including nurses and radiographers, had the required professional qualifications and registrations for their role. Managers checked these during appraisals. Bank and agency staff completed the hospitals full mandatory training package before commencing work. We saw evidence that all staff, substantive and non-substantive, had completed all required training for their roles. However, there was no process in place for this to be checked hospital wide. See the surgery report for details.
- The hospital had an appraisals policy, we found all staff within outpatients and imaging had undergone an appraisal during the last appraisal year (October 2015 to September 2016). The imaging manager and outpatient manager had also received an appraisal between September 2016 and March 2017.
- Two staff members told us their appraisals were useful to highlight areas for development; however, access to training and time to fulfil the objectives was limited. Senior managers told us they would address poor performance at the time any mistakes were made, and discuss these at appraisals.

Multidisciplinary working

Requires improvement

Outpatients and diagnostic imaging

- Consultants led clinics within outpatients, supported in care delivery and chaperoning by registered and unregistered nursing and care staff. The hospital did not have nurse specialist clinics.
- Consultants were able to refer patients to the onsite physiotherapy service, or other offsite therapy services such as occupational therapy and speech and language therapy.
- We found effective multi-disciplinary working between the outpatients and imaging departments to ensure patients received timely x-rays.
- The imaging department worked well with ward and theatre staff to ensure patients requiring x-rays during or following a surgical procedure received this in the timeframe required. However, one senior member of staff told us that collaborative working across the hospital was limited, despite the introduction of daily 'comms cell' meetings attended by heads of department.

Access to information

- Consultants had access to paper records for new and follow up appointments, for example following surgical procedures, and electronic imaging records through a picture archiving and communication system (PACS).
- Consultants with practising privileges did not leave copies of notes from consultations within patient records. Nursing, radiology and ward staff did not have access to copies of consultant outpatient records for follow up and admission guidance. We raised our concerns on site with the hospitals senior management team.
- Staff told us that they informed GPs of patient treatments through letters. However, we found no evidence of GP letters within medical records and no consultant documentation to support this. The hospital did not audit how effective and timely the communication with GPs were; therefore, we were not assured that communication with community services was effective.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- The hospital worked to a policy entitled; 'Consent to treatment for competent adults and young people'. We found this to be up to date and referenced national guidance. Staff we spoke with could explain the principles and importance of consent.
- Consultants did not undertake procedures requiring written consent within the outpatient or radiology departments. Therefore, we found no evidence of written consent within medical notes during the inspection.
- All outpatient and radiology staff had completed training on the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards 2010 as part of their mandatory training. When asked, staff could explain their responsibilities under the MCA and access the hospitals MCA and Deprivation of Liberty Safeguards 2010 policy.
- Staff showed an understanding of Deprivation of Liberty Safeguards 2010, despite the limited application of Deprivation of Liberty Safeguards 2010 within outpatients and imaging services.
- When asked, staff could not recall a situation where a patient did not have capacity to consent within the departments. However, staff could explain the procedure for accessing additional information and support should a patient present who they suspect may lack capacity.

Are outpatients and diagnostic imaging services caring?

Good

We rated caring as good.

Compassionate care

- Interactions between staff and patients were friendly and respectful during our inspection. We noted that patients were welcomed to the hospital and staff introduced themselves.
- The hospital received patient feedback through NHS Friends and Family Test (FFT). This mandatory test compares care given across NHS providers. It helps hospitals understand whether their patients are satisfied with the service provided, or where improvements are needed. The hospital scored, on average, 99% between April 2016 and September 2016.
- We observed staff treating patients with dignity and respect. Consultation rooms had separate areas where patients changed behind curtains. Diagnostic imaging had changing cubicles and curtains to protect patients' privacy and dignity during treatment.

Requires improvement

Outpatients and diagnostic imaging

- We saw evidence that the patients' confidentiality was protected. Consultations with medical and nursing staff took place in rooms with closed doors and could not be overheard. We witnessed staff knocking on doors, and awaiting an answer before entering.
- The hospital had a chaperoning policy and all staff were advised to explain the chaperoning procedure to patients when attending appointments and ask if the patient would like a chaperone in attendance during their appointment. A chaperone is a person who serves as a witness for both a patient and a medical practitioner as a safeguard for both parties during a medical examination or procedure.
- There was clear signage throughout, including on reception desks and in consultation rooms, offering a chaperone. We also witnessed this discussion taking place with a patient and reception staff. Physiotherapy used stamps in patients' notes to mark if they had accepted a chaperone or not.
- Patients were given the option to be accompanied into the consultation rooms with their relatives.
- All three patients we spoke to praised the care they received. One patient said, 'they could not have done more'.

Understanding and involvement of patients and those close to them

- We observed medical, nursing and imaging staff discuss and explain procedures in a calm and reassuring manner and answering questions from patients prior to undertaking an x-ray, which provided reassurance to the patient.
- Patients were able to bring a relative or friend with them to appointments to provide support, and staff encouraged them to be present if that was the wishes of the patient.
- Consultants provided clear, concise information to patients in a format that they could understand. This was further supported by written information for the patient to take home explaining the benefits and risks of their planned procedure.
- Reception staff discussed payment options for treatment in a sensitive way and provided verbal and written information to patients and those close to them.

Emotional support

- Staff supported patients throughout their time at BMI St Edmunds. Nursing staff gave a specific example when a patient returned to the department with a nosebleed. Staff sat with her for as long as needed until she was ready to go home.
- Staff had access to counselling services for patients if needed.
- Reception staff told us that if they observed a patient in the reception area who required some privacy or emotional support then they could offer use of an adjacent room and request support from care staff as appropriate.

Are outpatients and diagnostic imaging services responsive?

Good

We rated responsive as good.

Service planning and delivery to meet the needs of local people

- The hospital had planned outpatient and imaging services to reflect the treatments provided within the wider hospital. For example, the ability for patients to receive pre and post discharge x-rays and reviews by the same consultant.
- We found no concerns regarding accessibility to appointments at a time to suit the patient. Staff told us they would accommodate patient's preferences for appointment times wherever possible, including utilising Saturday clinics. All three patients asked were happy with the appointment times offered.
- The hospital did not offer patients consultations through alternative means (for example telephone and video calls) other than face-to-face.
- Car parking was available at the hospital for patients attending outpatient and imaging appointments, including accessible parking spaces for those patients with additional mobility needs.
- The reception desk, outpatient and imaging departments were well signposted and all departments easy to find. Waiting areas had comfortable seating available. Patients had access to information, such as charges, complaints policy and opening hours, within the waiting areas.

Requires improvement

Outpatients and diagnostic imaging

- Patients also had access to toilet facilities and hot and cold drinks within the main reception area. Due to the transient nature of the patients in the department, staff did not routinely offer them food.
- The hospital provided patients with information prior to their appointment, including appointment time and location, name of the consultant and how to find the hospital.

Access and flow

- Between October 2015 and September 2016, outpatients had 11,787 attendances, with 42% NHS funded and 58% non-NHS funded.
- There was an established process in place for monitoring compliance with NHS funded patients waiting less than 18 weeks from referral to treatment. The hospital met this target of 92% with 99.4% of admitted patients waiting 18 weeks or less, in the reporting period October 2015 to September 2016. For those patients not admitted, 100% received treatment within 18 weeks of referral, in the same reporting period.
- The hospital had one patient waiting six weeks or longer from referral for a non-obstetric ultrasound diagnostic test in 2016. The national standard from NHS England is for all patients requiring a diagnostic test to have received this within 42 days (or six weeks).
- The imaging department planned radiology services around outpatient and theatre activity, and were available 24 hours a day through an on call system. Staff told us appointments rarely ran late; however, the hospital did not record data in relation to this.
- The radiology department offered 'drop in' sessions during specific clinics, for example orthopaedic clinics. This allowed a 'one stop shop' for patients who needed additional or unscheduled x-rays, preventing patients making a further appointment and potentially delaying treatment.
- On the day of our inspection, clinics appeared to run smoothly and without delays. All patients we spoke with confirmed their appointments were running on time.
- Outpatient staff coordinated their working arrangements dependent on clinical need. We heard examples of preparing consultation rooms specifically for that day's consultant, by preparing leaflets and documents specific to their clinic.
- Across all 16 specialities seen within outpatients, the hospital had a low 'did not attend' (DNA) rate amongst patients, with a 5% or lower target for patients not attending their scheduled appointment. Between April and October 2016, for initial appointments, an average of 1.1% of patients DNA their appointment, with general surgery (5.6%), ophthalmology (3.9%) and gastroenterology (3.5%) having the highest average DNA rates. Out of the 16 specialities, 10 had no patients that DNA between April and October 2016, including dermatology, neurology and plastic surgery.
- During the same period for follow up appointments, an average of 1.2% of patients did not attend their appointment. Data showed that the highest DNA rates were Urology (9%), gynaecology (3.5%) and orthopaedics (3.3%). Out of the 16 specialities, 12 had no patients DNA for follow up appointments between April and October 2016.

Meeting people's individual needs

- Staff provided patients with information leaflets specific to their treatment. We confirmed that these had contact numbers for any further questions the patient may have had. We also saw this being pointed out to a patient when they received the leaflet.
- Staff had access to a spoken translation service for those patients whose first language was not English, which could be provided through telephone or in person. Staff told us that face-to-face translators would be booked in advance if they knew a patient required one.
- The service had a hearing loop at the reception desk for those patients using a hearing aid. This was accessible and could be utilised within consulting rooms if needed.
- We found the reception desk had areas of differing height to allow patients using wheelchairs to be able to access it. All consulting rooms were wheelchair accessible throughout outpatients. The imaging suit was wheelchair accessible; however, a wheelchair could not fit into the changing facilities within the department.
- There was nothing specific in place for people who had particular needs, for example a learning disability, sensory or mobility problems, or those living with dementia. Staff made arrangements on an individual basis and supported them during their visits to the departments, for example by staying with them throughout their appointment.

Learning from complaints and concerns

- The hospital supplied data that showed there were 43 complaints across the hospital departments between

Requires improvement

Outpatients and diagnostic imaging

July 2015 and June 2016. The Care Quality Commission (CQC) received three complaints in the same reporting period. A member of senior staff said that these were used to identify trends, and the majority were concerning financial arrangements for treatment.

- There was a BMI healthcare complaint policy in place, which included a three-step process for handling complaints internally and information on external complaint processes. Staff we spoke with were aware of this policy and described the procedures to handle complaints.
- There was no patient information on display to advise patients how to make a complaint. All three patients we interviewed, said they had no reason to complain, but would raise issues at the reception desk if they had. Reception staff confirmed they would print complaint forms if requested. There was also a feedback form available in the waiting areas and on their website. This had a further comments section that could also be used for complaints.
- See the surgery report for details of complaints handling.

Are outpatients and diagnostic imaging services well-led?

Requires improvement

We rated well-led as requires improvement.

Leadership and culture of service

- For our detailed findings on the senior management team (SMT), please see the well-led section in the surgery report.
- Heads of department (HoD), which included an outpatient patient manager (registered nurse) and imaging manager (radiographer), managed the service on a day-to-day basis. This included allocation of staff, sickness management and quality assurance. The HoDs reported directly to the hospitals director for clinical services.
- The current outpatient department manager commenced the role in May 2016 and the imaging manager had been in post for three years.
- Due to the nature of the departments, only one registered nurse and radiographer were on shift at any time. The HoD told us this provided challenges to supporting agency and junior colleagues within their roles. A member of staff told us they felt the SMT did not consistently listen to concerns raised, for example the lack of time to support staff and complete competencies.
- Furthermore, a member of staff told us that they found it difficult to challenge other staff, particularly those in a senior position, for example, the SMT at BMI St Edmunds or consultants with practising privileges.
- Within imaging, staff told us that they found clinical supervision and support lacking, as the SMT had no experience within an imaging environment. Staff could, however, access support from neighbouring BMI hospitals where needed.
- The HoD told us that where a member of staffs practice fell below the expected standard they would use the hospitals disciplinary policy. The HoDs we spoke with had a good understanding of this; however we did not find this applied equally throughout the departments. For example, neither the HoD, SMT or medical advisory committee had formally challenged consultants on the lack of documentation within medical notes.

Vision and strategy for this core service

- The hospital had an overarching vision and strategy; however, neither outpatients nor imaging had formalised and individualised visions or strategies. Staff asked were aware of the hospitals, and wider organisations, vision and values.
- Informally, senior staff within both departments told us they strive to ensure the experience of patients was at the forefront of everything they did. For example, providing unscheduled 'drop in' radiology sessions for clinics where consultants were known to request ad hoc x-rays.
- For our detailed findings on the hospitals vision and strategy, please see the well-led section in the surgery report.

Governance, risk management and quality measurement

- We reviewed minutes from the heads of department (HoD) meetings in September, October and November 2016. We noted that the outpatient manager had not attended any of the HoD meetings. No reason was documented for non-attendance and no update submitted in relation to outpatients. The imaging

manager had attended in September, but not in October or November. However, the imaging manager had submitted a written report to the HoD in November to provide an update in their absence.

- We found a significant issue with record keeping but this had not been identified as a concern by the senior management team, at clinical governance, or by the MAC.
- The HoD meeting minutes for September 2016 recorded that both outpatients and diagnostic imaging had not completed hand hygiene audits and submitted results in a timely manner. It was noted in the October and November 2016 minutes that the outpatient manager had not responded in a timely manner to the concerns raised and required monthly reminders to submit audit data.
- We reviewed clinical governance meeting minutes from April and May 2016. The imaging manager did not attend either meeting. The previous outpatient manager attended the April meeting; however, the current outpatient manager did not attend the May clinical governance meeting.
- Clinical governance meeting minutes followed a standard agenda with clearly documented items and actions, with imaging being one of the standard agenda items. The April 2016 meeting discussed the outpatient department generically with reference to carpeted consulting rooms. No other references were noted within the minutes relating to the outpatient department.
- We reviewed minutes of the medical advisory committee (MAC) from January and May 2016 and found a consultant radiologist attended both meetings. This allowed oversight of the hospitals processes from a diagnostic imaging perspective.
- We found no concerns or issues raised within the MAC minutes regarding outpatients or diagnostic imaging. The MAC had not discussed or identified the concerns regarding the lack of consultant documentation, and subsequent non-compliance with hospital policy.
- The SMT had also not recognised or acted to improve this, despite the requirement within hospital policy to include a copy of medical notes within hospital records. We were not assured that the department manager or hospital management team had adequate oversight of concerns within outpatients.
- The hospital documented all risks on the hospital wide risk register, with no individual departmental risk registers. However, the HoD meetings did review the risk register at each meeting. The SMT had reviewed all risks in October 2016; however, no formal further review date had been scheduled.
- We reviewed the hospitals risk register and found three generic risks relating to outpatients and diagnostic imaging. These were a risk of flooding from a pond next to the entrance to outpatients, the difficulties in recruiting staff to the hospital and carpeted areas including treatment rooms and waiting areas within outpatients. With the exception of flooding, the risk register had no other risks documented relating to imaging.
- We were not assured that department leads within outpatients and imaging had a good oversight of risk within their areas. The outpatient manager did not engage with either the HoD or clinical governance meetings, with the imaging manager participating in these meetings infrequently. The department managers had limited knowledge of the documented risks within their areas. The hospital's risk register did not comprehensively reflect the risks within each department.
- When asked, the outpatient manager was unable to describe the risks within the risk register that affected the department. The outpatient manager stated that staffing and documentation were the biggest risks, but did not identify carpeted rooms or the risk of flooding during adverse weather as documented risks to the department. The imaging manager was aware of the risk identified due to the lack of substantive staff; however, as with the outpatient manager was not aware of the remaining two risks on the risk register.

Public and staff engagement

- The hospital monitored patient satisfaction through internal BMI feedback forms and national feedback platforms, such as the Friends and Family Test.
- Within outpatients and imaging, staff told us they did not feel engaged with the wider hospital and often felt "isolated" as the surgical service took priority.
- The majority of staff within outpatients and imaging were agency or bank staff, making it difficult to undertake large scale staff engagement.

Innovation, improvement and sustainability

Requires improvement

Outpatients and diagnostic imaging

- The imaging department had recently stopped the mammography service. The imaging manager told us this was due to a low number of women attending and that the local NHS trust had a specialist breast service.
- We asked senior staff for examples of innovation and improvement plans. Neither senior staff members asked gave examples to demonstrate this.

Outstanding practice and areas for improvement

Outstanding practice

- The service had direct access to electronic information held by community services, including GPs. This meant that hospital staff could access up-to-date information about patients, for example, details of their current medicine.

Areas for improvement

Action the provider MUST take to improve

- The provider must ensure that all outpatient consultants maintain accurate, complete and contemporaneous hospital records in respect of each service user.
- Ensure that all consultants comply with the practising privileges policy and submit relevant documentation prior to privileges being granted.
- The provider must ensure that all imaging staff complete the required level of training and competency, as required under the Ionising Radiation (Medical Exposure) Regulations (IR(ME)R) 2000.

Action the provider SHOULD take to improve

- The provider should ensure that department managers and senior management team have good oversight of risks, and these are comprehensively documented.
- The provider should ensure that departmental managers are engaged with risk management and governance processes within the hospital.
- The provider should ensure all staff are aware of the procedures in the event of an emergency.
- The provider should ensure its audit process captures all aspects of patient documentation, particularly within outpatients and diagnostic imaging.
- The provider must ensure that all theatre staff have the required level of training and competencies to undertake their role, and keep an accurate plan of all planned and completed training.
- Consider commencing audits for waiting times in outpatient departments.
- The provider should review the use of carpeted rooms for patient treatment and ensure an achievable time scale for changing to non-carpeted flooring is in place, ensuring the Department of Health, Health Building Note 00:10 is considered throughout the process.
- The provider should ensure that all departments and heads of departments submit required audit data as required.
- Consider the hospital's poor compliance with best practice with regards to insertion of IV cannulas and ensure that improvements are made.
- All theatre staff should have an annual appraisal.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance Regulation 17 HSCA 2008 (Regulated Activities) Regulations 2014 Good governance, which state: The registered person must maintain an accurate, complete and contemporaneous records for each service user in outpatients, including a record of the care and treatment provided and of decisions taken in relation to the care and treatment provided. Regulation 17(2)(c) Records relating to the care and treatment of each person using the service must be kept and be fit for purpose. Fit for purpose means they must: · Be complete, legible, indelible, accurate and up to date, with no undue delays in adding and filing information, as far as is reasonable. This includes results of diagnostic tests, correspondence and changes to care plans following medical advice. · Include an accurate record of all decisions taken in relation to care and treatment and make reference to discussions with people who use the service, their carers and those lawfully acting on their behalf. · Be accessible to authorised people as necessary in order to deliver people's care and treatment in a way that meets their needs and keeps them safe. Why the regulation was not being met:

This section is primarily information for the provider

Requirement notices

We found incomplete records within outpatients from consultants, with limited or no documentation relating to the care delivered and treatment plans discussed and implemented.

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance Regulation 17 HSCA 2008 (Regulated Activities) Regulations 2014 Good governance, which states: The registered person must maintain securely such other records as are necessary to be kept in relation to – (i) Persons employed in the carrying on of the regulated activities, and (ii) The management of the regulated activities Regulation 17(2)(d) Records relating to people employed and the management of regulated activities must be created, amended, stored and destroyed in accordance with current legislation and guidance. Records relating to people employed must include information relevant to their employment in the role including information relating to the requirements under Regulations 4 to 7 and Regulation 19 of this part (part 3) of the HSCA 2008 (Regulated Activities) Regulations 2014. Why the regulation was not being met: We found the creation and amendment of records relating to staff inconsistent across BMI St Edmunds. For

Requirement notices

example, within theatres, senior staff did not have up to competency records for staff, and did not know which staff were currently competent to undertake specific tasks.

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing Regulation 18 HSCA 2008 (Regulated Activities) Regulations 2014 Staffing Regulation 18(2)(a) Persons employed by the service provider in the provision of a regulated activity must receive such appropriate support, training, professional development, supervision and appraisal as is necessary to enable them to carry out the duties they are employed to perform. Why the regulation was not being met: Health, social and other care professionals must have access to clinical or professional supervision as required, in line with the requirements of the relevant professional regulator. We found this was limited within the radiology department at BMI St Edmunds. Providers should have systems in place to assess the competence of employees before they work unsupervised in a role. They must provide appropriate direct or indirect supervision until the person is assessed as competent to carry out the role. The provider must ensure all staff receive a regular appraisal (in line with local policy) of their performance in their role from an appropriately skilled and experienced person.

This section is primarily information for the provider

Requirement notices

Training, learning and development needs should be identified, planned for and supported. We found this was inconsistent across BMI St Edmunds, particularly within the theatre department.

Staff should be supported to make sure they can participate in any additional training identified as necessary to carry out regulated activities as part of their job duties and, in particular, to maintain necessary skills to meet the needs of the people they care for and support. We found this was inconsistent across BMI St Edmunds, with theatre staff and radiology staff lacking required competencies, training and supervision. We also found that not all consultants had 'scope of practice' documents within their staff files.