

BMI The Priory Hospital

Quality Report

Priory Road
Edgbaston
Birmingham
West Midlands
B5 7UG
Tel: 0121 446 1600
Website: www.bmihealthcare.co.uk

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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	

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

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

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

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

Summary of findings

Overall summary

BMI The Priory Hospital is operated by BMI Healthcare Limited. The hospital has 65 inpatient beds (Bournville, Dudley, Aston, ITU and Highbury) and 17 day-case beds (Highbury and Paediatric Unit). Facilities include five operating theatres, a six-bed intensive treatment unit, a dedicated oncology centre, cardiac catheterisation lab, and X-ray, outpatient and diagnostic facilities.

The hospital provides surgery, medical care, critical care, services for children and young people, and outpatients and diagnostic imaging.

We inspected this service using our comprehensive inspection methodology, however we did not inspect services for children and young people or outpatient services. We carried out unannounced inspections of the surgical and diagnostic imaging services on 14 and 15 May 2019 and medical care and critical care on 17 and 18 July 2019.

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

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

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

Services we rate

Our rating of this hospital stayed the same. We rated it as **Requires improvement** overall.

We found areas of practice that require improvement:

- The service did not always provide mandatory training in key skills to all staff and make sure everyone completed it.

- The design, maintenance and use of facilities and premises was not always in line with national guidance.
- Staff did not always complete and update risk assessments for each patient and remove or minimise risks.
- Records were not always stored securely.
- In critical care staff showed a lack of understanding about the mental capacity act and deprivation of liberty safeguards. There was no set space for staff to record capacity concerns in patient notes.
- Managers did not always ensure staff followed up-to-date guidance in respect of diabetic foot care. In medical care, staff did not always support patients to make informed decisions about their care and treatment. They did not always know how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health.
- In medical care and diagnostic imaging, staff did not always ensure patients privacy and dignity was respected and took account of their individual needs.
- The service did not always take into account patients' individual needs and preferences. Staff did not always make reasonable adjustments to help patients access services.
- In critical care, patients and visitors may not know how to give feedback and raise concerns about care received.
- Leaders did not always operate effective governance processes throughout the service.

We found areas of good practice:

- Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.
- The service had enough staff with the right qualifications, skills, training and experience to keep

Summary of findings

people safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix, and gave bank and agency staff a full induction.

- Staff gave patients enough food and drink to meet their needs and improve their health. They used special feeding and hydration techniques when necessary.
- Staff assessed and monitored patients regularly to see if they were in pain and gave pain relief in a timely way. They supported those unable to communicate using suitable assessment tools and gave additional pain relief to ease pain.
- The service made sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and development.
- Key services were available seven days a week to support timely patient care.
- Staff gave patients practical support and advice to lead healthier lives.

- Staff treated patients with compassion and kindness.
- People could access the service when they needed it and received the right care promptly. Waiting times from referral to treatment and arrangements to admit, treat and discharge patients were in line with national standards.
- Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.

Following this inspection, we told the provider that it must take some actions to comply with the regulations and that it should make other improvements, even though a regulation had not been breached, to help the service improve.

We also issued the provider with four requirement notices. 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
Medical care (including older people's care)	Requires improvement 	Medical care services were a small proportion of hospital activity. The main service was surgery. Where arrangements were the same, we have reported findings in the surgery section. We rated this service as requires improvement as it required improvement in Effective, responsive and well-led. However, we found it was good in safe and caring.
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. We rated this service as requires improvement because it was good for effective, caring and responsive although it requires improvement for being safe and well-led.
Critical care	Good 	Critical care services were a small proportion hospital activity. The main service was surgery. Where arrangements with the same we have reported findings in the surgery section. We rated the service as good because it was safe, effective, responsive and well led. Caring was not rated because we could not speak to enough patients or relatives.
Diagnostic imaging	Requires improvement 	Diagnostic imaging services were a small proportion of hospital activity. The main service was surgery. Where arrangements were the same, we have reported findings in the surgery section. We rated this service as requires improvement because it was good for caring and responsive, although the safety and leadership requires improvement.

Summary of findings

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Requires improvement 

BMI The Priory

Services we looked at:

Medical care (including older people's care); Surgery; Critical care and Diagnostic imaging

Summary of this inspection

Background to BMI The Priory Hospital

BMI The Priory Hospital is operated by BMI Healthcare Limited. The hospital opened in 1982. It is a private hospital in Edgbaston, within one mile of Birmingham City Centre. The hospital primarily serves the communities of Birmingham. It also accepts patient referrals from outside this area.

The hospital has had a registered manager in post since June 2017.

The hospital has been inspected on four occasions, the last of which was in February 2016 where the hospital was rated as requires improvement overall and was served two requirement notices due to breaches of the Health and Social Care Act 2008.

We inspected this service using our comprehensive inspection methodology. We carried out an unannounced inspection on 14 and 15 May 2019 and 17 and 18 July 2019.

Our inspection team

The team that inspected the service comprised four CQC lead inspectors and four specialist advisors. The inspection team was overseen by Zoe Robinson, Inspection Manager.

Information about BMI The Priory Hospital

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

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

During the inspection, we visited wards, theatres and diagnostic imaging areas. We spoke with 58 staff including registered nurses, health care assistants, reception staff, medical staff, operating department practitioners, and senior managers. We spoke with 14 patients. During our inspection, we reviewed 45 sets of patient records.

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

Activity (January 2018 to December 2018)

- In the reporting period January 2018 to December 2018, there were 8,420 inpatient and day case episodes of care recorded at BMI The Priory Hospital; of these 17% were NHS-funded and 83% other funded.
- 5% of all NHS-funded patients and 12% of all other funded patients stayed overnight at the hospital during the same reporting period.
- There were 48,364 outpatient total attendances in the reporting period; of these 83% were other funded and 17% were NHS-funded.
- Five hundred and twenty-four doctors and dentists worked at the hospital under practising privileges. Four regular resident medical officer (RMO) worked on a one week on and one week off rota basis. BMI The Priory employed the equivalent of 99 full time equivalent (FTE) registered nurses, 28.9 FTE operating department practitioners and health care assistants. The accountable officer for controlled drugs (CDs) was the registered manager.

Track record on safety

Summary of this inspection

- Zero never events
- Clinical incidents: 411 no harm, 239 low harm, 29 moderate harm, zero severe harm, three expected deaths of patients on end of life pathways.
- Zero serious injuries
- Zero incidences of hospital acquired MRSA
- Zero incidences of hospital acquired MSSA
- Zero incidences of hospital acquired C. difficile
- One incidences of hospital acquired E-Coli
- One hundred and fifty-four complaints

Services accredited by a national body:

- Macmillan Quality Environment Mark awarded to the Highbury Centre in April 2018.

Services provided at the hospital under service level agreement:

- Agency staffing
- Cardiology testing services

- Clinical and non-clinical waste removal
- Grounds Maintenance
- Infection prevention and control doctor
- Intensivist provision - ITU
- Laundry
- Medical devices management
- Medical gases
- Medical records storage
- Microbiology advice for orthopaedics
- Night security
- Pathology
- Radiation protection
- RMO provision
- Stoma care
- Transfer of paediatric patients

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?

Our rating of safe stayed the same. We rated it as **Requires improvement** because:

- The service did not ensure everyone had completed mandatory training.
- The design, maintenance and use of facilities and premises was not always in line with national guidance.
- Staff did not always complete and update risk assessments for each patient and remove or minimise risks.
- Records were not always stored securely.

However:

- The service provided mandatory training in key skills to all staff.
- Managers regularly reviewed and adjusted staffing levels and skill mix, and gave bank and agency staff a full induction.
- Records were clear and up-to-date.
- Staff understood how to protect patients from abuse. Staff had training on how to recognise and report abuse and they knew how to apply it.
- The service had enough staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment.
- The service managed patient safety incidents well. Staff recognised and reported incidents and near misses.

Requires improvement



Are services effective?

Our rating of effective went down. We rated it as **Requires improvement** because:

- In medical care, staff did not always support patients to make informed decisions about their care and treatment. They did not always know how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health.
- Staff did not always monitor the effectiveness of care and treatment.
- Managers did not always ensure staff followed up-to-date guidance in respect of diabetic foot care.
- In critical care staff showed a lack of understanding about the mental capacity act and deprivation of liberty safeguards. There was no set space for staff to record capacity concerns in patient notes.

However:

Requires improvement



Summary of this inspection

- Staff gave patients enough food and drink to meet their needs and improve their health.
- Staff assessed and monitored patients regularly to see if they were in pain and gave pain relief in a timely way.
- The service made sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and monitor the effectiveness of the service.
- Doctors, nurses and other healthcare professionals worked together as a team to benefit patients. They supported each other to provide good care.

Are services caring?

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

- Staff treated patients with compassion and kindness.
- Staff provided emotional support to patients, families and carers to minimise their distress. They understood patients' personal, cultural and religious needs.
- Staff supported and involved patients, families and carers to understand their condition and make decisions about their care and treatment.

Good



Are services responsive?

Are services responsive?

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

- The service worked with others in the wider system and local organisations to plan care.
- People could access the service when they needed it and received the right care promptly. Waiting times from referral to treatment and arrangements to admit, treat and discharge patients were in line with national standards.
- The service treated concerns and complaints seriously, investigated them and shared lessons learned with staff.

However:

- The service did not always plan and provide care in a way that met the needs of local people and the communities served.
- The service did not always take into account patients' individual needs and preferences. Staff did not always make reasonable adjustments to help patients access services.
- In critical care, patients and visitors may not know how to give feedback and raise concerns about care received.

Good



Summary of this inspection

Are services well-led?

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

- Managers did not always have the right skills and abilities to run the service.
- The service did not always have a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The vision and strategy was not always focused on sustainability of services and aligned to local plans within the wider health economy. Leaders and staff did not always understand and know how to apply them and monitor progress.
- Leaders did not always operate effective governance processes.
- All staff were not always committed to continually learning and improving services.

However:

- Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service promoted equality and diversity in daily work and provided opportunities for career development. The service had an open culture where patients, their families and staff could raise concerns without fear.
- Leaders and teams did not always use systems to manage performance effectively. They did not always identify and escalate relevant risks and issues and identified actions to reduce their impact.

Requires improvement



Detailed findings from this inspection

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Medical care (including older people's care)	Good	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement
Surgery	Requires improvement	Good	Good	Good	Requires improvement	Requires improvement
Critical care	Good	Requires improvement	Not rated	Good	Good	Good
Diagnostic imaging	Requires improvement	Not rated	Good	Good	Requires improvement	Requires improvement
Overall	Requires improvement	Requires improvement	Good	Good	Requires improvement	Requires improvement

Notes

Medical care (including older people's care)

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

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

Good 

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

Mandatory training

The service provided mandatory training in key skills to all staff and made sure everyone completed it.

The service provided mandatory training for all staff.

The mandatory training was comprehensive and met the needs of patients and staff. Ward staff undertook 26 mandatory training modules, including fire, safeguarding, consent, infection control and life support.

Managers monitored mandatory training and alerted staff when they needed to update their training. We found mandatory training compliance was displayed in clinical areas, and staff were reminded by their line manager to complete training before they went over the allowed time.

Endoscopy

We found that at the time of the inspection, nursing and healthcare assistants were 91% compliant with mandatory training. This met the hospital target of 90%.

The clinical service manager was aware of which subjects were outstanding for which staff and had a plan in place to ensure all staff became compliant with the required mandatory training.

Life support training was provided yearly by an external company. Immediate life support was completed annually

by registered nurses and operating department practitioners. Healthcare support workers completed basic life support training. The service also trained all registered practitioners and healthcare assistants in acute illness management every four years. However, completion of life support mandatory training was lower than the provider's target across both theatres and wards. In theatres only 60% of eligible staff had completed basic life support and 65% paediatric intermediate life support. Only 60% of eligible wards staff had completed paediatric basic life support and 77% intermediate life support.

Oncology

Within oncology, 61% of staff were compliant with mandatory training at the time of the inspection. This did not meet the hospital target of 90%. However, the clinical services manager told us that this was due to a number of new staff starting, with one starting the day before the onsite inspection.

We requested current training figures for nursing and medical staff in relation to all levels of life support, including basic, immediate and advanced. The service told us this information was held centrally by BMI Healthcare and this would be provided in due course. However, the service never provided the information to CQC. Therefore, we were unable to determine compliance with life support training.

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.

Medical care (including older people's care)

All ward and theatre staff received training specific for their role on how to recognise and report abuse. However, at our July inspection the leadership team had changed and did not have the correct level of safeguarding training to be safeguarding leads.

Both Directors of Clinical Services had safeguarding adults and children level three at the time of the inspection. As the designated safeguarding professionals within the hospital, both the hospital managers should have children's safeguarding level three and adult safeguarding level three, as BMI has level 4 in adult and children's safeguarding staff at provider level. Both hospital managers were sighted on their training needs and had booked onto a safeguarding children's level three course by November 2019.

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them.

Staff knew how to make a safeguarding referral and who to inform if they had concerns.

The senior leadership team gave an example of a patient who had attended the hospital and disclosed abuse to a member of staff. Staff acted quickly to ensure the support and safeguards were put in place to support the patient and protect them from further abuse and harm.

The service told us that as of July 2019, 100% of staff on Dudley ward and 91.7% of staff on Highbury Unit had completed safeguarding adult's level two. The clinical service manager told us that the 91.7% compliance was due to a number of new staff starting shortly before the onsite inspection activity.

The completion of safeguarding adult's level two was in line with the Intercollegiate Document for Adult Safeguarding, published August 2018.

Cleanliness, infection control and hygiene

The service controlled infection risk well. Staff used equipment and control measures to protect patients, themselves and others from infection. They kept equipment and the premises visibly clean.

All ward areas were visibly clean and had suitable furnishings which were clean and well-maintained.

Staff cleaned equipment after patient contact and labelled equipment to show when it was last cleaned. We found staff used "I am clean" stickers, which were clearly dated, on equipment after they had cleaned it.

BMI The Priory scored 98% for cleanliness under the last Patient Led Assessment of the Care Environment (PLACE) assessment, published August 2018. This compared to a score of 98.8% nationally for BMI Healthcare hospitals, and 98.5% nationally for all independent healthcare providers who participated in the assessment.

Endoscopy

During the inspection, we observed all ward and theatre staff complying with good hand hygiene and infection control best practice.

We observed theatre staff using appropriate hand decontamination processes before undertaking any endoscopy examinations.

Primarily, theatre three was used to undertake endoscopies. Theatre three has clearly demarcated clean and dirty entrance and exits from the theatre to prevent cross contamination.

The endoscopy service had its own decontamination unit. This complied with Health Technical Memorandum HTM 01-06. Instruments came into the dirty side and left the decontamination unit on the clean side, where staff packaged them ready for re-use.

Oncology

We reviewed a hand hygiene audit from the oncology service undertaken November 2018. We found the service had a compliance rate of 97%. One member of staff was found to have a ring on with a stone in it and one alcohol gel dispenser was empty.

During the inspection, we observed all staff complying with good hand hygiene and infection control best practice.

We observed staff either washing or using hand sanitiser at regular and appropriate intervals.

Staff used personal protective equipment (PPE), such as gloves and aprons, when required, for example when preparing and administering chemotherapy.

The Highbury Centre used disposable curtains, which staff replaced at regular intervals. This helped to promote good infection control and reduce the risk of cross infection.

Medical care (including older people's care)

Environment and equipment

The design, maintenance and use of facilities, premises and equipment kept people safe. Staff were trained to use them. Staff managed clinical waste well.

Patients could reach call bells and staff responded quickly when called.

The design of the environment followed national guidance. We found all bedroom flooring and flooring in clinical areas (for example in theatres and treatment rooms) was hard laminate flooring. This allowed the service to ensure the floors were easily cleaned.

BMI The Priory scored 90.3% for condition, appearance and maintenance under the latest Patient Led Assessment of the Care Environment (PLACE) assessment, published August 2018. This compares to a score of 92.7% nationally for BMI Healthcare hospitals, and 94.5% nationally for all independent healthcare providers who participated in the assessment.

Throughout BMI The Priory we found fire prevention and management equipment, including fire doors, fire alarm call points and fire extinguishers.

The entrance to theatres was controlled, preventing unauthorised persons from entering.

Endoscopy

The service had enough suitable equipment to help them safely care for patients.

We reviewed the resuscitation trolley on Dudley ward. The resuscitation trolley was easily accessible for staff and secured with a security tag. Each security tag had an individual number printed on it, and staff checked this daily to ensure the trolley had not been tampered with.

We reviewed resuscitation trolley checks for June and up to 17 July and found staff had checked the trolley daily and signed documentation to confirm this. We checked the equipment within the resuscitation trolley to ensure it was in date and not damaged. We found all equipment checked in date and matched the stock list.

The endoscopy service had access to nine endoscopes for use within the theatre complex at BMI The Priory Hospital. The service had access to the required number of endoscopes for each list.

We requested information from the service about the decontamination of endoscopes. The service provided information that demonstrate compliance with national best practice and standards for decontamination of endoscopes, including the Department of Health Choice framework for local policy and procedures 01-06 – Decontamination of flexible endoscopes: Policy and management. All staff used the BMI flexible endoscopy standards of practice, which set out the requirements for all staff and users of endoscopes. The standards of practice included information on clinical and decontamination standards of care, environmental standards and staff roles, responsibilities and training.

The theatre complex had a difficult airway trolley available for patients who collapsed during sedation or anaesthetic and where staff were unable to regain control of their airway. The trolley was easily accessible to staff within theatres. However, we found the trolley was not tamperproof and staff had not undertaken daily checks since 10 June 2019. We raised our concerns with the theatre manager who ensured the trolley was checked in a timely manner.

We observed staff disposing of waste safely and using the correct disposal method, for example general or clinical waste bins or sharps bins. Staff took sharps bins with them to patients they were inserting a cannula in or taking blood from. This reduced the risk as sharps were disposed of at the point of use and not carried through the ward for disposal.

On Dudley ward, we found the ambient temperature was high, peaking at over 28 degrees centigrade during the inspection. Staff were monitoring and recording the ward, sluice and medication room temperatures daily, and had been completing weekly incident forms due to the high temperatures on the ward. We found the medication room was cooler as this had air conditioning.

The service leads told us that nothing additional had been implemented to support staff or patients with the heat, but the senior leadership team were considering permanent changes as part of a wider redevelopment of the ward.

We found the ward did have two fans in the corridors to circulate air and staff had offered patients fans for their rooms. However, this did not provide a cooling effect.

Oncology

Medical care (including older people's care)

We reviewed the resuscitation trolley on the Highbury Unit. The resuscitation trolley was easily accessible for staff and secured with a security tag. Each security tag had an individual number printed on it, and staff checked this daily to ensure the trolley had not been tampered with.

We reviewed resuscitation trolley checks for June and up to 13 July and found staff had checked the trolley daily and signed documentation to confirm this. We checked the equipment within the resuscitation trolley to ensure it was in date and not damaged. We found all equipment checked in date and matched the stock list.

Staff segregated waste well and ensured cytotoxic waste was disposed of safely. We found separate bins and sharps bins for general, clinical and cytotoxic waste. We observed staff using the correct bins and sharps bins to dispose of waste.

Assessing and responding to patient risk

Staff completed and updated risk assessments for each patient and removed or minimised risks. Staff identified and quickly acted upon patients at risk of deterioration.

All clinical staff completed basic life support training, registered nurses completed intermediate life support and specific members of theatre staff and resident medical officer (RMO) completed advanced life support.

We found a good system in place to respond to deteriorating patients. The hospital had two RMO's on duty 24 hours a day. One RMO was dedicated to critical care and the second to review patients, respond to concerns and attend medical emergencies across the hospital.

Staff used a nationally recognised tool to identify deteriorating patients and escalated them appropriately. The service used the National Early Warning Score (NEWS); which was in line with NEWS2.

The NEWS scoring that was in place did not contain guidance for staff of when to escalate care, although staff had a good knowledge of when to escalate patients. We found this posed a risk to patients not be escalated in line with current best practice, resulting in a delay in review.

The national early warning score (NEWS) charts used did point staff to consider a patient's consciousness level as alert, 'voice', 'pain' or unresponsive. However, the NEWS

charts did not support or prompt staff to consider undertaking a full Glasgow coma scale (GCS) assessment or a mental capacity assessment where a patient's consciousness level had reduced.

The service did have a sepsis pathway in place, and used the guidance and documentation published by The Sepsis Trust UK. We found staff had a good knowledge of sepsis care across the service.

Shift changes and handovers included all necessary key information to keep patients safe. Staff undertook a general safety handover at the start of each shift, which covered areas including incidents, bed capacity, expected admissions for the day and patients that were unwell. Each patient was then individually handed over to the nurse looking after them for the day.

Endoscopy

We asked senior nursing staff on Dudley ward about sepsis medication and access to rapid sepsis care. Senior nursing staff told us that they were currently working on implementing sepsis kits or bags to allow staff to quickly access the equipment required to deliver care in line with current standards. However, all equipment was available to staff within the drugs room, but required staff to gather and assemble the equipment, delaying the testing for sepsis and commencement of treatment.

Sepsis standards require that a patient identified as being at risk of sepsis receive antibiotics within one hour.

We found the service used the World Health Organisation (WHO) safer surgery checklist before undertaking endoscopies. We observed this process taking place and found the process to be embedded and undertaken well.

Oncology

We found staff had a good knowledge of sepsis and neutropenic sepsis. Neutropenic sepsis can affect those patients undergoing chemotherapy treatment.

We found sepsis grab bags available within the Highbury Centre for staff to access should they suspect a patient may be septic.

Nurse and allied health professional staffing

The service had enough nursing and support staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm

Medical care (including older people's care)

and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix, and gave bank and agency staff a full induction.

Endoscopy

Dudley ward had enough nursing staff to provide care and treatment on each shift.

All agency staff received an induction to Dudley ward. However, specific competencies around the post-procedural care of endoscopy patients was not specified as a required skill for agency staff to possess.

We found a low use of agency staff on Dudley ward between April 2018 and June 2019. The service told us that 1% of staff were agency in December 2018 and April 2019. None of the other months had any agency usage on Dudley ward.

For bank staff, we found five out of the 15 months reported had bank staff, and this reduced from 10% of the workforce in April 2018 to 0% from September 2018 to June 2019.

Within the theatre area where endoscopy procedures took place, theatre staff had been given training to support in the delivery of endoscopy procedures. However, there was only one dedicated endoscopy nurse who was the service lead and covered both BMI Priory and BMI Edgbaston. This posed a risk that a dedicated and experience endoscopy nurse would not always be present within theatre during procedures.

Oncology

The service had enough nursing, allied health professional and support staff of all grades to keep patients safe. Each shift had enough nursing and health care assistant staff to support inpatient and outpatient care.

Allied health professionals, including physiotherapists and dieticians, supported the wider care team to ensure patients received the specialist care they required. Physiotherapists would see inpatients in the Highbury Unit as required and assessed as needed. A dietician was available to review all patients as required to provide specialist input.

We found a high rate of bank and agency use within the Highbury Unit. Between April 2018 and June 2019, we

found an average agency use of 17.1% of the total workforce. The highest four months for agency use were May 2018 (28%), June 2018 (24%) and July 2018 and June 2019 (22%).

Between April 2018 and June 2019, we found an average bank use of 1.8% of the total workforce. The highest five months for bank use were June 2019 (7%), June 2018 (4%) and May 2018, March 2019 and May 2019 (3%).

Medical staffing

The service had enough medical staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment.

The service did not employ any medical staff directly. Consultants worked under practising privileges when providing care at the hospital. Individual consultants were responsible for the care delivery to their own patients.

The hospital had two resident medical officers (RMO) on duty 24-hours a day seven-days a week. The RMO could review patients that nursing staff had concerns about and prescribe medication, for example pain relief.

One RMO was allocated to the ward-based patients, and the second to the critical care unit. This ensured that should a patient deteriorate at any time, enough medical cover was in place to support patients, relatives and staff.

RMOs worked seven days on, seven days off. We found the RMOs were visible throughout the inspection. Nursing staff found the RMOs approachable and accessible.

Endoscopy

The service told us they had 14 consultants with practising privileges to undertake endoscopy procedures.

Oncology

The service told us they had 15 consultants with practising privileges to provide oncology services.

We reviewed the personnel file of one oncologist. We found it contained all required and relevant information, including a Disclosure and Barring Service (DBS) check, reference, employment history and training records.

Records

Medical care (including older people's care)

Staff kept detailed records of patients' care and treatment. Records were clear, up-to-date and easily available to all staff providing care. However, we found some instances of records being unsecure and accessible to those that should not have access to them on Highbury Unit.

Endoscopy

Staff completed surgical day case pathway booklets for day case endoscopy patients. However, we found that these records had no mention of endoscopy within them and were not specifically designed for use with endoscopy patients.

Staff completed generic medical admission pathway for all other non-endoscopy medical patients admitted into BMI The Priory hospital. Senior nursing staff on Dudley ward told us they had not admitted a medical patient for over a year.

We reviewed five sets of records for endoscopy patients. We found patients undergoing an endoscopy had pre-assessment documentation, assessments on the day of the procedure and intra-operative documentation. We found World Health Organisation (WHO) safer surgery checklists within patients records.

Staff had completed patient's identifiable information on all documentation, including name, date of birth and hospital number.

We found patient records were stored securely on Dudley ward and only accessible to those that should have access. We found staff locked or logged off computers to protect patient information.

Oncology

We reviewed six oncology records, including inpatient and outpatient records. All records reviewed contained evidence of daily ward rounds (for inpatients), clear multidisciplinary notes and fully completed risk assessments.

We found all five records contained notes of the discussions had with family members of patients. In three cases, where required, we found evidence to show antibiotics had been reviewed as required.

We observed that records were not always stored securely on Highbury Unit. Most records were within an office

behind the central nurse's station. However, the door was left propped open and therefore the room and records were accessible. We also found a small number of records in a notes trolley next to the central nurse's station. The top had been left open and had no way of locking this.

Medicines

The service used systems and processes to safely prescribe, administer and record medicines. However, we found some areas did not store medicines safely.

All medical patients were admitted under the generic medical pathway, which included documentation around medicines.

The front page of the generic medical pathway booklet contained a box to document allergies and a box to document sensitivities. Within the pathway there was a page for clinical staff to document the medication history of each patient, including if the patient was under a specialist for pain management.

For patients requiring medication to be administered as part of their medical admission, staff completed an acute medical medication chart. The chart contained separate areas for regular medication, variable dose medication, subcutaneous and intravenous infusions and antimicrobial prescriptions.

The front of the acute medical medication chart contained a clear area to document allergies and sensitivities, and this was repeated at the top of each page.

The chart also contained a venous thromboembolism (VTE) assessment which gave patients a low, high or very high risk of developing a VTE.

We reviewed five prescription charts during the inspection and found they were all completed as required. All prescriptions were signed and dated by a prescriber, allergies were clearly documented, and we found evidence that medication had been reviewed.

Endoscopy

We checked the controlled and non-controlled drugs cupboards on Dudley ward, as this was the ward that day case endoscopy patients would attend prior to their procedure.

Medical care (including older people's care)

A controlled drug is a medication that has specific requirements about its supply, prescribing and handling under the Misuse of Drugs Act 1971 and subsequent amendments.

On the first day of inspection, staff had not collected the medication keys from Bournville ward, where they were kept securely overnight when Dudley ward was closed. Staff on the ward at the time were not sure who had the keys or if they had been collected. This posed a risk of controlled drugs keys going missing and staff not realising. This also posed a risk of a delay in staff accessing and administering controlled medication when needed.

We checked three controlled drugs on Dudley ward and found the quantities matched the controlled drugs register. We found all three medications were in date.

We checked a number of non-controlled drugs and found these to be in date. However, we found the cupboard with oral medication was disorganised. We found half used boxes of medication of the same type and strength across multiple shelves. We found boxes of medication which could be confused with each other, for example codeine and dihydrocodeine, mixed up together on the shelf. We also found a strip of codeine-based pain relief in the bottom of the cupboard and not within a box.

We raised our concerns with senior staff at the time who assured us this would be rectified by the following day. On day two of the inspection we asked to check the medication cupboard and found some improvements. The strip of tablets had been removed. However, boxes of medication were still disorderly within the cupboard. We also found that different categories of medication, for example pain relief, antibiotics and anti-sickness medication, were not kept together.

Oncology

We reviewed the controlled, non-controlled and chemotherapy procedures on the Highbury Unit. We found all controlled drugs checked matched the controlled drugs register.

Chemotherapy prescriptions were completed on an electronic system. All chemotherapy was produced on site, specific for each patient. We found a good system in place to ensure that chemotherapy was ready for patients

coming in. The electronic system allowed nursing, medical and pharmacy staff to communicate together to ensure chemotherapy was only produced when required, but also available when needed.

Incidents

The service managed patient safety incidents well. Staff recognised and reported incidents and near misses. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support.

Staff reported incidents through an electronic system. Staff spoken to knew how to access the incident reporting system, and what incidents should be reported.

Staff received feedback in relation to incidents. Senior staff displayed information about incidents and feedback on the staff room wall and this was discussed at shift handover huddles.

The service reported no serious incidents or never events between July 2018 and June 2019. The service reported no incidents of moderate or serious harm to patients between July 2018 and June 2019.

We reviewed three other incidents from across the hospital and found the senior leadership team responded in a timely manner and the investigations were detailed. We found the investigations had considered all relevant information in order to form a conclusion and learning.

For further information on incident reporting, please see the Surgery report.

Safety Thermometer (or equivalent)

Staff collected safety information and shared it with staff, patients and visitors.

The service gathered safety thermometer information, including falls, pressure ulcers and harm to patients.

Senior staff ensured the information was displayed in each department for staff, patients and visitors to access.

The service produced a monthly report, which was shared at the medical advisory committee to ensure oversight of risks and performance.

Medical care (including older people's care)

We requested safety thermometer information from the service with regards to medical services, including Highbury Unit and Dudley ward. The service told us they had had no falls, venous thromboembolism (VTE) incidents, pressure ulcers or catheter acquired urinary tract infections affecting medical patients between July 2018 and June 2019.

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

Requires improvement 

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

Evidence-based care and treatment

The service did not consistently provide care and treatment based on national guidance and evidence-based practice. The service did not provide resources for staff to assess and support patients with their mental health.

We found the service did not fully comply with National Institute of Health and Care Excellence (NICE) guidance NG19 diabetic foot problems: prevention and management. Admission documentation did not prompt staff to review diabetic patients foot health in line with guidance.

The generic medical pathway, used for all medical admissions, contained the National Early Warning Score (NEWS) chart. This was in line with NEWS2.

The service used The UK Sepsis Trust guidance and assessment documentation for any patient they suspected of having sepsis.

Endoscopy

The service did not fully consider the mental health needs of patients. Staff asked patients during pre-admission telephone assessments if they had a mental health condition. However, admission documentation did not prompt staff to consider the mental health needs of patients admitted for endoscopy examinations. Admission documentation did prompt nursing staff to check the

telephone assessment information; however, the admission booklets did not provide further assessment or documentation areas for mental health conditions or support.

The service was not JAG accredited but was working towards achieving this. We reviewed the action plan to achieve JAG accreditation within the endoscopy service. We found the action plan addressed some of the areas that were highlighted within the Global Ratings Scale assessment undertaken; however, did not address all of them.

Following the onsite inspection, the service told us the areas without actions on the action plan were where the service were compliant with JAG requirements.

The areas with actions were allocated to an individual and were completed within timescales set out. We found no evidence to show when or if the action plan had been reviewed, and through which governance structures.

Oncology

We found the service used evidence-based pathways to treat patients. The oncology service was working in line with the NICE guidance NG12 suspected cancer: recognition and referral.

The service was working within the NICE guidance CG151 neutropenic sepsis: prevention and management in people with cancer.

Nutrition and hydration

Staff gave patients enough food and drink to meet their needs and improve their health.

On admission, staff assessed all patients' nutritional needs. This included documenting if patients had difficulty in swallowing, weight loss, recurring chest infections or were known to a speech and language therapist (SALT). Where a patient answered yes to any of these points, staff would undertake a swallow assessment to ensure patients were safe and getting enough nutrition and hydration.

On admission, staff assessed all patient's nutritional needs, including if patients were diabetic. This included reviewing what insulin patients were on, where applicable, and any special dietary requirements they may have.

Pain relief

Medical care (including older people's care)

Staff assessed and monitored patients regularly to see if they were in pain and gave pain relief in a timely way.

Staff assessed patients' pain using a recognised tool and gave pain relief in line with individual needs and best practice. Staff assessed pain during each set of routine observations.

Staff prescribed, administered and recorded all pain relief accurately. We reviewed five prescription charts during the inspection and found appropriate pain relief, including as routine and as required, was prescribed and administered as required.

None of the patients we spoke to during the inspection told us they were in pain or required pain relief.

Patient outcomes

Staff did not monitor the effectiveness of care and treatment.

We asked the service leads for endoscopy, the ward areas and oncology about monitoring patient outcomes. All service leads told us that individual consultants monitored their own patients; however, that information was not fed back into the services to improve overall patient care.

We specifically asked within oncology if comparisons and outcomes of patients with similar tumours receiving the same chemotherapy were monitored to allow the wider service to establish the effectiveness of specific types of chemotherapy. However, the service told us that they do not undertake such monitoring of patients.

We requested information about national audit programmes, including outcomes and action plans for improvement, following the onsite inspection activity.

For cancer outcomes, we received three documentation audits, and included no action plans for improvement. The service also submitted the audit and outcome for the MacMillan Quality Environment Mark. However, this was not directly linked to the outcomes of patients on the Highbury Unit.

For endoscopy outcomes, we received an action plan for achieving JAG accreditation. However, the service was not JAG accredited at the time of the inspection; therefore, the information was not in relation to patient outcomes, but the achievement of accreditation.

We were not assured from the information gathered during the inspection process, of the robust monitoring of patient outcomes across cancer and endoscopy services.

Competent staff

Managers did not always appraise staff's work performance. The service made sure staff were competent for their roles.

The service told us that all bank and agency staff undertook a full induction process upon commencement of each shift. The service has access to bank and agency staff's competencies and qualifications before they arrive to commence a shift. This allows senior nursing staff to allocate patients appropriately to those staff with the competencies to care for certain patients, for example those post endoscopic procedure.

The clinical services managers for Highbury Unit and Dudley ward told us that 100% of eligible staff had received an appraisal in the last 12 months. Although data received did not confirm this. Data received showed 90% of staff on the Highbury Unit received an appraisal in 2018 and 55% of staff on Dudley ward had received an appraisal in 2018.

Endoscopy

We reviewed the competencies undertaken by theatre staff to effectively support surgeons in endoscopy procedures. BMI Healthcare had competencies for healthcare assistants and registered nurses and practitioners.

The competency booklets were detailed and provided staff with the required knowledge and skills to support in the undertaking of endoscopy procedures.

For example, the registered nurse competencies included the following:

- Assisting in simple biopsy
- Preparing individuals for endoscopic procedures
- Providing care to individuals recovering from endoscopic procedures
- Acute illness management
- Room preparation for all endoscopic procedures

We reviewed the training matrix for theatre staff in relation to endoscopy procedures. All theatre staff

Medical care (including older people's care)

involved in endoscopy procedures completed a range of training, including decontamination methods for endoscopes. All training was completed either annually or three-yearly depending on the type of training.

The service told us that the following staff had completed endoscopy competencies within the theatre department:

- Two healthcare assistants
- Six registered nurses
- Two operating department practitioners

The service told us that the current level of staffing ensured someone with endoscopy competencies was available for each endoscopy list.

Oncology

Staff administering chemotherapy underwent a yearly review of administration competencies, signed off by a senior nurse. The competency assessment covered all areas of administration including the safe identification of chemotherapy, administration via differing routes and safety precautions around any chemotherapy spillages.

Multidisciplinary working

Doctors, nurses and other healthcare professionals worked together as a team to benefit patients. They supported each other to provide good care.

Endoscopy

We found good multidisciplinary working (MDT) in endoscopy services. We observed theatre, surgical and nursing staff working well together before, during and post procedure to ensure the effective delivery of care.

The service informed the patients GP upon discharge of the care delivered and any ongoing support or care needs once discharged.

We found some disjointed working between the endoscopy team and the theatre team in the coordination of endoscopy list. A newly implemented system to utilise one theatre had started four weeks prior to the onsite inspection visit. However, this was yet to become embedded.

Oncology

We found good MDT working amongst the oncology team. We observed medical, nursing, pharmacy, allied health professionals (for example physiotherapists) and complementary therapists working together for the benefit of the patients.

Patients attending the Highbury Unit for oncology care got a service that was focussed around a good MDT input. All patients had nurse and medical reviews and were referred to and assessed by all other relevant practitioners, for example physiotherapists, as required.

We found good links between the nursing and pharmacy teams to ensure that chemotherapy was prepared onsite and ready for when the patient arrived. This also helped to prevent chemotherapy being produced when no longer needed.

Following the onsite inspection visit, we requested information from the service about multidisciplinary meetings and the structure these took on. The service sent us meeting templates for:

- MDT meetings for recurrent or metastatic disease
- MDT meetings for newly diagnosed breast cancer
- Breast MDT team meeting

The service did not provide the structure in which these meetings took place or any information on the frequency of the MDT discussions or who attended them. Therefore, we were unable to assess how the MDT meetings functioned or if the required professionals were in attendance.

Seven-day services

Key services were available seven days a week to support timely patient care.

Endoscopy

Consultants managed their own theatre lists and endoscopies were undertaken in line with the agreed theatre slots for each consultant.

Should patients require inpatient care, this was available seven-days a week.

Oncology

Medical care (including older people's care)

Outpatient oncology services were available Monday to Friday and nursing staff were available throughout these times to provide support and guidance to patients. The service ran late clinics on a Monday and Tuesday.

The inpatient facilities were available seven-days a week, 24-hours a day. Dedicated nursing staff were available to support inpatient care within the Highbury Unit.

Consultants would visit their patients, when inpatients, each day, seven-days a week, to provide oversight and support.

Health promotion

Staff gave patients practical support and advice to lead healthier lives. However, this was not consistently done for all areas of healthy living.

Endoscopy

We found staff assessed patients smoking history and alcohol intake on admission. This included completing a CAGE assessment, which reviewed patient's alcohol intake, and offering written advice for smoking cessation and undertaking an Alcohol Use Disorders Identification Test (AUDIT) for alcohol intake.

Staff assessed endoscopy patients via telephone pre-operatively. During these discussions, staff asked about alcohol intake, mental health and smoking history.

However, we found no assessment or prompts for staff within the generic medical pathway admission paperwork to discuss other national health priorities, including dementia, obesity, drug use or cancer prevention for non-endoscopy medical patients.

Oncology

We found health promotion within oncology had a lot of written information for patients to support with making healthier life choices. Staff gave information to patients about healthier eating, smoking cessation and alcohol intake.

The oncology service also gave patients information on how to stay safe in the sun following skin cancer. The service also offered support and guidance on how to reduce the risk of infections whilst undergoing chemotherapy treatment.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff did not know how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health. Staff did not assess patients' capacity before or after treatment. Staff supported patients to make informed decisions about their care and treatment. However, they did not follow national guidance to gain patients' consent.

The generic medical pathway admission booklet used in oncology services, and the surgical pathway admission booklet used in endoscopy did not have a section to clearly document mental capacity. Consent forms did not contain any information about the patients' mental capacity.

This posed a risk to patients who lacked capacity as staff may not quickly identify and document within records to ensure the legal frameworks set out in the Mental Capacity Act 2005 were followed.

The generic medical admission booklet directs staff to support patients to self-administer medication, including insulin for diabetics. However, does not prompt staff to consider assessing capacity to ensure it would be safe for patients to administer their own medication.

We asked a senior nurse about the generic medical admission booklet lacking a section for the consideration of capacity. The senior nurse agreed this was missing and was unable to show us any other documentation to support in the consideration and assessment of the mental capacity of patients.

None of the admission pathways contained a prompt or questions around mental health. Staff asked during the pre-admission assessment for endoscopy patients about mental health. However, no further prompts were available to ask about patients previous or ongoing mental health conditions once admitted to the clinical areas for treatment. We found no prompts for staff to provide additional support or guidance to patients who had a mental health condition. This posed a risk that staff may not identify patients at risk of deterioration in their mental health or who require additional support.

We discussed our concerns with the safeguarding lead for the hospital around the lack of mental capacity consideration or documentation within medical pathways.

Medical care (including older people's care)

The safeguarding lead acknowledged this was missing and was unable to provide any further assurance that mental capacity was considered, assessed and or documented by staff within the hospital.

The service used the provider wide mental capacity and deprivation of liberty policy, implemented June 2017 and due for review June 2020. The policy is clear and concise in setting out the principles of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards 2010. The policy states under section 5.2 that all staff directly caring for patients or involved in the organisation of care for a patient were responsible for ensuring they have a comprehensive understanding of the extent of the requirements of the Mental Capacity Act 2005.

Staff did not always understand how and when to assess whether a patient had the capacity to make decisions about their care. We found mixed knowledge amongst staff about the requirements of the Mental Capacity Act 2005. All staff asked could explain what capacity was but had limited knowledge of how they would assess capacity in a patient.

The service provided us with training compliance information. The service told us that mental capacity and deprivation of liberty safeguards is covered across safeguarding training and dementia training.

As of July 2019, data provided by the service showed 100% of staff on Dudley ward had completed both safeguarding adult's level two and dementia training. As of July 2019, the service told us 100% of staff had completed dementia training and 91.7% of staff had completed safeguarding adult's level two training.

We found no evidence of staff undertaking mental capacity assessments on patients. In all 10 medical records reviewed we found mental capacity had not been considered or documented within multidisciplinary notes.

Endoscopy

Staff did not gain consent from patients for their care and treatment in line with legislation and guidance. We reviewed five sets of medical records to review the consent procedure in endoscopy. We found in all five cases, the consent form was signed on the day of the procedure. We found in two cases, the patient was not given a copy of the consent form. This is not in line with current best practice guidance from the Royal College of Surgeons.

The Royal College of Surgeons guidance on taking consent states that patients should sign a consent form at the end of the discussion around consenting to the procedure. Patients should then be given a copy of the consent form to allow time to reflect on the decision. On the day of the procedure, the lead clinician should reaffirm consent for the procedure.

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

Good 

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

Compassionate care

Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.

Throughout the onsite inspection visit we observed staff treat patients with dignity, respect and kindness.

We observed staff supporting patients to and from theatre, ensuring their dignity was maintained by fastening theatre gowns at the back. This promoted the dignity of patients.

Patient feedback gathered by the service was positive, and patients would recommend the service.

Endoscopy

We observed all staff on Dudley ward provide kind, respectful care to patients.

Patients on Dudley ward told us that staff were kind and they were happy with the care they had received.

The ward manager on Dudley ward visited each inpatient every day to ensure that they were happy with the care they had received the previous day. This allowed patients to voice concerns and have them addressed in a timely fashion.

Oncology

We observed nurses providing compassionate, understanding care to patients and those close to them on the Highbury Unit. Nursing staff understood when it was

Medical care (including older people's care)

suitable to smile and laugh with patients. This demonstrated a good understanding of the struggles cancer patients go through, and the need, when appropriate, for humour and normality.

All the patients spoken to on the Highbury Unit told us staff were supportive and respectful. One patient described the service and staff as “brilliant”.

We observed allied health professionals, including physiotherapists, providing support to inpatients who were struggling to mobilise. The physiotherapists were compassionate and showed patience with patients.

Emotional support

Staff provided emotional support to patients, families and carers to minimise their distress. However, staff did not always understand patients’ personal, cultural and religious needs.

Staff across the hospital could access a chaplaincy service for patients. However, we found that staff did not ask about patient’s religious or spiritual needs on admission to support with this aspect of holistic care.

Oncology

Within the Highbury Unit, we found staff supporting patients in a holistic way through the diagnosis, treatment and post-treatment phases of their care pathways.

We observed nursing and medical staff during the inspection providing comfort to patients undergoing chemotherapy treatment as an outpatient. We saw all staff giving time to patients and their families.

Staff had developed a respectful approach to patients and understood when patients needed to laugh and when they needed a quiet, thoughtful discussion, or just time to show emotion.

The service had access to an alternative therapist to help patients relax and deal with the emotions that come with a cancer diagnosis and treatment.

Staff encouraged patients to use all the areas within the Highbury Unit as they needed and wanted. For example, patients could sit and watch the television with other patients and relatives for group support. Equally, staff encouraged patients to have some thoughtful reflection time in the garden. Staff were available for patients and those close to them to call on for support throughout.

Understanding and involvement of patients and those close to them

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

Throughout the onsite inspection visit we observed staff speaking with both patients and those close to them in a way that allowed for questions and queries to be asked, and answers given.

Endoscopy

We observed surgeons explain to patients the procedure that was about to happen and allowed patients and those close to them to ask questions prior to starting the procedure.

Oncology

We observed staff explain procedures, including any possible side effects, to patients and those close to them prior to commencing treatment.

We found that consultants allowed time for patients to ask questions during consultations.

Consultants reviewed their patients who were admitted daily during the admission. This allowed patients and those close to them to ask questions and get timely responses from the consultant on a daily basis.

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

Requires improvement 

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

Service delivery to meet the needs of local people

The service was generally planned and provided care in a way that met the needs of local people and the communities served. It also worked with others in the wider system and local organisations to plan care.

Endoscopy

Medical care (including older people's care)

Endoscopy services met the needs of patients; however, leaders did not always plan services in line with best practice.

The service had not embedded an ambulatory pathway, allowing patients to attend as day case patients. All endoscopy patients attended Dudley ward where they were admitted as an inpatient and then discharged later in the day.

Endoscopy services at BMI The Priory had not been streamlined to provide continuity across the service. Staff had allocated a specific theatre for endoscopies to be undertaken four weeks prior to the onsite inspection. However, prior to this, endoscopies were undertaken in any free theatre.

Oncology

The Highbury Unit had two entrances, one through the hospital and the second directly from the outside of the building. The service had designed the Highbury Unit, so patients did not have to walk through the hospital to access the unit, reducing the risk of exposure to infections to those with lowered immune systems. This also allowed patients receiving chemotherapy to enter and exit the Highbury Unit without walking through the hospital to leave when they had reduced levels of energy due to the chemotherapy treatment.

Macmillan awarded the Highbury Centre, which treats oncology patients, a Macmillan Quality Environment Mark (MQEM).

The Highbury Unit was designed in a way that met the needs of patients and those close to them. The unit was designed with four distinct areas in mind, which were consulting rooms, outpatient pods, inpatient rooms and relaxation spaces.

This layout helped staff to guide patients through the process and pathway of oncology care. Patients entering the unit had a comfortable waiting area with a television that they could control, access to a water cooler and magazines to read.

Each of the six consulting rooms was laid out in the same way. The consulting rooms were spacious and contained an examination couch.

The 10 individual pods were designed to provide comfort, space, privacy and flexibility to patients undergoing

outpatient chemotherapy treatment. Each pod contained a reclining chair for patients and enough room for a loved one to stay with them. Each pod had a curtain to promote dignity and a small window to allow patients to look out into the ward area, but also the ability to closer shutters should they not want others to see in.

One pod was designed specifically to accommodate either a bariatric patient, patients with significant extended family or those requiring multiple infusions to run simultaneously. This pod was larger and contained additional equipment and a chair that could support a bariatric patient.

Patients and those close to them, whether an inpatient or outpatient, could utilise the relaxation spaces. These included a waiting area with a television and magazines and an outside garden area that had been specially designed for the patients. The garden had taken the specific needs of chemotherapy patients into account, including keeping the garden low maintenance, using scented planting and having a covered seating area to protect patients from direct sunlight. The garden was fully wheelchair accessible.

The oncology service had been designed with the patient at the heart of the service. Patients were reviewed by the same consultant from the point of referral to discharge from the service. The patient's own consultant saw patients when they were admitted daily, keeping continuity throughout the care process.

Nursing staff worked across the inpatient and outpatient setting, providing continuity to patients throughout their treatment.

The service had a 24-hours a day seven-day a week on call chemotherapy nurse for patients to access if they had any concerns or worries about their condition.

Meeting people's individual needs

The service took account of the majority of patients' individual needs and preferences. Staff made reasonable adjustments to help patients access services.

We found the service did not always meet the individual needs of patients, including those with a protected characteristic under the Equality Act 2010.

Medical care (including older people's care)

Within the generic medical admission documentation, we found staff did not ask about patients' religious beliefs or requirements. A patient's religious beliefs could influence their decisions on consenting to care. For example, some religions do not believe in accepting a blood transfusion.

Following the onsite inspection activity, the service did provide information that demonstrated staff had access to a refusal of blood products form that could be completed. The service also took account of specific dietary needs of patients. The service also provided evidence staff had access to advanced decision documentation, which could detail any specific requirements.

The service told us they provided dementia training to all clinical staff as a mandatory training module. As of July 2019, the service told us 100% of staff on Dudley ward and Highbury Unit had completed dementia training.

We asked the service if they provided training in learning disabilities to staff. The service told us they did not provide training in relation to learning disabilities to staff.

All staff had access to translation services, including face-to-face, telephone and document translation services. Staff knew how to access these services in both endoscopy and oncology services.

Oncology

Within the Highbury Unit, we found staff did support patient's and those close to them with their individual needs. The service considered the emotional and psychological impact upon patients and those close to them of a cancer diagnosis.

The service had access to psychological support for patients to access should they require this. The service also spoke with patients during pre-treatment appointments about psychological and emotional support, and signposted patients to other organisations that could help with this.

The Highbury Unit was wheelchair accessible throughout, including consultation rooms, treatment pods and the garden space.

Access and flow

People could not access services when they needed it or receive the right care promptly. Referral to treatment and arrangements to admit, treat and discharge patients were not consistently measured across all services.

Endoscopy

We requested referral to treatment (RTT) information from the service with regards the endoscopy service. The service told us endoscopy RTT was not collected but was encompassed within gastroenterology and general surgery information. Colorectal sat within general surgery. The service provided information within regards the RTT for gastroenterology and general surgery.

For general surgery, the service told us they admitted 126 patients between July 2018 and June 2019 for an endoscopy procedure. General surgery patients waited an average of 13 weeks from referral to treatment for their endoscopy procedure.

For gastroenterology, the service told us they admitted 96 patients between July 2018 and June 2019 for an endoscopy procedure. Gastroenterology patients waited an average of 16 weeks from referral to treatment for their endoscopy procedure.

Oncology

We requested information from the service about the ability for patients to access oncology services. The service responded and told us they did not monitor referral to access to treatment times as all the patients were either insured or self-funded.

Learning from complaints and concerns

It was easy for people to give feedback and raise concerns about care received.

BMI Healthcare had a complaints policy in place, which BMI The Priory followed. The policy clear outlined the roles and responsibilities of staff in relation to investigating and responding to a concern. We found the policy contained a clear timeframe for responding to concerns, which was within 20 working days.

Medical care (including older people's care)

On Dudley ward, a ward manager would visit each patient in the morning to discuss their care and deal with any complaints or concerns as soon as possible. Senior staff told us this had helped to resolve complaints and concerns much quicker and at a local level.

We reviewed complaints information from July to December 2018 and found no complaints had been received with regards endoscopy or oncology services at BMI The Priory.

We asked staff about how patients and relatives make complaints, and all staff asked were able to explain the process.

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

Requires improvement 

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

Leadership

Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff. They supported staff to develop their skills and take on more senior roles.

Across all medical services, we found leaders visible and approachable. All staff spoken to felt confident to speak to the leadership team. Staff told us that the senior leadership team at BMI The Priory were visible and visited clinical areas regularly to speak with staff and patients.

Endoscopy

The endoscopy service had two lead nurses overseeing the care delivery and service. One lead nurse was responsible for the procedure part of the service, including overseeing the procedures in theatres. The second lead nurse was responsible for the ward environment, including the pre and post endoscopy care.

Day to day, Dudley ward, where most endoscopy patients were admitted, was managed operationally by one of two ward managers. The lead nurse for the inpatient wards was available Monday to Friday to provide additional senior nurse support across the inpatient wards.

The lead nurse for endoscopy was available Monday to Friday to provide support to the theatre teams. However, we found the lead nurse worked across both BMI The Priory Hospital and BMI Edgbaston sites. This meant the lead nurse was unable to provide the level of support required at each site five days a week.

We found both lead nurses to be committed to delivering high-quality care across their areas. However, the lead nurse for endoscopy was stretched, working across both sites, and therefore had limited opportunities to deliver the improvements needed at BMI The Priory Hospital.

Both lead nurses could articulate clearly the challenges faced by their individual areas, and understood the actions required to improve. For example, the lead nurse for endoscopy could clearly explain the challenges faced at BMI The Priory Hospital in relation to achieving JAG accreditation across the service. The lead nurse could also articulate clearly the need to ensure the endoscopy pathway moves from an admission pathway to an ambulatory pathway.

Oncology

The Highbury Unit was overseen by a lead nurse for oncology, supported by a ward manager.

Day to day, the ward manager oversaw the operational management of the Highbury Unit, including staff allocation and trouble-shooting any problems or concerns from staff and patients. The lead nurse for oncology managed the service strategically and was available Monday to Friday daytimes to provide additional senior nurse support on the Highbury Unit.

Both the lead nurse and ward manager were committed to providing high-quality care across the oncology service. Both local leaders could articulate and demonstrate how the changes made had impacted on patient experiences over the last 12 months, and improved patient care.

Vision and strategy

Medical care (including older people's care)

The service had a vision for what it wanted to achieve; however, no measurable strategy to turn it into action, developed with all relevant stakeholders. The service followed the BMI Healthcare values.

The service followed the BMI provider wide vision, which was 'Serious about health. Passionate about care.'

BMI had provider wide strategic objectives built around the 2015-2020 five-year vision. The objectives focussed on specific areas including: people, patients, communications, growth, governance, efficiency, facilities and information.

Endoscopy

We requested a strategy for the endoscopy service following the onsite inspection visit. The service sent us information on what it wanted to achieve; however, no strategy to support the vision.

Oncology

We requested a strategy for the oncology service following the onsite inspection visit. The service sent us a clinical services framework, palliative care framework (including end of life) and palliative care framework – gap analysis.

The gap analysis submitted was blank and had not been completed. Therefore, we were unable to assess the information in relation to the gap analysis for BMI The Priory.

The clinical services framework was a generic framework for how all clinical services should be ran. It did detail the priorities and principles for the delivery of care to patients. However, there was no localised strategy to implement the framework at BMI The Priory within medical care.

The palliative care framework detailed how palliative and end of life care service should be managed and ran within BMI Healthcare settings. However, it did not detail specific information about the provision of non-palliative oncology care.

Through the information received from BMI The Priory, we were not assured that the service had a measurable and achievable strategy for the implementation of the frameworks.

Culture

The culture within medical services was mixed, and staff did not always promote a culture of respect,

cooperation and supportiveness. A culture of integration was not embedded across all medical services. However, staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service had an open culture where patients, their families and staff could raise concerns without fear.

Endoscopy

We found a mixed culture within the endoscopy service. The endoscopy lead nurse promoted a positive culture around endoscopy and was working hard to form a more integrated endoscopy service. However, we found a lack of oversight and commitment from senior leaders and other clinical areas.

The endoscopy service was not embedded within the theatre complex, and, until four weeks prior to the inspection, did not have a designated theatre in which to undertake procedures. The endoscopy lead nurse and theatre leads had only just started to forge a collaborative relationship to further the endoscopy service within theatres.

Within the ward setting, the lead nurse and ward managers were seen to support endoscopy patients; however, service-wide, there was a lack of positivity about endoscopy service.

We found a mixed approach towards rectifying concerns raised during the inspection within endoscopy. We raised concerns with regards the medicines cupboard and storage of medication. The lead nurse raised the concerns with the nurse in charge overnight and requested actions to be taken to rectify the concerns. However, these were not done, and limited change had been made when we checked the following day.

When the concerns were raised, we found staff did not take collective responsibility for the medication cupboard, with senior staff displaying a blame culture towards the pharmacy team who restock the medicines cupboards. This, combined with a lack of effective, timely actions, did not display a culture of cooperation and supportiveness on Dudley ward.

Oncology

We found a culture of positivity, inclusiveness and support throughout the oncology service.

Medical care (including older people's care)

We spoke with nursing, medical and support staff within the Highbury Unit and all displayed a culture of support and promoted pride in relation to working within the Highbury Unit and oncology services.

All staff spoken to displayed a culture centred on the needs and experiences of patients and those close to them. We observed staff implement care and services in a patient-centred way, and this was embedded as the norm across the oncology service.

We found cooperative, supportive and appreciative relationship between all staff on the Highbury Unit. Senior staff promoted a culture of mutual respect between different professions, and this fostered an environment where staff of all levels and professions respect each other's opinions and acted on concerns to ensure safe, high-quality care delivery.

Leaders within oncology had a focus on staff well-being and recognised the impact long-term patients who die can have on staff working on the unit. All staff had the option to discuss concerns with the ward manager or lead nurse following an incident or death of a patient.

The service had implemented a complementary therapist for patients. Staff were also able to access this service to support and promote holistic well-being.

Governance

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

We found a hospital wide governance structure in place with each service represented. Staff at all levels understood their responsibilities in relation to their role and who to report concerns to.

Both endoscopy and oncology had a programme of internal audit in place. Local leaders monitored results and these were shared monthly with staff. We saw the staff room on Dudley ward displayed the results from the previous month, set out in line with the CQC key questions of safe, effective, caring, responsive and well-led.

Before each shift, staff undertook a safety briefing that looked at incidents, complaints, staffing, bed capacity and

other areas that could impact on the day's activities. Senior staff also shared hospital wide information, such as changes in policies or procedures, and external updates for example from the National Institute of health and Care Excellence (NICE).

Each morning, the senior leadership team and the lead nurses from across all services met for a 'comms cell' meeting. This allowed the senior leadership team to have oversight of the whole hospital and included cross-site information relating to both BMI The Priory Hospital and BMI Edgbaston. This promoted effective cross-service and cross-site working and ensured that all senior leaders were briefed on the challenges facing the two hospitals that day.

The hospital had an embedded medical advisory committee (MAC) that met monthly. We reviewed MAC meeting minutes from June, July, September and October 2018. We found each set of minutes clearly identified action and who was responsible. The minutes highlighted concerns and issues at both BMI The Priory and BMI Edgbaston hospitals and these were discussed separately to ensure targeted actions could be taken.

We found a gastroenterologist sat on the MAC to provide a voice for endoscopy services. We found a haematology consultant sat on MAC to provide a voice for oncology.

Ward meetings happened on a monthly basis. We reviewed team meeting minutes from October and November 2018. We found the minutes to be detailed, with action identified. Standard agenda items included resuscitation, head of department updates, medicines management and infection control.

Endoscopy

The clinical services manager told us a new user's group was being established, headed by a gastroenterologist, and using the JAG accreditation criteria as part of the governance for the group. However, this group had yet to start at the time of the inspection.

Managing risks, issues and performance

The service did not identify and escalate relevant risks and issues or identify actions to reduce their impact. However, leaders and teams did use systems to monitor performance.

We reviewed the risk register as submitted by the hospital as part of the pre-inspection inspection request. We found

Medical care (including older people's care)

the risk register did not have any risks in relation to endoscopy or oncology listed on it. We were not assured that risks in relation to the medical core service had been considered and escalated in a way that allowed the service to have an overview.

During the inspection we identified risks to both patients and service continuity that had not been recognised on the risk register. For example, the risk register contained no risks in relation to the provision of endoscopy services at BMI The Priory, including having one specialist nurse to cover both sites, no allocated theatre space or time, no current ambulatory pathway for patients and a lack of JAG accreditation. Within oncology service, there were no risks associated with the production or delivery of chemotherapy, as chemotherapy is a cytotoxic product.

We also found generic risks that would cover all clinical areas during the inspection that were not on the risk register, for example the lack of mental capacity and mental health assessments on admission paperwork.

When asked, the inpatient lead nurse and the oncology lead nurse both understood the risks within their specific areas. Both lead nurses stated the recruitment and retention of staff was the biggest risk and concern within their clinical areas.

Performance was reported locally and nationally, and a national report was submitted annually, which compared BMI The Priory to other BMI locations around England.

During the previous inspection, published January 2017, we found staff were not using the World Health Organisation (WHO) safer surgery checklist for interventional procedures, for example endoscopy. However, during this inspection, we found the service had improved and staff were using the WHO safer surgery checklist within theatres for interventional procedures.

During the previous inspection, published January 2017, we found that staff stored medication at temperatures that could compromise the effectiveness of the medication. However, during this inspection, we found staff monitored the ambient temperature of the medication room and air conditioning had been installed within the medication room on Dudley ward.

Managing information

Staff could find the data they needed, in easily accessible formats, to understand performance, make

decisions and improvements. The information systems were integrated and secure. Data or notifications were consistently submitted to external organisations as required. However, the service did not consistently collect reliable data and analysed it.

Staff had access to a BMI internal intranet system that provided them with up to date policies, procedures and changes to practice.

We found a mixed approach to collecting data about patient outcomes and using it to improve care. Neither the oncology or endoscopy service gathered information on patient outcomes. Therefore, we were not assured the medical service had good oversight of the outcomes of patients or the ability to use information to improve care and outcomes.

Following the onsite inspection, the service told us that they had introduced a new system to gather information about patient outcomes. The service told us that this would help to improve monitoring of outcomes in the future.

Staff kept medical records safe and secure on Dudley ward. However, we found some records accessible on Highbury Unit in a records trolley next to the nurses' station.

On both Dudley ward and Highbury Unit, staff locked computers or logged off to protect patient identifiable information.

Quality and sustainability did receive equal coverage within meetings. We reviewed medical advisory committee meeting minutes and team meeting minutes and found both quality and sustainability, including finances, were discussed and each given sufficient time on the agenda.

We found the senior leadership team engage well with external stakeholders, including CQC as the healthcare regulator. The senior leadership have submitted, as required, notifications in a timely manner to CQC, as required by the Health and Social Care Act 2008.

We found the senior leadership team have been engaged before, during and after the onsite inspection visit, and have been open to improvements and challenge from CQC.

Engagement

Leaders and staff actively and openly engaged with patients and staff.

Medical care (including older people's care)

The service gathered feedback from patients through questionnaires given to patients at the end of their treatment or inpatient stay.

The ward manager on Dudley ward visited each patient daily to collate informal feedback about the care and approach of staff. This allowed senior nursing staff to address concerns from patients in a timely manner.

Endoscopy

The clinical service manager told us there is a BMI endoscopy nurses support group, which provides support to all endoscopy nurses across England.

The endoscopy service had published patient stories on its national website for other patients to read.

The service told us that it has commissioned local newspaper articles to engage with patients. However, this was not medical care specific and was more about general engagement with the local community.

Oncology

The Macmillan lead cancer nurse was a member of the corporate Cancer Clinical Development Group which met bi-monthly. Staff were consulted and encouraged to put forward their ideas or suggestions and these were fed into the committee for discussion. Information and progress on projects were cascaded back down to the local team. Topics range from policies, audits, training requirements and requests as well as issues for discussion around current practice.

The breast care service set up a patient support group called the 'foxglove breast cancer support group' based on patient feedback and now have an established group that was facilitated by the breast care nurse specialists. Patients met off site and the users set the agenda. Guest speakers were arranged as required.

Learning, continuous improvement and innovation

All staff were committed to continually learning and improving services. They had a limited understanding of quality improvement methods and the skills to use them.

We found a want across the medical service to continually improve and learn from when things went wrong and when things went well.

Endoscopy

We found the clinical services manager for endoscopy was dedicated to improving the service to ensure it met the needs of patients and met best practice outcomes.

The clinical services manager had a vision of where they wanted the service to be and understood the improvements that needed to be made.

The clinical services manager (CSM) for endoscopy demonstrated a good understand of the constraints of achieving JAG accreditation with an endoscopy service based within a theatre complex. However, the CSM explained the ways in which they wanted to implement innovative ideas to achieve the best practice standards of JAG, whilst still providing the service within the constraints of the current estate.

Oncology

The oncology service displayed continual improvement for both patients and staff. The service had recently introduced a complementary therapist into the team for both patients and staff to access to improve overall wellbeing.

Staff volunteers from different units piloted new equipment, and the Highbury Unit recently trialled a new chemotherapy closed intravenous system for increasing nurse and patient safety during chemotherapy administration. Post-trial feedback was provided on a conference call with other units who trialled the same products.

At local level staff contribute to the operational side of the Highbury Unit and new ideas were encouraged and tried. For example, the Highbury Unit was making better use of the resources and space on the unit by creating a mini nurses' station within the Chemotherapy area to increase the nurses presence and visibility to patients attending for Chemotherapy.

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

Are surgery services safe?

Requires improvement 

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

Mandatory training

The service provided mandatory training in key skills to all staff however, not everyone had completed it.

Mandatory training was provided on a range of subjects. There were 25 mandatory training modules for theatre staff and 26 for ward staff. Mandatory training was provided in subjects such as fire; safeguarding; conflict; consent; infection control and life support.

The service set a mandatory training compliance target of 90% including new staff, and 100% excluding new staff. Staff were ineligible for their nominal pay increase if they were not compliant with training. A target of 95% had also been set by the clinical commissioning group (CCG) as part of the service level agreement to treat NHS patients. At the time of inspection, overall mandatory training compliance for theatres was 88% and 91% for wards. This was below the targets set by both the provider and the local CCG.

Managers had a system to monitor staff compliance with mandatory training. Managers could access an online mandatory training tracker, staff were then individually informed if they needed to take any action. We were not assured that this system was effective due to low compliance rates in some individual modules.

Life support training was provided yearly by an external company. Immediate life support was completed annually

by registered nurses and operating department practitioners. Healthcare support workers completed basic life support training. The service also trained all registered practitioners and healthcare assistants in acute illness management every four years. However, completion of life support mandatory training was lower than the provider's target across both theatres and wards. In theatres only 60% of eligible staff had completed basic life support and 65% paediatric intermediate life support. Only 60% of eligible wards staff had completed paediatric basic life support and 77% intermediate life support. We were not told of or provided within any plans to increase these mandatory training figures.

Sepsis recognition and management was delivered as part of the care and communication of the deteriorating patient mandatory training module. However, at the time of inspection only 56% of eligible theatre staff and 39% of ward staff had completed this. A nurse education day was held in December 2018. Sepsis recognition and management was covered as a part of this day. Leaders were able to explain the staff member who taught the course had left the hospital and had recently been replaced. We were told it was a priority to start delivering this training course again. The low compliance with mandatory training rates was not entered as a risk upon the services risk register.

Low compliance was noted in information governance for both theatres and ward staff. Thirty four percent of eligible staff within theatres and 61% of ward staff had completed this training. We were not told of or provided within any plans to increase these mandatory training figures.

Staff and management told us they used times of lower activity to complete training. Any periods of lower patient occupancy or activity would be used to complete

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mandatory training. Staff were able to complete on-line learning at home at the discretion of the manager and take the time back as time off in lieu. Some face to face training was provided on off duty days so staff could attend.

The service only used one agency to provide staff. The agency ensured that all staff were compliant with mandatory training before allocating them to work at the hospital. We were told of occasions where the agency had stopped staff from working until their training had been updated.

All new staff and bank workers were required to complete all mandatory training within three months of starting their role.

Safeguarding

Staff understood how to protect patients from abuse. Staff had training on how to recognise and report abuse and they knew how to apply it.

Staff had access to safeguarding policies that reflected best practice guidance. The safeguarding adults policy was under review at the time of inspection. The policy provided information on mental capacity, Deprivation of Liberty Safeguards (DoLS) and PREVENT which aims to safeguard people and communities from the threat of terrorism. Staff we spoke to were aware of their responsibilities and how they would raise concerns.

All BMI employees received some form of safeguarding training. All clinical staff involved in the direct care of children were trained to safeguarding children level three every two years. Surgical ward staff were also trained to this level as children may attend the ward as visitors. At the time of inspection, staff also had access to two safeguarding leads who were level five children's safeguarding trained. All clinicians were also trained to safeguarding adults' level two every two years and had access to level three trained staff for additional advice and support.

At the time of our inspection, information provided showed compliance with safeguarding training for surgical ward staff was at 100%. Theatre staff were 98% compliant with safeguarding training overall. Modules that were not at full compliance were safeguarding children level two, which was at 97% and safeguarding adults level one, which was at 95%.

Staff we spoke to could discuss their roles and responsibilities in relation to safeguarding and knew who to contact for support if needed.

A chaperone policy was in place outlining staff responsibilities regarding chaperoning and when one should be offered to a patient. However, the copy of the policy we were provided with was under review at the time of inspection.

Consultants were required to evidence their safeguarding training as part of their practising privileges. We saw in meeting minutes that senior leaders discussed when these needed updating for certain individuals. Evidence of this training completion was required by the provider before practising privileges were issued and reviewed.

Cleanliness, infection control and hygiene

The service controlled infection risk well. The service used systems to identify and prevent surgical site infections. Staff used equipment and control measures to protect patients, themselves and others from infection. They kept equipment and the premises visibly clean. However, we were not assured that all of the physical environment in theatres was in line with infection prevention best practice.

All ward areas we visited were visibly clean and tidy. Cleaning was provided by an in-house team of BMI cleaning staff. We saw individual jobs were given to specific cleaners to ensure tasks were completed and individual patient rooms had charts for cleaners to complete when they had visited and cleaned each area.

Cleaning team leaders carried out cleaning audits and reported back any issues or areas of non-compliance for staff to follow up on. Throughout the inspection we saw nursing and cleaning staff working together to ensure rooms were cleaned in a timely way to ensure they were ready for the arrival of the next patients. We spoke with one member of cleaning staff who could describe the process if a deep clean was needed, for example; if an infectious patient had been in the room.

Nurses were allocated to clean medical devices. A cleaning folder was present on each ward to ensure all medical devices were thoroughly cleaned on a weekly basis. We saw the cleaning log on Bournville ward was not consistently completed, for example in February 2019 the cleaning schedule had not been completed at all in week one, had

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six gaps in week two, one gap in week three and four gaps in week four. However, improvements did take place through March and April 2019. Staff marked the date they had cleaned equipment with 'I am clean' stickers which were in use across both wards and the theatres.

Staff had completed mandatory training in infection prevention and control. At the time of inspection, 89% of eligible theatre staff and 93% of surgical ward staff had completed the required training. Infection prevention and control link nurses were in place. These staff members received additional training in infection prevention and control which they could then share with the department.

Infection prevention and control audits were conducted. Infection prevention and control equipment audits were carried out, which covered areas such as availability of cleaning materials, observation of cleanliness and cleaning schedule completion. Both wards scored 94% in March 2019, against a target of 95% in infection prevention and control observational audits. The same area of non-compliance was found with the equipment storerooms being cluttered and inappropriate items stored in them. A standard precaution audit was completed which observed staff compliance to basic infection prevention practices. We saw results improved from 91% in March 2019 to 100% in May 2019. Invasive device audits covering aseptic non-touch technique and catheter management were also performed, the results from March 2019 showed 100% compliance.

Infection prevention and control performance was discussed at committee meetings. We saw two sets of minutes of the infection prevention and control committee meetings. Infection control issues from across the two BMI Birmingham sites were discussed and escalated. Agenda items included infection prevention and control mandatory training, audits and link nurse feedback. We saw actions were logged and assigned to individuals and revisited at the next meeting.

Control measures to prevent the spread of infection and communicable diseases were in place. Personal protective equipment in a range of sizes and hand sanitizer was available in all areas of the hospital we visited. Disposable curtains within theatres had also been changed within the last six months. Respirator masks were available if necessary for procedures that carried a high risk of infection. Individual patient rooms enabled isolation and

barrier nursing of patients to be performed if needed. From October 2017 to September 2018 no cases of MRSA, MSSA or C.Difficile had been reported. One case of Hospital acquired E.Coli had occurred.

We observed staff complying with good hand hygiene practice. We observed staff members washing their hands between patient contacts and all staff were bare below the elbows. We reviewed hand hygiene audits for the ward and theatre staff from November 2018, theatre staff showed 100% compliance with ward staff achieving 93%. Areas of non-compliance for ward staff included not using hand gel to sanitise hands and one staff member wearing a stoned ring. Further results showed that compliance dropped in March to 59% for Bournville ward and 68% for Dudley ward then increased again in April 2019 to show ward staff overall achieved 92% compliance and 97% in May 2019 compliance target for hand hygiene audits was set at 95%.

A uniform policy was in place and management audited staff compliance with it. We saw audit results from March 2019 which showed high compliance. However, three staff members were non-compliant due to the amount of jewellery they were wearing. During the inspection we observed two ward-based nursing staff members who had more than the permitted number of earrings outlined in the policy.

Staff followed best practice guidelines to stop the development or spread of infection. During the inspection we saw nurses assessing cannula sites to ensure they were clean and free from signs of infection. We also observed care being given using aseptic non-touch technique (ANTT).

We noted various areas within the anaesthetic rooms where cleaning could not effectively be performed. We saw points where laminate work surfaces were chipped and broken. This is not compliant with Health Building note 26, facilities for surgical procedures 1(3.108) 'The quality of finishes in all clinical areas should be readily cleaned and resilient.' This was not on the risk register. We raised this as an issue during the inspection, we were provided with a theatre replacement plan which was due to start in 2019 which included replacing these areas.

Sterilisation of surgical devices was carried out off site. Sterilisation of equipment was carried out at another BMI location with a 24-hour turnaround time for equipment. Equipment to be sterilised was picked up and delivered

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twice per day at 6am and 3pm. Staff told us there was no ability for a fast turnaround of equipment however, we were told this had not impacted upon equipment availability as packs were ordered in per operation.

Surgical site infection rates at the service were low. Surgical staff followed best practice in relation to skin preparation and management of post-operative wounds. Surgical site infections were recorded as 0% for patients in January 2019, 0.14% in February 2019 and 0.15% in March 2019. When a surgical site infection had developed it was incident reported and reviewed. The consultant and procedure was identified to allow for ongoing monitoring of themes.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment did not always keep people safe. However, staff were trained to use them. Staff managed clinical waste well.

The service had two dedicated adult surgical wards, Bournville and Dudley. Each ward was made up 22 individual en-suite patient rooms. The corridors and doors were wide to allow for trolleys and wheel chairs to pass through with ease. Each ward also had a patient lounge that patients and their visitors could use. Door frames were protected with plastic bumpers to minimise marks and scuffs from contact with trolleys and wheel chairs.

Each patient bedroom contained a bed, arm chair, a chair for visitors and a sink with non-touch taps. Each room also had a bedside unit with a lockable draw to keep valuables in throughout a patient stay. Each room had an en-suite with hand rails for use to help disabled and post-operative patients.

The hospital had five operating theatres. Three of these theatres were laminar flow and were used for orthopaedic, implant and eye procedures. Each theatre had an attached anaesthetic room. The theatre corridors were cluttered with a lot of screening and other equipment stored there but fire exit routes were still accessible.

Resuscitation equipment was kept in a prominent location on both wards and within theatres. Theatres also had access to a difficult intubation trolley. We reviewed the

resuscitation trolley folder and saw that staff signed to confirm that equipment had been checked daily. We saw the trolleys were well ordered, and that drugs and consumable items were in date.

Bariatric surgery was performed and therefore a range of bariatric equipment was available such as beds and trolleys.

Implants for cosmetic surgery were ordered per patient. Implants were ordered in specifically for each patient and no stock was held on site this enabled details or specific implants to be easily tracked.

Some surgical equipment was aged and needed to be replaced. Seven of the anaesthetic machines were past their ten-year effective life cycle. At the time of inspection, the service did not have access to a spare anaesthetic machine. The Association of Anaesthetists of Great Britain and Ireland (AAGBI) have highlighted that clinicians should be wary of using equipment over the age of seven years. Issues with the age of some of the surgical equipment was raised at our last inspection but this was yet to be rectified. We saw documentation during the inspection that showed the equipment had still been maintained and serviced in accordance with manufacturers recommendations. We saw evidence that five new anaesthetic machines had been purchased and were due to be delivered mid-2019. The guidance system used for craniotomy surgery was also past its intended life span and had received its last software update, a contract of maintenance had been extended until August 2019 and after this point would need replacing, this was noted upon the risk register. Following our inspection both the anaesthetic machines and guidance system were replaced as a part of BMI's capital investment programme.

There was a dedicated staff member within surgery with responsibility for instrumentation and loan kit and machinery for procedures. We saw that surgical kits ready to be used in operations were stored in a temperature controlled sterile environment.

The environment of the theatres and anaesthetic rooms was not always fit for purpose. Anaesthetic room four had experienced a flood last year and repair work was yet to be carried out. We found two cupboard doors were not attached and the storage unit was in a general state of disrepair, therefore the finish of the room was not to a high standard and this also posed infection risks to staff and

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patients. We also noted various points in other anaesthetic rooms where laminate work surfaces were chipped and broken. This was not compliant with Health Building Note 26, Facilities for surgical procedures Volume 1 (6.15) that states the quality of all finishes should be of a high standard. Door frames within the theatre environment and the main exit corridor, where patients were transported through were chipped and marked. This is not compliant with Health Building Note 26, Facilities for surgical procedures Volume 1 (6.35) materials for doors and frames should be able to withstand frequent impact from mobile equipment and (6.16) finishes should be robust enough to withstand accidental impact, and additional protection should be provided at likely points of contact. Wall protection is advised in all corridor and heavy traffic areas. We saw evidence that contractors had been approached to complete a refurbishment of all anaesthetic rooms and quotes to carry out this work had been received. It was not clear from documentation we saw however, if this work extended to the corridors.

We also saw one of the sets of doors between an anaesthetic room and a laser enabled theatre had a length of skirting board nailed to the doors to seal the gap between the two doors. We felt that this did not safely or effectively address the problem. This issue was not upon the risk register and we did not see that a risk assessment had been performed. We saw evidence that the theatres were in the process of being updated. Replacement doors had been ordered and initial work towards replacing them was due to take place in 2019.

Not all laser signage was appropriate. Although laser signage was present above the theatre doors, these doors were not onto the corridors and were into the anaesthetic room. Therefore, there was a risk that staff may not be adequately alerted to the risk of a laser being in use. Two of the laser theatres did not have electronic signage on the rear set of theatre doors. This was on the theatres risk register but had been the case since 2015. Laminate posters were displayed on the anaesthetic rooms doors which faced onto the main corridor to warn staff that lasers were in use however, these signs were permanently displayed throughout our inspection. We therefore felt this mitigation was not effective. The Medicines and Healthcare products Regulatory Agency (MHRA) DB2008(03) guidance advises that 'signs should only be displayed or illuminated during the laser/IPL procedure. Wherever possible it is advised that the warning signs should be either removed or

reversed or switched off at the end of the laser/IPL procedure i.e. when the hazard is no longer present'. We raised the issue of laser signage at the time of inspection and were told that this was being included in the planned theatre replacement process.

Systems were in place for the segregation and correct disposal of waste materials such as sharp items and those contaminated by bodily fluids. This included secure sharps containers with temporary closure ability for the safe disposal of needles. Clinical waste was appropriately separated before disposal. However, when we first visited the clinical waste cupboard in theatres clinical waste bags and sharps containers were stacked above head height. This posed a health and safety hazard to staff members. We highlighted this during the inspection and later saw that this had been rectified.

Assessing and responding to patient risk

Staff completed and updated risk assessments for most patients and minimised risks. Staff identified and quickly acted upon patients at risk of deterioration.

Methicillin-resistant *Staphylococcus aureus* (MRSA) testing was carried out at pre-operative appointments for all surgical patients. We reviewed four sets of patient records and saw that MRSA swabs had been taken and results documented.

We observed one patient going through the admissions process to the ward. The nurse checked the patient's identity and all medical history and medication. Risk assessments were performed, and the patient measured for compression socks to help prevent the formation of deep vein thrombosis (DVT) during their admissions. Patients also had their observations taken and documented.

A combined risk assessment was performed upon each patients' admission. The joint risk assessment included pressure injury assessment, falls risk and moving and handling assessments which informed patients' care plan for their admission.

Venous thromboembolism (VTE) risk assessments were not always completed. Results from VTE monthly audits showed, in February 2019, 88% of patients had a VTE risk assessment completed at their pre-operative appointment or upon admission, this figure fell to 75% in March 2019.

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This had been highlighted by leaders and heads of departments had been reminded all patients, regardless of procedure or length of stay, should have a risk assessment performed. This was communicated to nursing staff through morning briefings. We saw this issue had been escalated and was discussed at the clinical governance committee. During inspection we reviewed four sets of patients notes and all had a completed VTE assessment in place.

Nurses performed patient observations regularly. We observed staff performing National Early Warning Scores (NEWS2). NEWS2 is a quick and systematic way of identifying patients who are at risk of deteriorating. Clinical observations such as blood pressure, heart rate and respirations were recorded and contributed to a total score. Once a certain score was reached a clear escalation of treatment was outlined. We observed staff performing NEWS2 observations in line with set time frames depending of the patients previous score. We saw both wards had recently started an initiative where the patients NEWS2 score and the time their next observations were due were written on a sign on their door to remind staff to complete them in a timely manner. Staff reported this had had a positive effect on ensuring patients observations were recorded in the desired time frame.

Managers completed monthly NEWS2 audits on both wards. We reviewed the last two NEWS2 documentation audits performed on the surgical wards and results showed 100% of scores had been calculated and escalated correctly. During the inspection we reviewed four sets of patients records and saw NEWS2 had been completed each half hour upon the patients return from surgery and then in line with their score following that. Senior nurses were proactively checking that observations were being performed.

A sepsis policy was in place that reflected national guidance. Staff we spoke with were knowledgeable about the triggers for sepsis and could describe the steps they would take if they suspected sepsis, which included immediate escalation to the nurse in charge and RMO. A sepsis folder with actions to take and sepsis screening forms was available on both wards and sepsis information was also displayed upon the ward walls for patients and staff to see.

At the time of inspection, there was low completion of the mandatory training course in care and communication of

the deteriorating patient by relevant staff. Fifty-six percent of eligible theatre staff and 39% of ward staff had completed this. However, during the inspection we saw staff appropriately escalating patients to the resident medical officer (RMO) if they were concerned about any of their observations. We observed one nurse escalate her patient immediately to the RMO and lead sister when they became concerned for a patient after their observations changed.

The service had two RMO's which staff could contact for support who provided medical cover 24 hours a day. Although one was dedicated to the intensive care suite they would help across the rest of the hospital if required. The RMO was available to be contacted via a bleep system in emergencies. Each ward also had a folder in which non-urgent requests for the RMO could be documented and this folder was checked when they visited the wards.

Consultants were responsible for reviewing their own patients. Nurses confirmed they were able to speak to consultants about specific patients when needed.

A resuscitation meeting was held every morning. Staff from across the hospital attended and roles individuals would take in the event of a cardiac arrest were assigned. Staff also discussed any patients who were particularly unwell across the hospital and those who had do not resuscitate orders in place.

Staff were aware of how to access out of hours support. A copy of the on-call rota covering all areas of the hospital was displayed. This enabled staff to contact the right member of staff quickly in an emergency. The RMO was also available to be bleeped overnight to attend to emergencies.

The service did not operate on very high-risk patients. The American Society of Anaesthesiologists (ASA) score assesses the physical status of a patient before surgery from one (normal healthy patient) to five (patient is not expected to survive). Surgery at The Priory Hospital was carried out on up to and including ASA level three which includes patients with severe systemic disease.

The hospital had an onsite intensive care unit (ICU). This could cater for up to level three patients and could be staffed 24 hours a day dependant on requirement. There

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was also an on-call rota for an ICU consultant to provide support in addition to the RMO. The ICU also provided an outreach team during the day that could assess patients that had been escalated to them on the wards.

There was a dedicated on-call full theatre team at all times for emergency surgery and returns to theatre. All theatres were suitably equipped to deal with emergencies if required.

A major haemorrhage protocol was in place and staff were aware of the procedure. Arrangements were in place in case of a life-threatening haemorrhage within theatres. Blood was available for immediate transfusion if required and was provided by automated dispensing to ensure the correct blood products were selected.

The hospital used the World Health Organisation (WHO) surgical safety checklist but staff were not always compliant with completing this. The completion of this checklist pre, during and post procedures keeps patients safe from avoidable harm or errors if followed correctly. The service audited its WHO compliance. We were provided with a copy of an undated audit of 30 WHO checklists, which showed an 89% compliance overall. Out of the 30 records audited none recorded 100% compliance on the audit. Results ranged from 19/32 criteria completed to 29/32. One WHO checklist had no information about the 'Sign out' step documented with others not having potential critical events or equipment availability documented during the process. We also reviewed a root cause analysis investigation for a surgery related incident that occurred in late 2018, non-compliance with the WHO checklist was cited as one of main contributing factors. However, during our inspection we observed staff following this process and checked completed checklists in patients' records. We found that all theatre staff were involved in the completion of the checklist and it was done collaboratively and to a high standard.

All clinical staff within theatres were trained to a minimum of intermediate life support (ILS). All anaesthetists were trained in advanced life support (ALS) along with the resident medical officers and some of the recovery team staff. According to The Association of Anaesthetists of Great Britain and Ireland (AAGBI) Immediate Post-anaesthesia Recovery 2013 guidance states 'At all times, at least one member of staff present should be a certified Acute Life support (ALS) provider and, for children, hold an appropriate paediatric life support qualification. All staff

should be encouraged to attain and maintain at least one such life support qualification.' The service was not always meeting these guidelines as they were unable to provide assurance that at least one ALS trained member of staff was dedicated to the recovery areas at all times. This was not on the hospital's risk register. However, both RMOs on site were trained to ALS level and would be able to attend if required in an emergency. Post inspection we were provided with data that showed only two of 22 eligible anaesthetists and recovery staff held an up-to-date ALS certification. We saw a training plan for anaesthetists and recovery staff to become ALS training and training dates had been booked throughout 2019 to increase the level of ALS trained staff available in this area.

The Control of Substances Hazardous to Health (COSHH) regulations were met. We saw COSHH items were stored in lockable metal cabinets.

Nursing and support staffing

The service had enough nursing and support staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix, and gave bank and agency staff a full induction.

Staffing levels were pre-planned. The service used the BMI healthcare nursing dependency and skill mix planning tool. This tool assisted management in ensuring that the right amount of staff were on duty at the right time to respond to patient acuity. As all admissions were elective this was populated and reviewed five days in advance to ensure staffing levels reflected activity.

Ward nursing levels had been set at one nurse to six patients to reflect the increased risk of patients being in individual rooms and complexity of some patient procedures. Any patients who may need a higher level of support but still ward based were nursed at a one nurse to four patient ratio.

We were provided with data showing bank and agency usage on the wards in the four months before our inspection. Data shown is for all wards at BMI The Priory and not just for the two adult surgical wards. Agency usage for registered nursing staff was 9% in January 2019, 9.7% in

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February 2019, 9.2% in March 2019 and had risen to 17.9% in April 2019. Bank and agency usage for health care assistants was 1.7% in January 2019, 1.8% in February 2019, 1.7% in March 2019, and 2.8% in April 2019.

We were provided with data showing bank and agency usage within theatres in the four months before our inspection. Agency usage for registered nursing staff was 2.2% in January 2019, 5% in February 2019, 4.4% in March 2019 and 2.6% in April 2019. No bank and agency health care assistants were used within surgery.

Sickness rates across the surgical wards and theatres were low. Data showed that the average monthly sick rate for ward-based nursing staff across the hospital in 2018. Data showed that the average monthly sick rate for theatre operating department practitioners and health care assistants was 0.6% in 2018.

A low turnover rate of staff was reported. A 0% turnover rate was recorded for nursing staff between January 2018 to December 2018. There was a 0.6% turnover rate for operating department practitioners and health care assistants.

At the time of inspection nurse staffing was the main risk documented for the wards due to vacancies and high agency usage. Leaders had taken multiple steps to increase recruitment and to secure the provision of bank and agency staff. The service had links with two local universities and took on student nurses. Five nurses had recently been recruited and were going through new starter checks and procedures.

Nurse staffing for each ward was displayed on entry to the ward. Dudley and Bournville wards had slightly different staffing allocations based upon the type and number of patients on each ward. On both days that we visited, both wards met their planned staffing levels for both registered nurses and health care assistants. In October, November and December 2018 there were zero unfilled shifts.

Each ward had a lead sister who was supervisory on each shift. This was put in place as leaders recognised a lot of agency staff were used. The lead sister was there to maintain consistency, seniority and to have oversight of all patients. The lead sister also provided a point of escalation for other staff.

A nursing associate was working on the wards. The service utilised the support of a nursing associate. The staff

member had previously been a health care assistant and was being supported through the completion of the nursing associates' course at a local university. This was the first position of its kind within the hospital.

Theatres were staffed in line with The Association of Anaesthetists of Great Britain and Ireland (AAGBI) and the National Institute for Health and Care Excellence (NICE) guidance. This ensured there was the right number of individuals with the correct qualifications and experience to care for patients.

An induction policy was in place that covered all new substantial and agency staff coming to work at the hospital. A 90-day workbook was part of induction process to be completed with the new starters line manager. The induction work book provided a framework to ensure they had accessed or knew where to find the information that would be useful as a part of their role.

Huddle meetings were held on the wards. A handover huddle was held each morning and evening at the start and end of nursing shifts. All nurses across both surgical wards attended. An overview of patient numbers, admissions, expected discharges and staffing was discussed. Nurses were then allocated to each ward based on patient numbers and the acuity level of patients at the time. Individual patients were then handed over from nurses leaving shift to those coming onto shift where their condition, NEWS2 score, any appointments for the day and other important information was discussed.

Theatre staff also held a morning huddle meeting. A huddle meeting occurred within the theatres where the lists for the day, any expected complications and staffing was discussed.

Medical staffing

The service had enough medical staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment.

The service did not employ any consultants directly. Over 500 consultants had practising privileges at the hospital and would make arrangements individually to review their patients when they were on the ward. Nurses were able to contact consultants about their patients if needed when they were off site.

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Consultants were granted practising privileges to see patients at the hospital. Practising privileges were granted at the discretion of the executive director in consultation with the medical advisory committee. These privileges were reviewed yearly to ensure consultants still met the standards expected by the provider.

Residential medical officer (RMO) provision was provided by an external company who was responsible for overseeing all training. The minimum requirement for an RMO was two years' post-registration experience in both medicine and surgery. Two RMOs were on duty, one mainly to cover the intensive care unit and the other to cover the surgical wards. The RMOs worked one week on one week off shift patterns to ensure adequate rest. We saw the RMOs were visible and accessible throughout our inspection.

Records

Staff kept detailed records of patients' care and treatment. Records were clear and up-to-date however, they were not always stored securely.

All patient records were in paper format. At the time of inspection, we were told there were no plans to move toward an electronic patient record.

Not all records were stored securely. We saw that patient's nursing records were stored in folders within their rooms to allow contemporaneous nursing notes to be completed. When patients left their rooms for extended periods rooms were locked. Medical records on both wards were kept in an unlocked cupboard behind the ward clerk's desk. Cupboard doors were often left open exposing the notes within. During the inspection we observed various occasions on both wards when the desk was not manned, and the cupboard doors were open. This meant there was a possibility notes could be lost, stolen or tampered with. We raised this as an issue on the first day of inspection, when we returned on the second day the issue remained. Following the inspection, we were told that records were now stored securely.

Records were completed in a way that kept people safe. We reviewed four sets of patient records, both nursing and medical on the wards. We saw they were all completed clearly and in detail with all relevant information about the patient's admission, procedure and risk assessments being completed. We saw communication letters between

patients GPs and their consultant were stored within their medical records. We saw four pre-operative assessments and checklists and saw that these were completed in detail.

We reviewed the last two documentation audits that were conducted. These audits were thorough and covered risk assessment, medication charts as well as overall note suitability. We looked at two audits from May 2019 conducted two weeks apart, one showed 97% compliance overall and the other 92%. Issues highlighted by the audit included not all patients having evidence of consultant sign off or being reviewed by the RMO if they were present on the ward more than 24 hours. We saw in team meeting minutes that ensuring daily sign off by the patients' consultant or the RMO was discussed.

Medicines

The service used systems and processes to safely prescribe, administer, record and store medicines.

Medicines were administered in line with best practice. We observed medications being checked by two trained nurses before administration. Drugs were administered with the prescription chart present. All drugs that we checked were in date.

Patients own medications were recorded upon admission and locked in a safe in their room.

Fridge temperatures were checked daily. We checked the medication fridge on Bournville ward and found fridge temperatures, along with maximum and minimum temperatures were checked daily. Dudley ward did not have a medicines fridge.

The ambient room temperature was recorded in both the clean and dirty utility rooms on the surgical wards. The actual, minimum and maximum temperature had been recorded daily with no issues noted. However, we noted the record sheet advised staff they only need to escalate a temperature issue if it was to increase above 30 degrees Celsius despite most drugs and fluids requiring to be stored below 25 degrees Celsius. This posed a risk that the temperature of the room may be too high and staff would not be prompted to take action. We checked all temperature recordings for 2019 and found it had not gone above 25 degrees Celsius in the clean utility where drugs

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were stored. We raised this with management on the inspection and the charts were immediately changed to reflect 25 degrees being the maximum accepted temperature.

Medications were stored securely. Medicines on the wards were kept in either a locked drugs trolley or drugs cupboard. The controlled drugs cabinet was a wall mounted, lockable, metal cabinet away from the main ward areas. The lead sister of the shift held the keys to the controlled drug cupboard. We checked drugs present against listed stock and found it to be correct. We also reviewed the controlled drugs books and saw they reconciled accordingly. We saw evidence on pharmacy input to checking drug levels within controlled.

Medications and fluids within the theatres were also kept locked securely. Pharmacy representatives conducted controlled drugs audits on the ward. When full compliance was not achieved we saw that action plans were created. We saw previous areas of non-compliance in the October 2018 audit. This included the stock balance not always being brought forward with two signatures by registered nursing staff.

A medicines management committee was in place and we saw they reported into the clinical governance committee.

Pharmacy support was available Monday to Friday 8am to 6pm and weekends 9am to 1pm. On-call pharmacy support was available either over the phone or could attend site to provide out of hours support if necessary.

Incidents

The service managed patient safety incidents well. Staff recognised and reported incidents and near misses. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support.

An electronic incident reporting system was in place and staff received training in how to use it. Staff we spoke with knew how to access this system to report an incident. We saw feedback from incidents displayed on the huddle room walls and any incidents from the previous shift were

discussed at handover meetings. We saw feedback and learning from incidents across the hospital was also displayed on the huddle room walls. We reviewed staff meeting minutes and saw that incidents were discussed.

Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event. No never events were reported in surgery in the reporting period.

In the 12 months before our inspection zero serious incidents were recorded within surgery.

Route cause analysis (RCA) investigations were performed when incidents graded moderate and above had occurred. We reviewed two of these after the inspection. A standard format was used for both to ensure all necessary factors were explored in each investigation. Each investigation had evidence of executive level sign off and which BMI committees the findings had been shared with. We saw the two incidents were thoroughly investigated and changes to practice were identified and adopted in order to prevent the same type of incident from reoccurring.

Managers were able to describe the duty of candour. Duty of Candour (DoC) is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain notifiable safety incidents and provide reasonable support to that patient. We saw duty of candour action and completion cards that were to be filled out when this duty was being exercised. The card prompted staff to record the name of the person performing it, who was present during the discussion and what actions had been taken.

In the months before our inspection 49 incidents were recorded in April 2019, 90 in March 2019 and 77 in February 2019. Most incidents recorded regarded patient length of stay, where a day case patient had been converted to an overnight stay. The provider was in the process of changing how these were recorded as after analysis they found a lot of cases where patients still had been in the hospital less than 24 hours, but their surgery had been performed late in the day and were then required to stay for supervised recovery.

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Changes were made in response to incidents. We were told of one example of how a patient had deteriorated in their room after their operation. This prompted a greater focus on consistent NEWS2 reporting and the placement of reminder charts on each patient's door. An increase in clinical concern incidents had been reported due to not all patients having a daily clinical review by their consultant. Nursing leaders were now spot-checking patient records to ensure this was taking place and reminding consultants of their duty to document the daily review of their patients.

We reviewed clinical governance meeting minutes and saw that incidents and RCAs across all areas of the hospital were discussed.

Safety Thermometer (or equivalent)

The service used monitoring results well to improve safety. Staff collected safety information and shared it with staff, patients and visitors.

The service used safety monitoring results well. Staff collected safety information and shared it with staff, patients and visitors. Managers used this to improve the service.

Ward boards were in place which displayed information about the service for patients and visitors to read. Audit results and summaries were displayed within the staff huddle room, so staff members were informed on recent results and actions.

The service produced a monthly quality report which it shared with its staff and medical advisory committee to monitor performance.

Are surgery services effective?

Good 

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

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence-based practice. Managers checked to make sure staff followed guidance. Staff protected the rights of patients subject to the Mental Health Act 1983.

All procedures performed were elective. The Priory did not treat emergency patients. All patients had chosen to have their operation or treatment at The Priory.

A process was in place to monitor and implement best practice guidance. An internal register of new and updated best practice guidance issues for the National Institute for Health and Care Excellence (NICE) was kept, with updates provided to staff via the clinical governance bulletin.

Policies and guidelines were based on NICE guidance. Staff could access up to date evidenced based guidelines. Staff had access to an intranet system to access policies and guidelines related to their area of practice.

Sepsis screening and intervention was carried out in line with national guidance from the UK Sepsis Trust. Screening pathways were available to use within specified sepsis folders in the ward.

Pre-assessments were performed prior to patients being admitted. We saw in records patients had been risk assessed before being admitted to the ward. Nurses then checked this documentation with patients upon their admission to ensure it still reflected the most up to date information. We saw that MRSA testing was performed prior to patients being admitted in line with best practice guidelines.

We saw that patients were assessed for venous thromboembolism (VTE) upon admission or soon after in accordance with NICE guideline (NG89). The surgical wards contributed to VTE audits, results were combined with the sister BMI hospital for submission. Leaders told us how compliance had dropped due to VTE risk assessments not being signed off by consultants. As a result, practice had been changed to only needing review from a consultant if the risk assessment showed the patient was at high risk of VTE development.

Nutrition and hydration

Staff gave patients enough food and drink to meet their needs and improve their health. The service made adjustments for patients' religious, cultural and other needs.

The service adhered to fasting guidelines where necessary. We saw nurses checking their patients fasting status upon admission.

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Catering staff were employed by an external catering company. They provided a full service throughout the day. Each surgical ward had its own servery area where food and drinks were prepared.

Meals were provided three times per day with an extensive menu available to patients. Patients were provided with a full and varied menu throughout their stay and there were also specials that changed daily. Patients allergies and medical conditions were discussed upon admission to ensure the correct food choices were provided. The servery staff had full details of allergens and were able to contact hospital chefs for further clarification if needed.

We saw servery staff interacting with patients and staff to check if patients were ready for their food or if they would to eat at an alternate time. Patients had a call bell that directly went through to servery staff if they required any further food or drink during their stay.

Pain relief

Staff assessed and monitored patients regularly to see if they were in pain and gave pain relief in a timely way.

Patients pain was assessed regularly. We saw patients pain levels were recorded upon NEWS2 charts. We also heard nurses asking patients if they were in pain or required further medication throughout their stay.

Patients we spoke with were happy with their treatment and reported no problems regarding pain relief.

We saw the importance of regular and timely pain relief was discussed in team meeting minutes.

Pain relief audits were conducted. We reviewed an audit from November 2018 which assessed a patient's pain relief pathway on 18 separate criteria. An overall score of 90% was attained with areas of low compliance being patients not having it documented in their notes what analgesia they took and not reviewing the effectiveness of analgesia given.

Patient outcomes

Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for patients.

The service collected outcome data and used it to improve services. Impact of interventions were assessed using a range of measures.

Systems were in place for submission to national audits where cases met the requirements. Patient reported outcome measures (PROMS) were recorded for NHS patients treated at the service. PROMs data provides measures surrounding the health and wellbeing of patients before and after certain operations to assess the effectiveness of the procedure. Reporting categories include EQ5D index which highlights improvement in 5 broad health areas including, mobility, self-care, usual activities, pain/discomfort and anxiety/depression and EQ Visual Analogue scale (EQVAS) which is a simple measure of a patients reported wellbeing.

For hip replacements taking place between April 2017 and March 2018 EQ5D results showing 82.6% of patients had seen improvements in health which was lower (worse) than the England average of 90%. EQVAS results showed 72.7% of patients reported an increase in overall wellbeing which was higher (better) than the England average of 68.3%.

For knee replacements taking place between April 2017 and March 2018 EQ5D results showed 86.7% patients reported improvements in health which was higher (better) than the England average of 82.6%. EQVAS results showed 64.3% of patients reported an improvement in wellbeing which was higher (better) than the national score of 59.7%.

The response rate for all procedures between April 2017 and March 2018 was 41.1%. The service had recognised its response rates for PROMs surveys was low and affecting their outcome measure. Some questionnaires had not been completed at all and others not within the set timeframes. Staff and patient education on the importance of PROMs documentation had started in 2018 with the hope to improve the amount and quality of future PROMs submissions.

The service also submitted data to the Oxford hip and knee audit. These audits assess function and residual pain in patients after undergoing total hip and knee replacements. Twenty-four operations were eligible for analysis between April 2017 and March 2018 for the Oxford hip audit which showed 95.8% had seen improvement compared to 97.2%

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nationally. This was better than the national average. Oxford knee scores saw 100% of patients report improvements compared to 94.6% nationally. This was also better than the national average.

The service submitted information to the National Joint Registry (NJR) which collects information on all hip, knee, ankle, elbow and shoulder replacement surgery. The most recent published NJR data for BMI The Priory hospital relates to 2016-2017 and showed the hospital performed better than expected in the consent rate indicator. Data provided showed that in 2018, 380 eligible operations were performed with 87% of patients consenting to their information being submitted to the NJR.

In a 12-month period from October 2017 to September 2018 there were 27 unplanned returns to theatre. Reasons included to perform remove fluid from surgical sites and to review potential infections of wound sites. We saw that reasons for returns to theatres and actions and learning from these cases were discussed by the MAC within the monthly clinical governance reports.

Competent staff

The service made sure staff were competent for their roles. Managers did not always appraise staff's work performance. Supervision meetings were held with staff to provide support and development.

A localised induction was in place for new starters, bank and agency staff. This included an orientation to the area in which they were working and how to raise concerns.

All new starters had a four-week supernumerary period supported by a 90-day induction programme.

Consultants who were granted practising privileges had to demonstrate relevant clinical experience in their fields and high standards of professional behaviour. Practising privileges would only be granted for consultants to carry out procedures that were part of their normal NHS practice. Practising privileges were reviewed yearly for consultants by the executive director and the MAC chair.

A formal appraisal system was in place however, not all staff had received one. In the last full appraisal year of October 2017 to September 2018, 80% of ward staff and 70% of theatre staff received an appraisal.

Physiotherapists completed in-service training and could also access internal continual professional development across the BMI sites.

Multidisciplinary working

Doctors, nurses and other healthcare professionals worked together as a team to benefit patients. They supported each other to provide good care.

Different specialities worked well together. We saw staff of various disciplines working together to provided joined up patient care. Throughout our visit we saw consultants, nurses, therapy staff and theatre staff working together to improve the quality of care given to their patients.

Physiotherapists met with nurses every morning to discuss patients on the ward and to organise and prioritise sessions for the day.

We saw communication between consultants and patients' GPs in medical records.

Seven-day services

Key services were available seven days a week when needed to support timely patient care.

Physiotherapy services were provided to the wards Monday to Friday from 8.30am to 4.30pm as standard and at the same times on the weekend if required. Physiotherapists also provided a 24 hour on call rota.

All services were able to be provided seven days in line with consultant demand. Most operations were performed weekdays between 8am and 8pm. Wards remained open if patient activity required, alternatively Dudley ward was often shut overnight and nursing staff reallocated.

Health promotion

Staff gave patients practical support and advice to lead healthier lives.

A health promotion form was completed for each patient. Assessing areas of significant life events, relationships, psychological and physiological health and pain. This helped to inform ongoing patient care.

Physical activity was encouraged. Physiotherapists encouraged patients to get out of bed and perform rehabilitation exercises in line with their care plan.

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Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients' consent.

Staff understood their responsibilities in gaining consent. Consent was gained ahead of the procedures as all were elective. We observed staff adhering to patient wishes who wished to end their therapy sessions early.

Staff received mandatory training that covered mental capacity and Deprivation of Liberty Standards. This content was delivered as a part of the safeguarding modules which we saw had high compliance for both ward and theatre staff. At the time of our inspection, information provided showed compliance with safeguarding training for surgical ward staff was at 100%. Theatre staff were 98% compliant with safeguarding training overall.

Managers told us that they did not often experience issues in relation to mental capacity and Deprivation of Liberty Standards due to the elective nature of the patients. However, staff still received training on both topics and could access support on site from the safeguarding leads if required.

We saw consultants took consent from patients prior to surgery. However, we reviewed four sets of patient notes and although consent had been obtained the patient copy of the consent form was still present in the notes and had not been given to them.

The service did not treat any patients who had ongoing psychological health issues. These patients would be treated by their consultants at NHS trusts with more specific support facilities.

Managers told us that staff did not often have to assess mental capacity and deprivation of liberty safeguards due to the elective nature of the patients and the service did not treat any patients who had ongoing psychological health issues. If needed support on these issues was available through the safeguarding leads.

Are surgery services caring?

Good 

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

Compassionate care

Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.

We observed nurses interacting with patients with kindness and compassion. All patients we spoke to confirmed this was the case.

We observed nurses supporting patients between chairs and their bed and offering reassurance and not rushing patients.

We observed care being given to patients. We saw nurses explained what they were doing and why and gave patients time to ask questions if needed.

We observed patients having post-operative physiotherapy. We observed therapists supporting patients to mobilise after their surgery and providing words and acts of reassurance. We saw one patient who was struggling with confidence and pain whilst with the physiotherapist and his therapy session was ended early.

Feedback from people who used the service was continually positive about the way staff treated people. We saw thank you cards, and letters sent in from patients. Patients we spoke to told us they were, 'very happy and had no complaints' and 'staff can't do enough for me'.

Patient satisfaction surveys were collected from patients. In April 2019, results showed that 98.4% of patients would recommend the hospital. Due to decreasing responses staff were encouraging patients to complete a short satisfaction survey before being discharged from the hospital.

Staff respected patient's privacy and dignity while they were in the department. We observed staff closing patients' doors while delivering treatment or having discussions. Patients on their way to theatres were given gowns to wear or were adequately covered if being transported on a trolley.

Emotional support

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Staff provided emotional support to patients, families and carers to minimise their distress. They understood patients' personal, cultural and religious needs.

A chaplaincy service was available for patients.

Staff would orient patients to the ward and service if needed. Staff were able to facilitate orientation visits to the ward to introduce any patients who needed it to the staff who would be providing their care and to familiarise them with the ward and the equipment that would be used throughout their stay. We were also told of examples where care plans had been provided to the nurses on the wards before a patient was admitted allowing them time to ensure they met the patients' needs during their stay.

Understanding and involvement of patients and those close to them.

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

The service encouraged regular contact with friends and family. Visiting times on the ward were flexible to accommodate this.

Patients were given the opportunity to talk privately with their consultant and nurses throughout their stay. We saw nurses receiving telephone calls from patients' families and updating them upon their condition.

We saw staff of all professions ensure the length of time allocated for appointments allowed time to go through information, provide reassurance and allow flexibility to meet the needs of patients.

Are surgery services responsive?

Good 

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

Service delivery to meet the needs of local people

The service planned and provided care in a way that met the needs of local people and the communities served. It also worked with others in the wider system and local organisations to plan care.

Patient views were considered in the improvement of the service. Satisfaction surveys were performed to enable the hospital to continually improve its services. For example, menus provided at the hospital has recently been revisited due to a fall in food related satisfaction scores.

Visiting times to the wards were flexible to allow friends and family to visit at a time convenient to them. Visiting was available from 7am to 10pm.

The hospital provided solely elective procedures. The service worked with consultants who used the hospital under practising privileges agreements and would ensure facilities and equipment to meet patient demands was supplied.

NHS patients could access the service through the national choose and book portal. This gave patients a choice of appointment times and enabled the hospital to manage its capacity and workloads. This also gave patients a greater choice of appointment time.

Private patients could choose to have procedures undertaken at The Priory hospital. Private patients could book appointments through a centralised BMI healthcare team or the hospital's website, which included a 'live chat' support function.

The ward environments were suitable for the type of services provided. The area was bright and spacious. A patient lounge was available for patients and their visitors to use during their stay.

The hospital had an onsite intensive care unit which could provide planned or unplanned care to inpatients during their stay. The availability of this unit allowed slightly more complex procedures to be performed.

Free Wi-Fi access was available to patients during their stay. There were instructions in each bedroom about how to access the hospital's Wi-Fi Service. Each patient bedroom had a television for use.

A patient lounge was available for use by patients and their visitors. This had access to a hot drinks machine that visitors could use free of charge.

Meeting people's individual needs

The service was inclusive and took account of patients' individual needs and preferences. Staff made reasonable adjustments to help patients access services.

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The service could meet individual needs when necessary. Leaders described how they were happy to meet individual needs in agreement with patients and their insurance companies. The service could staff the ward to a higher nursing to patient ratio if needed to respond to individual patient need. However, this had to be done with agreement due to the increased costs this would incur.

Dementia friendly equipment was available for use. The service did not frequently treat patients who were living with dementia however, mandatory training in dementia awareness was provided to all staff. At the time of inspection 97% of theatre staff and 100% of ward staff had completed this training. Equipment was available to make a patient's room dementia friendly if required such as day and night clocks and different coloured cutlery. The service also undertook the patient-led assessments of the care environment (PLACE) audit and used results to identify any further dementia adaptations they could make.

The service was able to provide surgery to patients who required bariatric equipment. We saw theatres and wards were equipped with specialist equipment such as trolleys and chairs.

The ward environment was appropriate for those with a physical disability. Corridors within the department were wide and uncluttered to allow passage of wheelchairs or children using walking aids. Bed bays were also spacious to allow storage of multiple aids without causing an obstruction.

Telephone or face to face translation services were available where English was not the patient's first language. Any communication needs would be identified during referral or pre-operative assessments so that this could be arranged ahead of the patients' procedure.

Staff responded quickly to patient call bells. When patients had to use their call bells for attention we saw that these were quickly responded to.

Access and flow

People could access the service when they needed it and received the right care promptly. Waiting times from referral to treatment and arrangements to admit, treat and discharge patients were in line with national standards.

The service had access to five theatres. Five theatres could be staffed and functional Monday to Sunday 8am to 8pm if required.

Average referral to treatment times for all groups of NHS patients were provided. NHS patients should have a maximum wait of 18 weeks from for non-urgent treatment referrals. In February, March and April 2019 waits were within this target for general surgery, trauma and orthopaedics and urology surgery. Longer waits were experienced in gastroenterology in February 2019, 21.2 weeks and gynaecology in April 2019 at 19 weeks. The gynaecology speciality had the highest wait time record for all services in this time period with a wait of 25.4 weeks recorded in August 2018.

Ward occupancy rates were low. In March 2019 71% of available bed days were used compared to 51% in April 2019 and 55% in May 2019.

The service had an intensive care unit capable of providing up to level three care. The occupancy rate of the intensive care unit was also due to the nature of predominately low-risk operations being performed at the hospital. In March 2019 23% of available beds days in ICU were used, with 13% in April 2019 and 17% in May 2019.

In a 12-month period from October 2017 to September 2018 the service had 16 unplanned readmissions within 28 days of discharge for a related condition. We saw that reasons for readmissions and actions and learning from these cases were discussed by the Medical Advisory Committee within the monthly clinical governance reports.

Learning from complaints and concerns

It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff. The service included patients in the investigation of their complaint however, not all complaints were acknowledged or responded to within the desired timeframes.

A BMI complaints policy was in place which was followed when formal complaints were made. This outlined staff roles and responsibilities in regard to managing complaints. The Executive Director and Director of Clinical Services were responsible for managing individual complaints. The policy outlines how written

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acknowledgment of the complaint should be issued within three working days and a full written response was to be provided within 20 working days when the outcome of the investigation was known. We were told any complaints would try to be resolved at a local level before them being escalated to formal complaints.

Information given to patients as part of their treatment included details of how to make a complaint about their care. A patient liaison lead was appointed in November 2018 to facilitate easier and effective interaction between patients and the hospital.

In the 12 months before our inspection 34 complaints had been received by the surgery service. These covered a range of issues including discharge, clinical care and communication. Not all complaints were acknowledged or responded to within the desired timeframes.

Complaint themes were collected and discussed. We saw outcomes of each complaint and trend details were recorded after each complaint had been investigated. We reviewed various team meeting minutes and saw that complaints and lessons learned were shared across the organisation. We saw in meeting minutes ward staff discussed an increase of complaints regarding call buzzers not being promptly answered, staff discussed ensuring to seek help from another staff member to attend to the patient if they were not available to go immediately.

Are surgery services well-led?

Requires improvement 

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

Leadership

Leaders had not identified, addressed or mitigated all issues within the department. However, leaders were visible and approachable in the service for patients and staff. They supported staff to develop their skills and take on more senior roles.

The local leadership team worked well together. We observed leaders were visible within their departments.

The ward managers office was within the ward, making them visible and accessible to staff. The ward manager was visible on the ward and interacting with staff and patients throughout our visit.

Leaders for each shift were identified. A notice board on both wards identified the lead nurse for each shift.

Staff we spoke with told us they felt supported by their local management who was visible within the department and they were happy to seek support from them.

A senior leadership meeting took place every morning. Leaders from each department met to discuss sickness, activity, concerns and incidents across the hospital. This was to ensure all leaders were well informed of what was happening across the hospital that day. These meetings were recorded and kept on file.

Leaders communicated important messages to staff. We saw messages being conveyed from leaders to staff during staff huddles. The huddle rooms also had an array of information on the walls from policy updates to audit results so staff were aware of any issues that affected them.

Not all known risks to the department were upon the risk register to allow continual oversight and management of risk. Of the risks that had been identified leaders could discuss actions taken to address them and the potential impact they could have upon the service.

Vision and strategy

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

The Priory Hospital is part of the BMI Healthcare Group. BMI has a network of hospitals across the UK all of which share the same vision which was 'Serious about health. Passionate about care'. BMI had outlined its eight strategic objectives in their five-year vision 2015 – 2020 which focused on the areas of people, patients, communications, growth, governance, efficiency, facilities and information.

BMI The Priory had recently merged with another local BMI hospital following a management restructure. The two locations together were known as BMI Birmingham. BMI

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Birmingham had the vision of ‘Stronger Together’ with the mission statement of ‘To integrate BMI The Priory and Edgbaston Hospital into BMI Birmingham, taking best in class to create a two site, single hospital, delivering outstanding care in the right location.’ The four high level aims of BMI Birmingham were to: Streamline working practices across both sites applying best practise and removing duplication; focus on quality; drive efficiency – not cost cut and to invest wisely doing it once to support growth and mitigate loss to competition.

The recent merger of the two hospital sites had been communicated to staff and various engagement methods employed to communicate messages to all staff. Work was ongoing to ensure all BMI Birmingham staff were aligned to the services vision and values.

Culture

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

Staff were happy working within their departments. Staff we spoke with were happy in their role and described it as a friendly supportive team to work in.

Staff put the patients care and experience at the heart of what they did.

The service had a speak up champion. Each BMI hospital had a speak up champion and an overarching speak up guardian at provider level. Staff could also contact speak up service via a whistleblowing email and telephone hotline.

Staff were provided with development opportunities. The service had recently appointed a nursing associate who had been supported to develop from a health care assistant. Continual professional development opportunities were available to staff across the BMI sites. A new theatre manager had recently come into post and described their vision to focus on developing leaders within the theatre team.

A healthy lifestyle was promoted to staff. We saw in the monthly newsletter that staff were encouraged to sign up to the summer cycle to work scheme and information on how to access it was provided.

The service was committed to improving the health and wellbeing of its staff. BMI The Priory had an action plan to work towards achieving the health and wellbeing commissioning for quality and innovation (CQUIN). This included various initiatives aimed at staff wellbeing including walk and cycle to work schemes, leadership training, healthy workshops and flu vaccination campaigns.

Governance

Not all governance processes were effective. However, most staff were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.

A hospital governance structure was in place with all individual services feeding into it. We reviewed minutes from various meetings including two sets of heads of department meeting minutes, two sets of senior management meeting minutes and two sets of clinical governance meeting minutes across BMI Birmingham. We saw these meetings were well attended by operational and corporate staff and that minutes were detailed and comprehensive and flowed from one meeting to the next. We saw that information flowed from ward to senior level and standard agenda items such as risks, complaints, incidents and staffing were regularly discussed.

We were not assured that there was a robust governance system in place to provide oversight of mandatory training across the service, some individual modules including life support and governance had low completion rates. The risk register for the service included long standing risks that were yet to be rectified and not all known risks to the service were entered upon it.

A programme of internal and external audit was in place. We saw audit results were discussed at local level and performance at a national provider level was analysed. Audit results were a standard agenda item for BMI Birmingham senior management meetings.

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Quality meetings took place with all hospital heads of departments. All incidents that required formal investigation were presented at these meetings with high level complaints. Audit result and actions were also discussed across all departments.

A quality report was produced monthly and presented to the medical advisory committee (MAC) for comment and discussion. These minutes were recorded in detail with actions allocated to named individuals. The reports outlined matters covering safety, effectiveness and patient experience. We reviewed four sets of MAC meeting minutes.

A senior leadership meeting took place every morning. This was to ensure all leaders were well informed of what was happening across the hospital that day and any urgent updates were communicated.

Consultants working at the hospital under practising privileges were reviewed regularly by the executive director and MAC chair. Consultants were required to provide updated information on their fitness to practice annually. More in-depth reviews of consultants practising privileges was undertaken twice a year which included analysis of clinical outcome data such as return to theatres and infection rates. We saw examples where consultants had had their practising privileges removed for not meeting the required standards.

Not all action plans devised after an incident had occurred were robustly and effectively followed up. We saw that consultant attitude was cited as a main factor that contributed to the occurrence of an incident in December 2018. Despite this there was no evidence that the consultant had been spoken to formally until April 2019. We saw that further informal complaints had been received for the same consultant. We were not assured that similar incidents would be prevented as the cause had not been addressed in a timely way. After our inspection the provider produced further documentation of this issue being addressed and assured us that this incident would be explored in depth as a part of the individual's appraisal.

Managing risks, issues and performance

Leaders and teams used systems to manage performance. Some but not all risks were identified. Not all risks and issues were escalated and actions to

reduce their impact were not always taken. They had plans to cope with unexpected events. Staff contributed to decision-making to help avoid financial pressures compromising the quality of care.

A risk register was in place that listed the risks to both the surgical wards and theatres. However, we were not assured all relevant risks had been entered upon on it. There was an entry on the risk register about medical records being stored in an unlocked office on Dudley Ward however, this entry was not up to date as these records were not in an unlocked office but were behind the ward clerk's desk. No entry was made on the risk register about patient note security on Bournville Ward even though it was a known risk. No risk regarding the potential impact of the physical environment of the theatres upon infection prevention and control was present at the time of inspection. Although the environment of the theatres was entered as a risk this was not in relation to infection prevention. The lack of ALS trained staff in recovery was also not recognised as an issue at the time of inspection and was not meeting national guidance. Low rates for mandatory training modules was not entered on the risk register despite it being listed as a control for other risk items. Finally, audit activity and incident investigations had highlighted compliance issues with the WHO surgical checklist however no risk specific to WHO surgical checklist completion was present.

We were not assured that all risks were being progressed in a timely manner. The age of some surgical equipment had been identified in our previous inspection. This issue was on the risk register rated as a 'medium risk' with a risk score of 12 the acceptable risk the provider had set for the risk was one. We were not assured that actions to reduce this risk level had been addressed in a timely manner. A further issue in relation to inadequate laser doors and signage had remained on the risk register since 2015.

We saw details of the main risks that were on the risk register and actions taken around ward based risks on information sheets within the huddle room for staff to review.

Performance was monitored at local and national level. BMI The Priory produced quality reports monthly to analyse key performance data such as incidents, returns to theatre and cancellations this was analysed at location level and also compared to BMI locations nationally. Yearly quality accounts were also produced.

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A back up power generator was in place but there was no uninterrupted power supply (UPS) system for theatres. This is against the advice of Health Building Note 26 which advises that essential equipment within theatres should be protected against generator start-up delays by the provision of uninterruptible power supplies. In the event of power failure there is a risk that patients may be subjected to harm if vital equipment is not maintained. A backup generator was in place which would allow any operations in progress to be finished however this may not be able to power all essential systems. This was on the departments risk register and was also highlighted during our last inspection when we were told provision had been made to purchase one in 2017. This issue had now been outstanding for over two years. Information provided during this inspection highlighted again that installation of a UPS would again form a part of the upcoming theatre development.

We saw one of the sets of doors between an anaesthetic room and a laser enabled theatre had a length of skirting board nailed to the doors to seal the gap between the two doors. We felt that this did not safely or effectively address the problem. This issue was not upon the risk register and we did not see that a risk assessment had been performed.

Managing information

The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were integrated however, they were not always secure.

Staff had access to accurate information to allow them to do their job. Staff had access to computers to access up to date policies and procedures. Meeting minutes were shared with staff so they were kept up-to-date with current issues from across the service and the hospital.

Management told us they had access to the right information to do their job well. Managers received information on performance outcomes that enabled them to drive improvement in their specific areas. Data provided to managers included audit outcomes covering areas including training, infection control and records.

Patients records were not kept securely on both surgical wards.

We reviewed various meeting minutes and found both quality and sustainability of the services provided were discussed and each given sufficient time on the agenda.

Engagement

Leaders and staff actively and openly engaged with patients, staff, equality groups.

The department gathered feedback from patients through the patient satisfaction survey. Leaders told us how they were working on increasing participation in these surveys by asking patients to complete them before they were discharged to ensure the views of more patients are captured.

Monthly newsletters were distributed to staff from BMI Birmingham which provided news and updates for issues covering both BMI Birmingham sites. A specific Priory Hospital wards newsletter was also circulated with more specific information for the surgical ward staff.

Monthly team meetings were held for both theatre and ward staff and were well attended. We reviewed minutes of team meetings and saw that they covered the most important issues to the areas at the time. Ward meeting minutes followed a more structured agenda with a list of actions assigned to staff members, the same format was not followed within theatres.

Learning, continuous improvement and innovation

All staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them. Leaders encouraged innovation and participation in research.

BMI Birmingham has recently been formed to incorporate the two BMI sites in Birmingham. Senior management teams were now working across the two sites to combine and promote services, share learning and best practice and to provide better joined up care across the BMI Birmingham sites.

Staff and leaders were committed to learning from when things went well, complaints and incidents. We saw that learning was shared across the hospital and BMI Birmingham to improve care and treatment for patients.

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Learning and development was encouraged for all staff. Training and development both internally and externally was promoted by leaders within the service. Staff had access to BMI training held at all BMI locations and to external courses through a local university.

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

Are critical care services safe?

Good 

We rated safe as **good**.

Although some elements require improvement, the overall standard of service provided outweighs those concerns. We have deviated from our usual aggregation of key question ratings to rate this service in a way that properly reflects our findings and avoids unfairness.

Mandatory training

The service provided mandatory training in key skills to all staff and made sure everyone completed it.

Nursing staff received and kept up to date with their mandatory training. Nursing staff had a completion rate of 86.7%. The doctors working within the critical care unit had a 100% completion rate for their mandatory training. The organisations target was 90% for staff who had worked for the organisation for more than three months. Mandatory training was provided in subjects such as fire; safeguarding; conflict; consent; infection control and life support.

The mandatory training was comprehensive and met the needs of patients and staff. A mandatory training record was held for every staff member by the unit manager.

Managers monitored mandatory training and alerted staff when they needed to update their training. In order to ensure that staff members had read updated policies, staff could not access their mandatory training until they had read the policies and signed to say they understood them. Staff told us this ensured they kept up to date with the policies.

Safeguarding

Staff had training on how to recognise and report abuse and they knew how to apply it.

Staff received training specific for their role on how to recognise and report abuse. Safeguarding training was part of the services annual mandatory training programme. Of eligible staff working in the unit 100% had completed safeguarding level 1 and 2 adults and children’s training. BMI had recently updated their safeguarding policy and safeguarding adults level 3 had been added for some staff in the unit to complete. Before this the training was only undertaken by the director of clinical services. At the time of our inspection training had been allocated to five team members and two were in the process of undertaking the training.

Staff could give examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act. Staff we spoke with had an understanding of safeguarding concerns and what they would seek advice and support with referring.

Although children and young people were not treated within the unit, staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. The unit had not made any safeguarding referrals in the year before our inspection. However, staff had an awareness of what they would raise as concerns with the safeguarding leads.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. Staff in the unit told us they

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would liaise with the hospitals safeguarding lead and would approach them if they had any concerns. The hospital had designated safeguarding leads and their contact details were displayed on noticeboards.

Cleanliness, infection control and hygiene

The service controlled infection risk well. Staff used equipment and control measures to protect patients, themselves and others from infection. They kept equipment and the premises visibly clean, however we found some items of equipment with some dust on them in a bed area that was not in use.

The unit area was generally clean and had suitable furnishings which were clean and well-maintained. The unit had disposable curtains in use, these had been changed and were dated and in date at the time of our inspection. However, during our inspection we noted some dust on some equipment that had not been thoroughly cleaned in a bed area that was not in use.

The unit had a side room which had laminar air flow which could be used for patients who needed to be in isolation.

Cleaning records were up to date and demonstrated that all areas were cleaned regularly. The hospital's cleaning team came into the department once a day to clean the floors. Staff who worked in the unit were responsible for cleaning all other aspects of the unit and out of hours.

During our inspection we looked at the monthly cleaning schedule. This contained a list of all the areas staff were to clean at least once per month. This had been completed for the six months before our visit. Although not all records stated the exact date when the cleaning had been completed, this meant the cleaning could be done on the first day of one month and the last day of the next, resulting in a potential two month gap.

Staff followed infection control principles including the use of personal protective equipment (PPE). During the inspection we observed staff using aprons and gloves appropriately and washing their hands before and after patient contact. All staff members were bare below the elbow. The unit conducted monthly hand hygiene audits.

During the inspection we found hand sanitising facilities at the entrances to the unit and throughout.

Staff cleaned equipment after patient contact and labelled equipment to show when it was last cleaned. During the inspection we observed staff cleaning down a bay that a patient had been in before any other patients would use the bay.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment kept people safe. Staff managed clinical waste well. However, the sluice area was unlocked on the day of our inspection and some cleaning chemicals were out in the sluice area.

Patients could reach call bells and staff responded quickly when called.

The design of the environment followed national guidance. All bed spaces were visible from the nurses' station which allowed them to observe patients when required.

At the time of our inspection the unit was commissioned for six critical care beds. However, the unit was in the process of decommissioning the sixth bed space to allow the unit to have a dedicated storage area which would be in line with national guidance.

All soft furnishings were in line with government guidance they were clean, fit for purpose and wipeable.

The unit did not have access to a shower or toilet for patients to use. The nearest toilets were down the corridor which staff said they would support patients to use if they were well enough and if not, they would use a commode. This could result in patient care not being delivered in a dignified way.

Staff carried out daily safety checks of specialist equipment. We saw that resuscitation equipment; including defibrillators and difficult airway management trolleys were available. Records indicated that these were all checked daily. All the equipment we checked during the inspection was in date and ready for use.

The service had enough suitable equipment to help them to safely care for patients. All bed spaces were fully equipped with the equipment required to care for a critically ill patient. The hospital stored some of the specialist equipment that was not used frequently at other hospital sites. Staff told us this equipment could be brought to the hospital within one hour of it being requested.

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The unit had put in a ten-year plan for the replacement of equipment. This was to allow the unit to purchase new equipment in advance of it breaking down and to avoid large expenses at one time.

All the equipment we checked was tested and ready to be used when a patient was admitted. All disposable equipment we looked at during this inspection was in date.

Staff disposed of clinical waste safely. The units clinical waste disposal was in line with the government guidance on the safe management and disposal of healthcare waste from the department of health 2013. The units' sharps waste disposal was also in line with best practice.

The sluice area of the unit was left unlocked on the day of our inspection. Some chemicals were also stored within the sluice room which was not in line with the Control of Substances Hazardous to Health Regulations 2002 which state they should be locked away.

Assessing and responding to patient risk

Staff completed and updated risk assessments for each patient and took action to remove or minimise risks. Staff identified and quickly acted upon patients at risk of deterioration.

Staff used a nationally recognised tool, national early warning scores (NEWS2), to identify deteriorating patients and escalated them appropriately. The organisation had a care of the deteriorating patient policy which included information on observations, escalation, transfer of patients and sepsis. This was written in line with best practice guidance.

The unit had a paper critical care observation chart which was standard across BMI Healthcare's critical care units. On this staff recorded patients' vital signs. The unit also had a nursing care plan, this included assessments of the patients respiratory, cardiovascular, pain and sedation and neurological states as well as other areas. When patients were going to be transferred back to the ward areas a set of observations was transferred onto the national early warning scores (NEWS2) charts to enable continuity of care for the patients.

The hospital had a sepsis lead who staff were aware of. The unit manager was also in the process of developing a sepsis pack this was to be rolled out across the hospital. This included all the necessary resources to begin treating

patients who were suspected to have sepsis to help reduce the time taken to begin treatment. The unit manager had also developed a sepsis manual to help to educate and prompt staff.

Staff completed risk assessments for each patient on admission to the unit and updated them when necessary and used recognised tools. The unit did body mapping to identify any current concerns relating to patients who had wounds or pressure ulcers. In three out of the four records we looked at staff had completed Venous thromboembolism (VTE) assessments. In four out of the four records we looked pressure areas had been documented. We saw falls risk assessments had also been completed.

Staff knew about and dealt with any specific risk issues. The hospital had a morning meeting in which all patients in the hospital were discussed. This allowed staff working in the unit to prepare for any patients who had been highlighted at risk of deterioration. They also discussed who was due in for surgery and who would require a critical care bed post-surgery.

Staff shared key information to keep patients safe when handing over their care to others. The service had specific guidelines on who they would treat and who would require treatment at local NHS hospitals with more facilities. The service would not take patients who had chest pains, these would be transferred to a local NHS acute trust.

The service had an agreement with the local ambulance trust for urgent transfers and had a direct phone number for the call controller to speed up the process of getting an ambulance in an emergency. Staff also told us they would phone the unit the patient was being transferred to, to aid the handover process. There had been no patients transferred out of the unit from July 2018 to July 2019.

Staffing

The service had enough staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix, and gave bank, agency and locum staff a full induction.

The service had enough staff of all grades to keep patients safe. During our inspection we were told the unit could

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always access more nurses when required. The hospital had a resident medical officer (RMO) always onsite. Staff also told us they could phone patients individual consultants when required for advice or for them to visit the patient.

The service did not have a set ward clerk or coordinator. Staff raised this as an area which could be improved upon particularly during peak times of activity to enable clinical staff to focus on direct patient care and to allow the continued administrative tasks to continue. This was not in accordance with the guidelines for the provision of intensive care services (June 2019). These guidelines recommend that each critical care area should have ward clerk/receptionist cover seven days per week. These are guidelines that NHS organisations should follow and that the unit also followed.

Following our inspection, the service provided us with assurance that the unit was able to access administrative support from other areas of the hospital and that going forward the clinical data submissions critical care units submit to the intensive care national audit and research centre (ICNARC), would be managed by a different team.

Managers accurately calculated and reviewed the number and grade of nurses needed for each shift, in accordance with national guidance. The unit had six full time nurses employed including the unit manager. The unit was staffed with one nurse regardless of whether there was a patient in the unit. If a patient was admitted to the unit a separate nurse would be called in to support so that there would be two nurses for one patient.

The unit manager could adjust staffing levels daily according to the needs of patients. The unit manager gave examples of when they had extra staff members to support patients who required additional support.

The number of nurses on all shifts matched the planned numbers. The service had six regular nurses who worked on the unit and any additional staff members required to meet patient acuity ratios would be bank or agency nurses.

Vacancy rates

The service had no vacancies at the time of our inspection. The service had recently recruited an additional nurse who was due to commence employment in August 2019.

Turnover rates

The service had low turnover rates, the unit had two leavers in the year before our inspection.

Bank and agency staff usage

The service had a high rate of bank and agency nurse use in the unit. The service used regular agency staff to cover gaps in the rota or where extra staff were required to meet the acuity needs of the patients. From August 2018 to July 2019 the service had 30.5% of shifts covered by agency staff and 11.5% of shifts covered by bank staff.

Managers made sure all bank and agency staff had a full induction and understood the service. The unit manager told us they only used agency staff from a small number of agencies and most staff who came to the unit were regular staff members.

The service always had a consultant anaesthetist on call during evenings and weekends. The hospital had a contract with an organisation who provided on call consultant anaesthetist cover 24 hours a day.

Records

Staff kept detailed records of patients' care and treatment. Records were clear, up-to-date and easily available to all staff providing care.

Patient notes were comprehensive, and all staff could access them easily. The unit had a comprehensive nursing care plan for use in the intensive care unit. This contained all the assessments and contained space to monitor the patient throughout their stay. In four out of the four records we looked at, all notes were signed and dated by the individuals completing them.

When patients transferred to a new team, there were no delays in staff accessing their records. Staff working in different teams told us that they could access and understand the patient records easily.

Records were stored securely. Records were paper based and were stored by patient bed areas.

Medicines

The service used systems and processes to safely prescribe, administer, record and store medicines.

Staff followed systems and processes when safely prescribing, administering, recording and storing medicines. The hospital had a dedicated pharmacy team

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and pharmacy area. The pharmacy team came onto the unit daily and were available 24 hours, seven days a week through an on-call system. Staff working on the unit had access to the pharmacy for medicines out of hours if required.

Staff reviewed patient's medicines regularly and provided specific advice to patients and carers about their medicines. In four out of the four records we looked at all had reviews of antibiotics completed. All the records we looked at had all the prescriptions signed and dated with allergies clearly documented.

Staff stored and managed all medicines and prescribing documents in line with the provider's policy. Controlled drugs (CDs) were stored and managed appropriately and met the standards of Clinical Guidance 46 of the National Institute of Health and Care Excellence (NICE). Controlled drugs are a medicine whose manufacture, possession, or use is regulated by a government this is due to their potential to cause harm if misused. CDs were checked twice a day by two registered nurses.

We checked the intravenous (IV) medicines and oral medicines and these were in date. We saw staff had completed monitoring of fridge and the ambient temperature of the room and this had been recorded and signed and dated.

Staff followed current national practice to check patients had the correct medicines. In all the records we looked at patient had their antibiotics prescribed as per best practice guidelines.

The hospital's pharmacy team visited the ward daily. They checked stocks and patients' medicines to check that patients were receiving the correct amount and dose of medications required. If any medicines were out of date the pharmacy team would remove them from the unit for safe disposal.

The service had systems to ensure staff knew about safety alerts and incidents, so patients received their medicines safely. Any alerts or incidents would be discussed during handover or throughout the day depending on the concern.

Decision making processes were in place to ensure people's behaviour was not controlled by excessive and inappropriate use of medicines. In four out of the four records we looked at all had reviews of sedation completed.

Incidents

The service managed patient safety incidents well. Staff recognised incidents and near misses and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support. Managers ensured that actions from patient safety alerts were implemented and monitored.

All staff knew what incidents to report and how to report them. Staff used an electronic system to submit incident reports that enabled them to be tracked and investigated. The unit manager took responsibility for investigating each incident depending on where it occurred and whether it resulted in harm or risk.

Staff reported all incidents that they should report. We saw evidence the incidents that had been reported were appropriate. The service had appropriately submitted a statutory notification regarding a patient death to the Care Quality Commission.

The service had no never events. Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.

There had been no serious incidents reported in the year before our inspection. Therefore, we could not fully assess how the service handled serious incidents.

Staff understood the duty of candour. They were open and transparent and gave patients and families a full explanation if and when things went wrong. Staff told us they would escalate any issues to their manager and keep the patient and family involved in the process.

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Staff received feedback from investigation of incidents, both internal and external to the service. Staff were aware of how to access learning from incidents and managers told us how they shared this information with staff.

Managers debriefed and supported staff after any serious incident. The provider had access to a counselling service for any staff who required it.

Are critical care services effective?

Requires improvement 

We rated effective as **requires improvement**.

Evidence-based care and treatment

The service provided care and treatment based on national guidance and best practice. Managers checked to make sure staff followed guidance.

Staff followed up to date policies to plan and deliver high quality care according to best practice and national guidance. Staff working in the unit had a good understanding of different national guidance such as the National Institute for Health and Care Excellence (NICE).

The unit manager had worked with The Faculty of Intensive Care Medicine for a section to be included in the guidelines for the provision of intensive care services in independent healthcare to help strengthen the guidance for other independent health providers. They also followed the Faculty of Intensive Care Medicine guidelines to ensure the unit was managed in line with NHS critical care units.

There was a range of local policies, procedures and standard operating protocols in place, which referenced evidence-based guidance and these were easily accessible through the service intranet. The service had a care of the deteriorating patient policy which included information on observations, escalation, transfer out of the unit, sepsis and acute kidney injury.

Nutrition and hydration

Staff gave patients enough food and drink to meet their needs and improve their health. They used special feeding and hydration techniques when necessary.

Staff made sure patients had support with nutrition and hydration to meet their needs. Hot and cold drinks were available at all times. The catering department were in the hospital until 8pm and after that time staff could provide patients with sandwiches and snacks if required.

Staff fully and accurately completed patients' fluid and nutrition charts where needed. In four out of the four records we looked at there was evidence of assessment of fluid and nutritional scores. In all the records there was evidence of intravenous (IV) fluids given and recorded.

Staff used a nationally recognised screening tool to monitor patients at risk of malnutrition. This was completed daily for patients in the unit.

Specialist support from staff such as dietitians was available for patients who needed it. Staff on the unit described how they would phone dietitians at the local NHS trust who would come out and assess the patients.

Pain relief

Staff assessed and monitored patients regularly to see if they were in pain and gave pain relief in a timely way. They supported those unable to communicate using suitable assessment tools and gave pain relief to ease pain.

Staff assessed patients' pain using a recognised tool and gave pain relief in line with individual needs and best practice. Staff utilised a paper based visual pain scoring tool. This was displayed on the wall in the critical care unit.

Patients received pain relief soon after it was identified they needed it, or they requested it. As part of their individual care plan all patients in critical care were assessed in respect of their pain management. This included observing for the signs and symptoms of pain.

Staff prescribed, administered and recorded all pain relief accurately.

Patient outcomes

Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for patients.

The service participated in all relevant national clinical audits. The service performed well in national clinical outcome audits and managers used the results to improve

Critical care

services further. The service submitted data to the Intensive Care National Audit Research Centre (ICNARC) and a cardiothoracic data set, both of which they had started collecting data in June. This would enable them to benchmark outcomes of care delivered and patient mortality against similar units nationwide. Due to the unit only recently starting to submit data to ICNARC there were no reports available at the time of our inspection.

The service conducted ventilator associated pneumonia (VAP) audits for patients who were ventilated for more than 24 hours.

Managers carried out a comprehensive audit programme. The service had a number of different local audits. The manager conducted these audits and results were displayed on the unit.

Managers used information from the audits to improve care and treatment. Following the audits, the unit manager created action plan logs and these were updated as the improvements were made to the service.

There was follow-up of audit outliers. Following audit results managers created action plans and we saw these during our inspection.

Managers shared and made sure staff understood information from the audits. Managers told us that they shared information from the audits with staff working in the unit.

The service was part of the West Midlands Critical care network. The service was not currently part of any escalation plans for the area. However, they were in discussions that in the event of an emergency that staff would go to help at local hospitals to help in their critical care units.

Competent staff

The service made sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and development.

Staff were experienced, qualified and had the right skills and knowledge to meet the needs of patients. Staff working in the unit were undergoing training based on the national competency framework for adult critical care nurses levels one, two and three. This was all staff regardless of if they had previously completed this to act as a reminder to

ensure that everyone was up to date with best practice. Three out of the six nurses had completed their level two and two out of the six had completed their level one. The manager told us that their plan was to get everyone up-to-date.

The bleep holder was an individual who was high dependency trained or who had experience of working at that level. Ten out of the eighteen members of staff who carried the bleep had paediatric intermediate life support (PILS) and an additional two were in the process of completing the course. The service had plans to train the additional five members of staff in (PILS) to ensure staff were qualified to treat children who had deteriorated elsewhere in the hospital. The hospital also always had on site two resident medical officers who were European Paediatric advanced life support trained and they formed part of the hospital resuscitation team.

The unit manager told us that they were in discussions with a local NHS trust for staff to do one shift a month in the critical care unit there to ensure staff practices stayed up to date and they could practice their skills. This was because they had identified that the unit was not always busy and staff did not get to treat a variety of patients on a regular basis.

The unit helped to train student nurses from the local university. They only had one student nurse at a time in the unit so that the permanent staff working in the unit could fully support them.

Managers gave all new staff a full induction tailored to their role before they started work.

Managers supported staff to develop through yearly, constructive appraisals of their work. Staff working in the unit told us they had regular supervision and appraisals. Four out of the six staff members working full time in the unit had an up to date appraisal at the time of our inspection.

There were enough clinical educators to support staff learning and development. The unit had a link worker for teaching and training.

Managers made sure all staff attended team meetings or had access to full notes when they could not attend. We saw minutes from meetings which showed who had attended and team meeting notes were kept in a folder on the unit for staff to review if they could not attend.

Critical care

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. The unit did scenario training to enable staff to learn in a 'live' environment.

Staff had the opportunity to discuss training needs with their line manager and were supported to develop their skills and knowledge. The physiotherapist team had an in-service training programme and delivered training to staff working in the unit.

Managers made sure staff received any specialist training for their role. The service used equipment suppliers to come in and deliver training on the equipment used in the unit.

Staff told us that external courses were promoted, and staff were given time to attend.

Managers identified poor staff performance promptly and supported staff to improve. Staff working in the unit had their critical care competencies signed off by the sisters and the consultant intensivist. If this highlighted any areas of improvement, then the unit manager told us they would first try to manage that in the unit and support the individual to improve.

Multidisciplinary working

Doctors, nurses and other healthcare professionals worked together as a team to benefit patients. They supported each other to provide good care.

Staff held regular multidisciplinary meetings to discuss patients and improve their care. Every morning staff from across the hospital met to discuss all patients in the hospital. This meeting was to discuss any risks to patients or pressures across the hospital. Staff told us that this meeting allowed them to be aware of any patients who might need a critical care bed throughout the day.

Shift changes and handovers included all necessary key information to keep patients safe. Staff handed over to other staff coming on shift. Every morning there was a cross hospital meeting which allowed staff to be aware of patients across the hospital who may require their assistance from both outreach or admitting into the department.

The unit also held a daily meeting every morning following the hospital meeting to update staff on the unit about the plan for the day and to give any updates for the service.

The service had regular physiotherapy input into the unit. Staff working in the unit described the physiotherapists as 'brilliant' and told us they were always available and could be contacted 24 hours, seven days a week. The physiotherapist team tried to keep the same patients through their journey in the hospital, so they had an awareness of the patients' needs and could build a positive relationship with the patient.

The service had access to an occupational therapist when required.

Seven-day services

Key services were available seven days a week to support timely patient care.

Staff on wards could call for support from the critical care outreach team seven days a week. The service did not have a separate outreach team. However, staff told us they performed outreach into the hospital for patients who were at risk of deteriorating or to assist staff working on the wards with complex patients.

Consultants led daily ward rounds on all wards, including weekends. Patients were reviewed by consultants depending on the care pathway. These were documented in patient records and staff told us that they could always contact patient's individual consultants if they had any concerns.

Health promotion

Staff gave patients practical support and advice to lead healthier lives.

The service had relevant information promoting healthy lifestyles. The service promoted independence for patients on the ward. They promoted patients to get up and out of bed as early as possible.

The service had access to leaflets on blood transfusions should patients receive this treatment.

Staff assessed each patient's health when admitted and provided support for any individual needs to live a healthier lifestyle. Staff working in the unit told us that information for patients on leading healthier lives was mainly done pre-admission or on the wards once they had been discharged out of the critical care unit.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Critical care

Staff had limited awareness and understanding about the Mental Capacity Act and Deprivation of Liberty Safeguards. There was no set space for staff to record capacity concerns in patient notes.

Staff had limited knowledge on how and when to assess whether a patient had the capacity to make decisions about their care. Staff had a lack of awareness and understanding about the Mental Capacity Act and Deprivation of Liberty Safeguards (DoLS). Staff told us that if they had any concerns then they would contact the wards in the hospital for advice. We were also told that mental capacity assessments would routinely be done on the medical wards before patients accessed the unit. Staff had a good understanding of delirium, what to assess and how to manage it within the unit.

There was no set space for staff to record consent or capacity concerns in patient critical care notes. This was documented pre-admission that they consented to all necessary treatment during the duration of their stay. However, throughout the patients stay in the critical care unit their capacity may change and require additional assessments.

Managers did not monitor how well the service followed the Mental Capacity Act. The unit did not have any audits on the Mental Capacity Act.

Staff gained verbal consent from patients for their care and treatment in line with legislation and guidance. During the inspection we observed staff speaking with a patient and informing them what they would be doing and why.

When patients could not give consent, staff made decisions in their best interest, taking into account patients' wishes, culture and traditions.

All nursing staff completed training on the Mental Capacity Act and Deprivation of Liberty Safeguards. All staff working in the unit had completed Mental Capacity Act, mental health awareness, Deprivation of Liberty Safeguards and dementia awareness training at the time of our inspection. Managers made sure staff completed training.

Staff working in the unit could not provide us of any examples where patients had DOLS put in place.

Staff knew how to access the policy and get advice on Mental Capacity Act and Deprivation of Liberty Safeguards. Staff working on the unit told us they would contact the patient's consultant or the medical wards if they had any concerns around a patient's capacity.

Are critical care services caring?

Not sufficient evidence to rate 

We did not rate this service for caring.

During the inspection we were only able to speak with one patient therefore we have chosen not to rate this domain.

Compassionate care

Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.

Staff were discreet and responsive when caring for patients. Staff took time to interact with patients and those close to them in a respectful and considerate way. During the inspection we observed staff interacting with a patient and their family throughout their time in the unit.

The patient we spoke with told us staff treated them well and with kindness.

Staff followed policy to keep patient care and treatment confidential. During the inspection we observed staff using curtains to protect patient's privacy when delivering care.

Staff understood and respected the personal, cultural, social and religious needs of patients and how they may relate to care needs.

Emotional support

Staff provided emotional support to patients, families and carers to minimise their distress. They understood patient's personal, cultural and religious needs.

Staff gave patients and those close to them help, emotional support and advice when they needed it. One patient told us that they had been very reassured by all the staff.

Staff working in the service had access to counselling if required.

Critical care

Staff understood the emotional and social impact that a person's care, treatment or condition had on their wellbeing and on those close to them. Throughout the inspection staff we spoke with described how they supported patients in the unit throughout their care and treatment. Staff told us how patients regularly told them that they did not want to leave the unit after their treatment had ended.

Understanding and involvement of patients and those close to them

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

Staff made sure patients and those close to them understood their care and treatment. Feedback that staff told us they regularly received from patients is that they were involved in their care. Families and loved ones were able to stay on the wards. The unit had a recliner chair that could be used as a bed if required for people to stay overnight on.

We spoke to one patient who told us that they had been given options on his treatment.

Staff talked with patients, families and carers in a way they could understand, using communication aids where necessary.

Are critical care services responsive?

Good 

We rated this service as good for responsive.

Service delivery to meet the needs of local people

The service planned and provided care in a way that met the needs of local people and the communities served. It also worked with others in the wider system and local organisations to plan care. The unit had an emergency policy however, this was not printed for use in the event of an electrical or technical failure.

Managers planned and organised services, so they met the needs of the local population. During the inspection we spoke with a patient who had opted to have their operation

at this hospital instead of another local private hospital. The hospital had not had to cancel any operations in the year before our inspection because of a lack of critical care bed.

Facilities and premises were appropriate for the services being delivered. Staff could facilitate families staying overnight in a recliner chair at the bed space of the patient.

Families and friends were permitted to visit the unit between set hours. This was to enable patients to receive enough rest whilst they were in the unit to aid recovery. The hospital had a canteen which served hot and cold food and this was available for families and carers to use.

The service had systems to help care for patients in need of additional support or specialist intervention. The unit had not transferred any patients out of the unit to another critical care unit in the year before our inspection.

Staff told us they performed outreach into the hospital for patients who were at risk of deteriorating or to assist staff working on the wards with complex patients.

The service had an emergency policy. However, the unit did not have a printed copy of this which is a requirement in case of an electrical or technical failure.

Meeting people's individual needs

The service was inclusive and took account of patients' individual needs and preferences. Staff made reasonable adjustments to help patients access services. They coordinated care with other services and providers. However, the unit did not have access to a room where they could deliver bad news to patients' families or where patients families could sit out of the unit.

Staff supported patients living with dementia and learning disabilities by using 'This is me' documents and patient passports.

Staff working in the service were aware of delirium and how this could affect patients in the unit. Due to the unit not having any windows, staff tried to get patients to the wards as soon as they were medically fit for them to be able to see daylight and to help with delirium.

Critical care

Staff told us that they would contact the community mental health team if they had concerns about an individual's mental health. We were also given examples of where patients had their carers stay on the unit with them to enable their care to be continued.

Staff understood and applied the policy on meeting the information and communication needs of patients with a disability or sensory loss. The service could access communication aids when required from other wards in the hospital.

The service had access to information leaflets available in languages spoken by the patients and local community. These would have to be translated by an external company on request.

Managers made sure staff, and patients, loved ones and carers could get help from interpreters or signers when needed. The unit had access to language line for translation of information for patients and their loved ones.

The service did not have suitable facilities to meet the needs of patients' families. Staff told us the unit did not have access to a room where they could deliver bad news to patients' families or where patients families could sit out of the unit. This would instead be delivered in another area of the hospital and families could use canteen/common areas to have a break from the unit.

The unit did not have any windows and so if patients were well enough staff took them to other areas of the hospital and would facilitate them moving back to wards in the hospital as soon as they were well enough.

The unit had a television for patient use, staff told us this was used and helped alleviate boredom for patients.

Patients were given a choice of food and drink to meet their cultural and religious preferences.

Patients had access to a physiotherapist session twice a day as standard. However, the physiotherapists could flex their time and could attend as deemed appropriate for the patients need.

Access and flow

People could access the service when they needed it and received the right care promptly. The service admitted, treated and discharged patients in line with national standards.

Managers monitored waiting times and made sure patients could access services when needed and received treatment within agreed timeframes and national targets. In four out of the four records we looked at all patients were admitted into the unit within four hours of the decision to admit. From January 2018 to December 2018 the unit had a bed occupancy across level 2 and 3 patients of 34%.

Managers monitored waiting times and made sure patients could access emergency services when needed and received treatment within agreed timeframes and national targets.

Staff did not move patients between wards at night. Staff told us they mainly moved patients in the morning after their breakfast or after their lunch.

Managers worked to keep the number of cancelled operations to a minimum. In the year preceding our inspection the hospital had not cancelled any operations because of a lack of availability of critical care beds.

Managers monitored that patient moves between wards were kept to a minimum. The unit had not had any readmissions in the year before our inspection.

Staff supported patients when they were referred or transferred between services. Physiotherapists working in the hospital tried to follow patients throughout their journey in the hospital to create continuity of care. The staff working in the unit could visit patients following their discharge to the wards if there were any concerns.

Learning from complaints and concerns

There was a process for patients to give feedback on the service they received that staff understood. However, the unit did not display information on how to make a complaint.

The service had not received any complaints in the year preceding our inspection, so we were not able to explore how previous complaints had been managed or assess patient complaint themes.

The service did not clearly display information about how to raise a concern in patient areas. During the inspection we did not see information displayed in the unit for patients to be able to see on how to raise concerns.

Staff understood the policy on complaints and knew how to handle them. Staff were aware of where to refer patients

Critical care

to if they had a complaint. The hospital had a patient liaison lead who would visit patients on the unit and listened to patient concerns and helped them through the process.

The unit collected thank you cards. However, these were not formally logged so the service could not give us any figures on how many had been received.

Are critical care services well-led?

Good 

We rated this service as good for well-led.

Leadership

Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff. They supported staff to develop their skills and take on more senior roles.

The critical care unit had a unit manager who oversaw the running of the unit. They were an experienced critical care nurse who had the skills and abilities to run the service and to manage the priorities and issues the service faced.

Staff working in the unit spoke highly of all levels of the leadership team. They told us they were really supportive and regularly visited the unit to check how they were.

The unit manager told us they were well supported and represented by the senior management team. They also told us there were positive working relationships with other critical care managers at other BMI hospitals and other local hospitals.

The leaders for the service understood the challenges of the service and had put actions in place to address them. The unit manager told us how the hospital management team were supportive of the unit's actions.

Vision and strategy

The organisation had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. Leaders and staff understood and knew how to apply them and monitor progress.

As part of the mandatory training that staff completed they also completed values workshops to ensure that all staff were aware of and worked in line with the organisation's values.

The organisation had a five-year vision from 2015 to 2020. The vision was displayed in the unit.

The aim of the organisation as a whole was to 'continuously improve our quality, safety and patient experience'. The aim of the strategy was to ensure an integrated approach where risk management, clinical governance and quality improvement were part of the culture and everyday management practice. The objectives of the strategy were to 'promote an honest, open and blame-free culture where risks were identified and addressed at every level and escalated appropriately, to ensure standards outlined by the Care Quality Commission (CQC) were achieved and maintained and to ensure that the best possible care is delivered by suitably qualified staff.'

Culture

Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service had an open culture where staff could raise any concerns.

Staff told us they felt respected, supported and valued by both the leadership of the service and of the other staff working in the unit. Staff told us they were able to raise their concerns and felt listened to. The hospital had freedom to speak up guardians which were individuals who staff could go to if they need to raise any concerns but want to do it anonymously.

There was a strong emphasis on staff safety and wellbeing. The unit manager told us that they would have more staff working on the unit to meet the needs of the patient above and beyond the numbers that best practice guidelines would dictate. Staff working in the unit also gave examples of when they had been busy senior leaders had come into the department to check on their well-being.

Governance

Leaders operated effective governance processes, throughout the service and with partner

Critical care

organisations. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.

The service participated in the hospital's clinical governance and quality risk meetings. These meetings covered attendances, incidents and significant events, unplanned transfers, readmissions and returns to theatres, deaths, equipment issues, audits, any external inspections, any new procedures developed, patient feedback, complaints, compliments and practising privileges. These meetings occurred monthly and discussed the whole hospital. These meetings included discussions around action plans to address any issues.

There were clear lines of accountability in the service. The quarterly team meetings fed into the hospital clinical governance and quality and risk meetings and these fed down into the team meetings.

The hospital had a sepsis lead who was also the manager of this unit. They had put in place measures to help with the treatment of patients with suspected sepsis and had ideas of how they were going to develop this further.

The hospital had a medical advisory committee (MAC). The MAC met quarterly and reviewed the minutes and actions from the clinical governance meeting and the various sub-committees (health and safety, infection prevention).

Management of risk, issues and performance

Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events.

The unit had a risk register which fed into the hospital's risk register. Staff updated this regularly and there were actions in place to address issues. Staff were aware of the risks to the service which featured on the risk register. The top three risks identified on the risk register related to insufficient investment in facilities and equipment.

The service monitored its performance through a comprehensive audit plan. This was followed up with action plans which were monitored by the unit manager to ensure they were completed.

The service had plans on what to do in an emergency. However, these were stored on the computer system and so could not be accessed if there was a computer failure.

Information management

Staff could find the data they needed, in easily accessible formats. The information systems were integrated and secure.

Staff working in the service were aware of how to find information and this was easily available on the organisations computer systems.

All staff working in the service had undertaken data security and awareness training as part of their mandatory training. Staff we spoke with understood their responsibilities around information governance and risk management.

The service had had one expected death in the unit. The unit appropriately submitted a notification to the Care Quality Commission.

Engagement

Leaders engaged with staff to plan and manage services. However, engagement with patients was limited.

The service held quarterly team meetings. These meetings shared any learning that had occurred in the previous three months and any updates for staff. Staff told us they received information on an ongoing basis through informal conversations on the unit and through the morning huddles.

The hospital had a weekly newsletter for staff in the hospital and a weekly newsletter which covered the whole of BMI. The national newsletter shared good news from across the organisation with staff.

The service conducted yearly staff surveys to gather staff views on the service and what it was like to work there.

The unit did not undertake patient feedback surveys and instead relied on the hospital wards to promote this. However, the unit did speak with patients before discharge to gather informal verbal feedback which staff told us was mainly positive.

Learning, continuous improvement and innovation

Critical care

All staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them. Leaders encouraged innovation and submitted external notifications when required.

This service had not had any internal or external reviews in the year preceding our inspection.

Critical care network meetings were held across the organisation where leads from all the critical care units met

to share best practice and learning. Staff working in the unit also told us how they could contact other critical care units for any queries and other local organisations critical care units.

The organisation held 'Pride of Priory' awards and this unit had recently won an award.

At the time of our inspection this unit was not involved in any research.

Diagnostic imaging

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

Are diagnostic imaging services safe?

Requires improvement 

We previously inspected diagnostic imaging with outpatients and cannot therefore compare ratings with the previous inspection. We rated it as **requires improvement** for safe.

Mandatory training

The service provided mandatory training in key skills to all staff however not everyone had completed it.

All staff were appropriately trained and signed off as competent to administer radiation which met with the Ionising Radiation (Medical Exposure) Regulations (IR(ME)R).

Staff were assigned to mandatory training modules appropriate to their role. All staff were required to complete key modules such as fire safety, information governance, dementia, consent and life support. An electronic system called BMI-Learn was used to keep track of training and access the modules required for e-learning. The imaging manager who had oversight of the training records and key dates for required renewal would raise with staff if they were required to complete it.

We saw evidence that the overall staff compliance rate for mandatory training, for staff within the imaging department, was 90%. The hospital target was 90%. We were not assured that there was a robust governance system in place to provide oversight of mandatory training across the service. Some modules had low

compliance rates for example care and communication of the deteriorating patient 57%, information governance at 77% and, patient moving and handling 86% chaperoning 67%.

All staff in the department were expected to have completed basic life support training however the completion rate was only 65% at the time of the inspection. Staff trained in paediatric intermediate life support rate was 75% and for adult intermediate life support training compliance was at 80%.

Safeguarding

Staff understood how to protect patients from abuse. Staff had training on how to recognise and report abuse and they knew how to apply it.

There was an up-to-date safeguarding policy in place for children available for all staff. The safeguarding adults policy was under review at the time of the inspection yet still available for staff to access. Staff were aware of the named lead for safeguarding and knew the processes to follow to escalate safeguarding concerns and make a referral.

Information about safeguarding was visibly displayed across the department to ensure that staff could access timely advice and support from the safeguarding lead.

The safeguarding adults policy included information about the Mental Health Act (MHA). Both policies included PREVENT advice. PREVENT aims to safeguard vulnerable people from being radicalised to support terrorism or becoming terrorists themselves. There was also specific information incorporating female genital mutilation (FGM) and actions staff should take if they had concerns about these issues.

Diagnostic imaging

At the time of the inspection we saw evidence that 100% of imaging staff had completed the appropriate level of safeguarding training. Staff in the department received level two children's safeguarding training which included child sexual exploitation training. This was in line with the safeguarding children and young people intercollegiate document (2019). Four staff in the department had also completed level three safeguarding children training.

Staff told us when children attended the department they were always supported by a paediatric nurse who was trained in safeguarding at level three. Staff told us if they had any safeguarding concerns prior to, during or after a child's appointment they could discuss them with the paediatric nurse and the safeguarding lead.

Cleanliness, infection control and hygiene

The service controlled infection risk well. Staff used equipment and control measures to protect patients, themselves and others from infection. They kept equipment and the premises visibly clean.

There was a policy that covered standard infection prevention and control precautions for all staff working at the hospital. Infection prevention and control meetings for key staff members to attend took place quarterly. We saw, from the minutes, any issues which arose were discussed, disseminated and action taken appropriately. Staff told us information relating to infection prevention and control was cascaded by email or verbally by their manager. Any infection prevention and control issues were also discussed in departmental meetings.

An infection control nurse conducted monthly infection prevention and control audits that included cleaning, risk assessments and clinical waste checks. We reviewed the latest audit which showed 100% compliance.

All areas inspected were visibly clean and clear of clutter. We observed staff cleaning equipment between uses and items not in use were labelled that they had been cleaned.

Data provided showed 95% of staff across the department had completed mandatory training for infection control in healthcare. Staff we spoke with were aware of current infection prevention and control guidelines.

We saw hand gels were available across the department and available for staff and visitors. Personal protective

equipment was available and used as necessary. A uniform policy was in place and staff adhered to this. Staff were arms bare below the elbow when within the clinical area.

Staff were observed washing their hands and using hand sanitisers in accordance with the National Institute for Health and Care Excellence (NICE) guidance (QS61 statement three). The imaging department completed monthly observational hand hygiene audits. The average compliance over the previous 12 months was 90%. In March 2019, the audit results showed staff were 92% compliant, the only area for improvement was that a staff member's hands had not been decontaminated at the point of care (no sink washing but hand gel only was used).

Staff who attended theatres were observed to adhere to the infection control and prevention guidelines to ensure they did not contaminate the environment.

Staff followed processes to minimise infection risk of insertion and maintenance of vascular access devices in accordance with NICE guidance (QS61 statement five).

We saw staff used and updated cleaning schedules and checklists to ensure tasks for cleaning the environment and equipment were completed in line with recommendations. Arrangements were in place for the appropriate handling, storage and disposal of clinical waste, including sharps.

Patient-Led Assessments of the Care Environment (PLACE) scores for the cleanliness at the hospital in 2018 were 98%. PLACE audits are annual assessments of the non-clinical aspects of the patient environment, how it supports patients' privacy and dignity, and its suitability for patients with specific needs e.g. disability or dementia.

There were protocols to prevent the spread of infection when treating patients known to be contagious. Appropriate equipment was available, and staff knew the additional precautions required in such circumstances such as isolating patients although there were no recent examples of them having to put this into practice.

Environment and equipment

Diagnostic imaging

The design, maintenance and use of facilities, premises and equipment kept people safe. Staff were trained to use them. Staff managed clinical waste well. However, not all required signage was displayed.

The service was located across two floors of the main hospital building. Magnetic resonance imaging (MRI), nuclear medicine and computerised tomography (CT) facilities were on the ground floor and all other diagnostic imaging services were on the first floor.

The department had a range of equipment which included one MRI machine, one CT, two computed radiography (CR) x-ray and two ultrasound machines. The mammography machine was still in use but was being replaced the week following the inspection. There were two image intensifiers and a nuclear gamma camera. For each item of equipment there was a folder of information to support staff in the event of a fault such as telephone numbers of suppliers. This folder also included fault records.

The necessary tests had been conducted on equipment to ensure it was safe for use before it had been used in the department. Records of regular service maintenance of all equipment were complete.

At the last inspection we found that the capital replacement programme for equipment was inadequate. During this inspection we found the MRI and CT scanners had been replaced and although other equipment was nearing or past guideline replacement dates this was on the department and hospital risk register. When equipment was not fit for purpose it was decommissioned. This was the case for an orthopantomogram (OPG) dental x-ray machine so patients were referred to another local clinic that could provide these investigations.

Risk assessments were completed for all new or modified use of radiation. We saw that this considered the risks for both staff and patients in the environment.

All relevant MRI equipment was labelled in line with Medicines and Healthcare products Regulatory Agency (MHRA) recommendations. Equipment stored for use in the MRI had been checked for safety with stickers attached to demonstrate.

The MRI and CT areas required a security fob to access. There was some signage to highlight the MRI area was only for authorised persons and outlined some risks, however warnings did not cover the potential hazards of pacemakers. This did not meet MHRA recommendations.

There had been a projectile incident in the MRI area where an unauthorised piece of equipment had entered. Following this an investigation was conducted and training rolled out by the MRI team to the department and whole hospital staff group. We saw that a document reminding of safety in the MRI area had been distributed to all staff in the hospital with staff signed to demonstrate they had read and understood the safety procedures.

Rooms where ionising radiation exposures occurred were clearly signposted with warning lights. We saw these in use during the inspection.

Staff wore lead aprons to protect themselves from the risk of radiation exposure. The aprons were tested annually to ensure their effectiveness. We saw that these were in good condition and that any deemed to be not fit for purpose were taken out of use.

Staff radiation exposure was monitored by the radiation protection supervisor and records of dose badges were recorded. All staff wore radiation exposure devices to ensure they were not over exposed. Appropriate action would be taken if overexposure was identified.

Substances marked as Control of Substances Hazardous to Health Regulations (COSHH) were stored securely and there was an up to date policy in place that outlined requirements.

Staff managed waste appropriately with separate colour coded arrangements for general and clinical waste. All sharps disposal bins were labelled correctly and not overfilled.

The service used a Picture Archiving and Communication System (PACS) to store patient images. This was a central off-site server for clinicians to securely access and view images. There were two main PACS servers and if one went down the service would automatically connect to the other. There was a business continuity policy in place to cover the event of connectivity issues. The BMI IT network was monitored 24 hours per day, seven days a week and engineers were alerted if a failure occurred.

Diagnostic imaging

Adult and paediatric resuscitation equipment was available and located close to the department. We saw records of daily checks completed and all equipment was within expiry dates and stored securely.

Assessing and responding to patient risk

Staff completed and updated risk assessments for each patient but did not always remove or minimise risks. Staff identified and quickly acted upon patients at risk of deterioration.

There was a protocol for staff to follow in case a patient became unwell in the department including in the MRI room. This was displayed on the walls of clinic areas. Staff told us what action they would take in the event of a patient deteriorating or becoming distressed which was to call the crash team who held an emergency bleep. This was in line with the hospital protocol. If called through this system, an emergency response team led by the resident medical officer (RMO), who were advanced life support trained and available 24 hours per day, would attend to the patient.

Emergency resuscitation equipment was available in the department which included a paediatric 'grab bag' which contained equipment for treating children.

The service had access to support from a radiation protection advisor (RPA) and had five radiation protection supervisors (RPS) who worked on the unit, led on specific areas and provided guidance and support to staff across the department.

The department had written and displayed local rules, as required by the Health and Safety Executive, in all areas where medical radiation was used. Staff followed the local rules and adhered to radiation protection procedures.

An annual radiation protection audit was conducted in all imaging areas. We saw compliance was good in the most recent audit in June 2018. The actions identified in the audit had been agreed and implemented.

A comprehensive questionnaire was given to patients to complete prior to an MRI scan which included asking if they had ever had any metal fragments in their eyes or had a cardiac pacemaker fitted. The questions were also

asked verbally prior to the patient entering the MRI area. Due to the magnets in the scanner these items could create safety issues and so the scan would not be conducted.

There were signs displayed in all areas in the department including changing rooms and waiting areas to inform patients of the importance of discussing with staff any possibility of pregnancy.

Patients were risk assessed to ensure they were suitable to receive contrast prior to procedures. This was in line with the Royal College of Radiologists standards for intravascular contrast agent administration. A screening process where patients were asked about pre-existing clinical conditions that could impact on kidney function took place prior to procedures. Staff also ensured patients were well hydrated before contrast was administered.

The provider guidance for non-medical referrers (NMR) for authorisation covered the requirements for justification of x-ray requests. This was clear and had recently been reviewed at the time of the inspection. We saw when patients were assessed, prior to cardiothoracic surgery, chest x-rays were requested as standard procedure. However, the justification for this was not always documented and the service did not provide evidence they routinely checked if patients had a chest x-ray in the previous three months.

Systems to promote security and safety were in place and well managed. There were alarm systems for secure access areas and key coded locked doors. There were fire alarm procedures and extinguishers were available and well maintained.

At the last inspection we highlighted concerns about the lack of records for cardiologists with practising privileges undertaking cardiac catheter procedures. We reviewed these records during this inspection and saw all the cardiologists had up to date competency checks and training records on file. We saw all staff across the department were acting in the appropriate role and only conducting procedures they had been assessed as competent to do.

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Staff took appropriate action following several suspected contrast reactions. Staff treated patients according to their needs and remained in the department until it was confirmed that they were well enough to be discharged with advice.

There was an on-call rota for urgent out of hours radiography. A minor interventional service was offered by radiologists during department opening hours. However, there was no current formal procedure for radiologist out of hours cover which had been operating on a goodwill basis. There were plans for a teleradiology service for reporting which was to be in place the month following the inspection.

At the time of the inspection there were no specific targets set for the service to meet with reporting times. We saw that reporting times were tracked by managers and audited and at the time of the inspection the average time for reporting was between 24 and 48 hours although could be up to seven days. Staff we spoke with were clear of the process to follow in the event of unexpected or significant findings at the examination and upon reporting. Referrers were contacted directly via email or letter and so sharing of results was done in a timely manner.

We observed the processes to ensure the correct patient received the right scan at the right time. Staff completed checks in line with the requirements of IR(ME)R to safeguard patients against incorrect investigations.

Sepsis information including protocols and up to date guidance was available in a folder in the department and displayed visibly.

Arrangements within the service when treating children were safe. A paediatric nurse trained in paediatric immediate life support was always present when a child was being treated in the department.

Staffing

The service had enough staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment.

Managers regularly reviewed and adjusted staffing levels and skill mix, and gave bank, agency and locum staff a full induction.

Staff worked across both hospital sites and comprised of: one whole time equivalent (WTE) clinical service manager, one WTE deputy clinical service manager, four WTE lead radiographers, six WTE senior radiographers, one WTE radiographer and 1.3 WTE nurses. All staff working within the service had current professional registrations. There was 0.9 WTE technologist and 4.4 WTE imaging department aids. There were also 22 bank staff members including sonographers, radiographers, nurses and imaging department aids.

Managers planned rotas adjusting the staff numbers and skill mix around the requirements of patients attending.

Vacancies within the service were managed safely. There was one whole time equivalent (WTE) nurse vacancy and 1.6 WTE radiographer vacancy. These positions were being actively recruited for with both being out to advert at the time of the inspection. Bank staff were covering these gaps to meet staffing requirements.

Sickness within the service was low. The staff sickness rate in the department was 1.8% in the 12 months prior to the inspection. This was below the BMI corporate target of 3%.

Medical staffing

The service had enough medical staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment.

Medical staff were employed by other organisations (usually local NHS trusts) in substantive posts with practising privileges with The BMI Priory Hospital.

The department employed 37 radiologists in total across both hospital sites. Staff in the department told us they had good working relationships with the radiologists who were allocated for services and were always able to access for advice and support.

Records

Staff kept detailed records of patients' care and treatment. Records were mostly clear, up-to-date, easily available to all staff providing care but not always stored securely.

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We reviewed patient records which included imaging requests and World Health Organisation (WHO) safety checklists. Of those we reviewed we saw documentation was not always fully completed and signed.

Staff in the department audited WHO checklist documentation monthly. The two most recent audits for the catheterisation laboratory in April and March 2019 showed 80% and 79% compliance. When we reviewed the records that were marked as incomplete we saw the documentation had actually been completed correctly and therefore the audit was incorrect. As a result, the service manager planned to review the audit process to check staff understanding of how to answer the audit questions accurately.

The service provided electronically encrypted reports within a picture archiving and communication system. This was medical imaging technology which provided storage and convenient, secure access to images from multiple modalities. This system enabled patient information to be shared across teams and services requiring the information in line with NICE QS15 Statement 12.

Patient records were stored in a room within the imaging department. Although this room could be locked, staff told us it was not routinely locked when unattended, records were not in a locked cabinet and so could potentially have been accessible to the public. Following the inspection, the provider informed us that a keypad lock had been installed.

All computers observed were locked and password protected when not in use. Computers were in rooms out of public areas which reduced the risk of confidential patient information being seen by other patients or visitors.

Medicines

The service used systems and processes to safely prescribe, administer, record and store medicines.

All medicines were kept in locked cabinets in the radiology department. All but one of the medicines we checked were within expiry dates. The out of date medicine which expired in January 2019 was immediately removed and disposed of.

There was a medicines log book and staff in the department checked this daily. A monthly audit of

medicines was carried out and led by the pharmacy team. We reviewed this and saw that the environment, storage and random samples of expiry dates for medicines were checked. As we found that there was an out of date medicine in the department this part of the audit process was ineffective.

Patient group directions (PGDs) arrangements were safe. PGDs allow specific health care professionals to supply and/or administer a type of medicine directly to a patient with an identified clinical condition without the need for a prescription or instruction from a prescriber. There were two PGDs in this department to allow trained and assessed radiographers to administer such medicines including contrast medium. We reviewed the PGDs which were in date and contained the appropriate information.

Staff took precaution to ensure the right patient received the right medicine. Patient identity and dose was checked and, confirmed prior to administering. Radiographers checked the contrast solution with a colleague after cannulation to ensure the accurate medicine had been given.

Incidents

The service managed patient safety incidents well. Staff recognised and reported incidents and near misses. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support. Managers ensured that actions from patient safety alerts were implemented and monitored.

The clinical service manager had oversight of all the incidents reported within the department. An electronic system was used to manage incident reporting. From May 2018 to April 2019 there had been 32 incidents reported in the diagnostic imaging service.

If an incident occurred staff apologised to the patient and provided open, honest information as well as appropriate solutions. We reviewed examples of incidents and saw that appropriate investigations were conducted and that lessons learnt were shared across the whole team.

From May 2018 to April 2019 the diagnostic imaging service had not reported any incidents classified as never events. Never events are serious patient safety incidents which should not happen if healthcare providers follow

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national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need to have happened for an incident to be a never event.

In the twelve months prior to the inspection there had been no ionising radiation incidents reported at the hospital. We did review an incident that occurred slightly before this timeframe, an appropriate investigation took place and the patient received a letter with an honest explanation and apology. The referral form for radiology had been changed nationally to reflect the learning. The appropriate bodies had also been informed about the incident.

The service received external safety alerts appropriately and sought advice from external bodies when required as a response to incidents that occurred in the department.

Incidents and themes were discussed in the diagnostic imaging department monthly staff meetings. These included incidents raised across both hospitals and nationally when relevant.

We saw minutes from the medical advisory committee (MAC) where incidents were discussed, and actions identified.

Are diagnostic imaging services effective?

Not sufficient evidence to rate 

We currently do not rate effective for this core service.

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence-based practice.

Managers checked to make sure staff followed guidance.

The service followed the policies and guidance from the BMI group. We reviewed the standard operating procedures (SOPs) in place across the department and saw they were clear and up to date. We saw the SOPs were based on national guidance and regularly reviewed. The clinical service manager and deputy clinical service manager had oversight of all the SOPs and ensured that new starters, and all staff when there were updates, reviewed and signed the documents.

At the time of the last inspection the service was not routinely using iRefer (an imaging referrals guideline). However, we saw this was now in use and therefore the referral criteria for clinicians was clear.

There were five radiation protection supervisors (RPS) appointed in line with Ionising Radiations Regulations. The RPS ensured staff followed standard operating procedures and guidance. They were accessible to staff for advice and support with radiation protection procedures.

Dose reference levels were set by an external radiation protection service in line with the national reference levels. Patient doses were monitored and audited. We saw results of annual audits conducted by the radiation protection advisor and action taken to investigate the cause of higher radiation for certain procedures.

Nutrition and hydration

Staff gave patients enough food and drink to meet their needs.

Patients received information to advise about timescales for when they could eat and drink in advance of any invasive procedures. This was provided in the appointment letter.

Water and hot drinks were available in the waiting room for patients and those attending with them.

Staff told us if a patient had a condition that affected their need for regular dietary intake, such as diabetes or frailty, they would be prioritised to avoid as much disruption to their usual routine as possible.

Pain relief

Staff assessed and monitored patients regularly to see if they were in pain.

Radiology staff did not routinely use pain relief. However, staff assessed patients comfort prior to completing procedures and aided with repositioning if required.

Patient outcomes

Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for patients.

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The radiology department conducted local audits such as infection control and World Health Organisation (WHO) checklist documentation. The results were compared with other departments and services.

An internal audit to self-assess the department had been undertaken in December 2018. The score was 88% and we saw all but one of the areas for improvement had been addressed. The outstanding point for improvement was 24-hour availability of a radiologist. From the month following the inspection, a plan for a tele-reporting radiologist service would be available.

Radiologists working in the department under practising privileges participated in peer review of findings. If there were reports of discrepancies the service was informed. There had not been any such reports in the twelve months prior to the inspection.

Competent staff

The service made sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and development.

There were records of radiographer's Health and Care Professional Council registration in line with the Society of Radiographers' recommendations.

Radiographers in the department completed competency assessments prior to using equipment. We saw records of staff training and competencies which were up to date and clearly documented. The manager of the service reviewed competencies during the annual appraisals and identified any further training needs.

Data provided showed, at the time of the inspection, 88% of applicable staff were up to date with their appraisal. Staff we spoke with said they found the appraisal process to be of value and development opportunities were identified through it.

All radiologists working in the department had practising privileges which gave them the authority to work at the hospital. Appraisal information was shared by their main employer (usually a local NHS trust). There had been some cases where it was unclear of the current work areas in which radiologists were currently practising and

so the process had been improved in the twelve months prior to the inspection. This was still included on the hospital risk register due to the ongoing potential risk of the lack of information.

For radiologists granted practising privileges at the hospital, appropriate information was sought from their main employer (usually a local NHS trust). This included their most recent appraisal, information with regards to training and competencies and discrepancy audits which were peer reviewed.

The service had developed a comprehensive induction booklet for new staff. This included general information about the hospital, working for the provider, systems and processes as well as training and competencies. There was a separate induction process for bank and agency staff adapted to meet their needs but ensure they were working to the requirements of the service.

There was information on the intranet and printed copies displayed for staff to access that covered up to date information about the local and national guidance. This was kept up to date and staff knew where to access this information.

There was a paediatric nurse available to attend when children were seen in the department. In addition to this support four staff were trained to level three in safeguarding children, six trained in paediatric basic life support and two trained in paediatric immediate life support.

Multidisciplinary working

Staff of different kinds worked together as a team to benefit patients. They supported each other to provide good care.

There was effective team working between all staff groups. We saw that staff across disciplines prioritised the patient experience and communicated well to meet their needs.

There was a daily communications meeting attended by staff from all departments in the hospital. Information was shared and then disseminated across the services.

Radiologists were accessible and there was a good working relationship with staff across the hospital. Staff told us they could contact them at any time for support and guidance despite no formal on call arrangement.

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Information was shared between radiologists and referring consultants in a direct and timely manner.

Seven-day services

Key services were available seven days a week to support timely patient care.

The department was open 8:30am to 8pm Monday to Friday and 9am to 1pm on Saturdays.

Radiographers covered an out of hours on call rota for urgent night and weekend services.

There was no formal on call rota for radiologists. Staff told us they were able to access radiologists to perform urgent scans, but this was done on a goodwill basis. At the time of the inspection a teleradiology service for reporting was being arranged to be in place the following month.

Health promotion

Staff gave patients practical support and advice to lead healthier lives.

There was a range of information displayed in the waiting area on health and health promotion. There were some leaflets available to advise patients about health issues including breast care.

Consent and Mental Capacity Act

Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients' consent. They knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health.

Training on the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DOLS) formed part of staff mandatory training. We saw that 100% of staff in the department had completed this training.

The hospital policy for MCA and DOLS was up to date and accessible for all staff. The safeguarding adults policy also included information to guide staff about the MCA.

Staff were aware of the process to follow if they had concerns about a patient's mental health or capacity to consent verbally to investigations. Staff told us if this was the case they would discuss with the imaging manager, radiologists and the patients GP when appropriate.

Children over the age of 16 who attended for investigations accompanied by a responsible adult were asked by staff to consent to their treatment when deemed competent to do so.

Are diagnostic imaging services caring?

Good 

We have rated this service as good for caring.

Compassionate care

Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.

We saw staff treat patients in a respectful and caring manner. Staff spoke about the personal, cultural, social and religious needs of patients in a non-judgmental way. We saw staff introduce themselves and explain their role. All the patients we spoke with told us they had felt the staff were attentive and took the time to treat them with a caring manner.

The reception desk was situated away from the waiting area and so allowed for patients to speak to the receptionist without being overheard.

The provider conducted a patient satisfaction survey. Results for the diagnostic imaging department in March 2019 showed 99.4% of patients would recommend it to their friends and family. Comments from patients included "staff are so friendly, helpful and professional" and "the staff are wonderful. They are all so kind and put you at ease."

We spoke with patients and their relatives who were all positive about the care and treatment provided in the department. A patient told us "staff are really helpful and kind".

Staff informed patients that chaperones were available. Only 67% of staff had completed mandatory training for chaperoning.

Patient-Led Assessments of the Care Environment (PLACE) in relation to privacy and dignity scores were high. PLACE are annual assessments of the non-clinical aspects of the patient environment, how it supports

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patients' privacy and dignity, and its suitability for patients with specific needs e.g. disability or dementia. PLACE scores for privacy and dignity at the hospital for 2018 were 86%.

Emotional support

Staff provided emotional support to patients, families and carers to minimise their distress. They understood patients' personal, cultural and religious needs

Staff supported patients through procedures by keeping them well informed throughout and provided reassurance.

Staff adapted their approach to provide appropriate additional reassurance for patients who appeared anxious about the processes. Staff provided information and timescales to help patients feel informed and comfortable.

Staff kept patients informed of any waiting times to reassure and minimise distress. The department had a calm and quiet atmosphere at the time of the inspection and patients told us they had not experienced a long wait.

Understanding and involvement of patients and those close to them

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

Prior to their procedure, staff took the time with patients to go through any concerns or preference in line with NICE Quality Standard 15 Statement four: Patient experience in adult NHS Services.

Staff told us if patients informed them they were particularly anxious about any part of the procedure they were offered the opportunity to attend in advance to see the department and equipment. This was always offered to children using the service.

Relatives or carers were permitted to remain with the patient throughout the appointment when appropriate and safe, if requested.

Are diagnostic imaging services responsive?

Good 

We rated this service as **good** for responsive.

Service delivery to meet the needs of local people

The service planned and provided care in a way that met the needs of local people and the communities served. It also worked with others in the wider system and local organisations to plan care.

The department planned services around the needs of patients with appointments available Monday to Saturday including evenings.

The hospital and department were clearly signposted and there was ample car parking close to the department. The facilities and premises were appropriate for the services being delivered. The MRI and CT department had been relocated and equipment replaced which was an improvement from the previous inspection.

At the time of the previous inspection there were limitations on the service provided. This included MRI scans being available every other week and CT scans for patients aged under 50 were unavailable. These services were now available, and appointments could be booked and patients seen within three days.

The waiting area was suitable and comfortable for adults. There was enough seating, toilet facilities and drinks available. However, there was no separate waiting room for children or quiet areas for patients who may find it distressing to wait in a busy environment.

Information was provided to patients prior to their appointments. Information included relevant information about the procedure, any fasting or samples required and directions. The information was only available in standard format and not in any other language, large print or any other format.

Staff assisted patients with transport needs if required. For example, staff arranged for a taxi to transfer patients to other sites when there had been issues with equipment.

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Meeting people's individual needs

The service was inclusive and mostly took account of patients' individual needs and preferences. Staff made reasonable adjustments to help patients access services.

Appointment times allowed for patients to ask questions and take their time prior to and after procedures. Staff went through information, provided reassurance and allowed flexibility to meet the needs of patients.

Staff told us alerts would be put onto referral forms for patients with disabilities, sensory loss or complex needs including mental health, dementia or learning disabilities. When appropriate staff would encourage carers and/or relatives to attend appointments with patients. Staff told us they would try to accommodate the needs of patients to ensure their comfort.

Wheelchair access was available at the main entrance of the department with automated doors. All areas across the department were large enough to accommodate wheelchairs and patients with mobility issues. An MRI safe trolley or wheelchair was available to assist patients with mobility issues enter the MRI scanning room.

The MRI scanner was wide bore and equipment adaptable to accommodate the needs of bariatric patients.

Noticeboards in waiting areas were up to date and had a range of information about the processes conducted in the department and reassuring advice.

Although staff offered patients the choice of waiting in the changing area if they preferred, the waiting area for x-ray was shared with the pathology service. Patients would use the private changing rooms to undress and wear an appropriate gown. However, this meant that patients wearing gowns may be waiting with other patients who were fully dressed and was an issue with regards to their privacy and dignity. This was not on the service risk register.

Telephone or face to face translation services were available where English was not the patient's first language. Information leaflets were available in other languages or other accessible formats when required.

Access and flow

People could access the service when they needed it and received the right care promptly.

The service met the six-week diagnostic test national standard. We saw waiting times had been up to two weeks however, improvements with staffing had reduced this and at the time of the inspection there were appointments available within three days. This was an improvement from the previous inspection where there were longer waits for MRI scans.

A bookings and administration team managed patient appointments. NHS patients could use the Choose and book portal. Appointments for urgent cases, such as cancer were prioritised. There was flexibility with dates and times so people could access the service at a time to suit them.

Although there was no local key performance indicator set, diagnostic tests were usually reported on between 24 and 48 hours, although this could be up to seven days for specific tests depending on radiologist availability. Reports were sent to the referring clinician.

At the previous inspection CT scans for the under 50s were not offered due to the standard of equipment. This has since been replaced and so these scans were now available.

Did not attend (DNA) rates were monitored by the service. The number of appointments unattended were very low for example only 10 patients did not attend for their MRI appointment in April 2019.

Learning from complaints and concerns

It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff. The service included patients in the investigation of their complaint.

Leaflets to inform patients of the complaints process were available in the waiting area. We reviewed the information provided which outlined the process for making a formal complaint and what steps to take if complainants were dissatisfied with the outcome.

Staff were clear of the protocol to follow if there were concerns raised. There was an up to date policy which

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outlined the process and responsibilities. They told us they would try to resolve this at a local level where possible but would also inform the patient of the formal complaints process.

The hospital analysed and discussed complaints during the quality and risk meeting. The imaging service had received four complaints in the twelve months prior to the inspection. Staff told us that site and cross site wide complaints were discussed in departmental meetings.

We saw an example of the response to a complaint about the department. We saw that the issues raised had been fully investigated. An open explanation and apology were provided to the patient as well as offering appropriate solutions.

We saw there had been learning in the department from concerns raised and changes made as a result of complaints. A recent example included concerns about communication during an MRI scan and lack of clarity of who was present in the area. Following investigation, the team ensured that they introduced the entire team to patients and took additional time to ensure roles were clear to patients.

there were a number of risks identified during the inspection that had not been identified by managers or included on the department risk register and therefore not escalated or managed appropriately. This showed the management team did not have full oversight of all of the challenges to quality and sustainability of the service.

Staff told us the managers were visible and approachable. They demonstrated they had most of the skills, knowledge and experience through the support provided to the team.

The department managers told us they were well supported and represented by the senior management team. They also told us there were positive working relationships with other diagnostic imaging department managers at other BMI hospitals.

There was a mix of staff members who had worked at the hospital for a long time and new staff groups. The MRI staff had all been appointed within the previous eighteen months. All staff told us their line managers kept them informed and supported them in the running of the department.

Vision and strategy

The service did not have a local vision for what it wanted to achieve and workable plans to turn it into action, developed with staff, patients, and local community groups.

There was no clear local department strategy. There was a plan to relocate the diagnostic imaging service to the ground floor of the hospital alongside the MRI and CT area. Replacing all the outdated equipment formed part of the strategy. This was still in the initial stages of planning at the time of the inspection.

BMI had a corporate five-year vision to “deliver the best patient experience, in the most effective way”, from their comprehensive UK network of acute care hospitals. Staff in the department were aware of this overall provider vision and the way their department and work fed into this.

The local BMI vision was “to integrate BMI The Priory and Edgbaston Hospitals into BMI Birmingham, taking best in class to create a two site, single hospital delivering outstanding care in the right location”. This was displayed throughout the department and staff knew what this was and their role to achieve this.

Are diagnostic imaging services well-led?

Requires improvement 

We rated this service as **requires improvement** for well-led.

Leadership

Managers at all levels in the service did not have all the right skills and abilities to run a service providing high-quality sustainable care.

Since the last inspection a new clinical service manager was in post. All staff we spoke with told us there had been much positive development and change in the department. Staff said they felt there was good leadership within the service and organisation.

Several issues and risks had been addressed and rectified by the new manager or were in the process with mitigation in place. Longstanding matters and challenges in the service had been investigated and worked on by the current management team. However, we saw that

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The clinical service manager had attended the local university to promote the hospital to students which was part of the recruitment strategy.

At the time of the previous inspection in 2016 the department strategy outlined plans for a new MRI and CT unit. This was up and running at the time of this current inspection.

Culture

Managers across the service promoted a positive culture that supported and valued staff, creating a sense of common purpose based on shared values.

Staff told us they were proud to work in the department. They felt there was a good team working culture and that they were respected and valued. They said they had ample opportunity to develop and if they requested training they were usually given the funds and time to participate.

Staff had a positive attitude to patient care. Patients were the focus of the service and wherever possible, care was delivered around the individual needs of patients.

Managers encouraged learning and an open culture. Staff told us they were supported and encouraged to report incidents and raise concerns. Staff were clear of their responsibilities under the duty of candour and gave clear examples. The details of the speak up guardian were displayed in the department.

The appraisal process had been improved since the previous inspection. Staff told us they had welcomed the opportunity to receive feedback about their work and it was an opportunity to discuss plans for development in their role.

Staff told us monthly departmental meetings were useful and an opportunity to be updated with important information in the department and across the hospital sites. We saw minutes were available following the meeting for any staff unable to attend.

Staff had requested further clinical and professional development opportunities and so training sessions were added to the agenda of team meetings every other month. There was a list of the upcoming development

sessions displayed and staff told us they had input into what was included. External speakers had attended for some sessions and some were delivered by leads within the team.

Staff told us they were well supported by the current management team and that there had been significant improvements with this since the last inspection. Some staff required flexible working arrangements which were managed well.

There was a Commissioning for Quality and Innovation (CQUIN) target for staff health and wellbeing that the hospital worked towards achieving and was managed overall by the senior executive team.

Governance

The service did not always systematically improve service quality and safeguard high standards of care by creating an environment for excellent clinical care to flourish.

The oversight of medicines within the department did not robustly ensure that medicines stored were safe. During the inspection we found one medicine that was past the expiry date. This had not been identified during department checks or pharmacy team audits and therefore these may have been ineffective.

The signage in the department did not adequately cover all potential risks to patients or staff. This had not been identified during department audits.

There was a clear structure and process to support the delivery of the service. We saw how information flowed from the department to the senior management team through meetings and communications and how information was cascaded down. Departmental meetings reported into the clinical governance committee which reported into the medical advisory committee (MAC).

The local radiation protection committee reported into the radiation protection advisory board (RPAB). The RPAB reported into the BMI national radiation protection committee and that into the BMI national health and safety committee.

The senior management team reported to the regional and national clinical governance structure. Performance in audits was benchmarked and discussed at regional and national meetings.

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The clinical service manager for the imaging department told us the department was well represented at all levels. When information needed to be escalated this was done in a timely and effective manner with appropriate actions instigated.

The department had a lead radiologist who acted as a representative for radiology at the radiation protection and medical advisory committee meetings.

We saw monthly medical advisory committee (MAC) quality reports that clearly outlined incidents, patient satisfaction, complaints and audit results. The reports were discussed at the MAC meetings as we saw in the detailed minutes.

Daily communications meetings took place at the hospital and key information from these were cascaded to the team. Staff across the department were clear about their roles and what they were accountable for.

There was a service level agreement to outline the responsibilities and expectations of the radiation protection third party provider.

Managing risks, issues and performance

Leaders and teams did not manage all performance effectively. They identified and escalated most relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events. Staff contributed to decision-making to help avoid financial pressures compromising the quality of care.

The risk register was held at hospital level with the imaging department feeding into this. We saw a more detailed service level risk register which included full detail and mitigation for risks. All staff were aware of the top risks for the service.

For imaging, the main risk identified was multiple pieces of equipment nearing or at the end of life. The lack of formal out of hours cover by radiologists was also on the risk register. We saw that the departmental register outlined the specific equipment and what quality assurance was required to ensure the safety and quality of the service provided with its use. The departmental risks on the register were reviewed regularly at monthly clinical governance meetings and updated when required.

The lack of complete documentation of risks for patients in accordance with best practice had not been identified by managers. We were not assured that there was management oversight of these risks for patients and that appropriate monitoring was taking place.

We had concerns about the waiting area being shared with pathology and the potential risks for privacy and dignity issues. This was not on the department or hospital risk register.

There had been significant improvements with the management of risks and performance since the previous inspection. The current clinical service manager had uncovered an issue with historical reporting, dating back to 2009, where over 2000 imaging examinations were unreported. The department now had a robust process to ensure this did not occur again. Each historical case had been individually investigated to ensure there were no missed diagnosis of patients. At the time of the inspection there had been no cases of harm however there were still 140 cases left to review. An action plan was in place which included these cases assigned to radiologist for review and further investigation if necessary. This was also an item on the risk register to ensure continued oversight at corporate level.

During our last inspection we saw the equipment replacement programme was not locally risk based. We saw the current risk register outlined specific equipment and the detail required to mitigate risks. Local needs for equipment were therefore adequately reflected.

Managing information

The service collected, analysed, managed and used information well to support all its activities, using secure electronic systems with security safeguards. However, paper records were not always stored securely.

Staff had sufficient access to information to deliver effective care. Staff showed us how to access information through the computer system which was easy to navigate. There were also paper versions of standard operating procedures and key information.

This included internal audits of the department and comparisons across other BMI services.

Diagnostic imaging

There were enough computers available and the system was effective for staff to access patient records.

Radiologists were able to access diagnostic results remotely through the electronic system. This prevented delays with information sharing and reporting to the referring consultants.

We saw that paper records were kept in a room in the department. Staff told us that when left unattended this room was not always locked. This was a risk to the confidentiality and security of patient information and was not on the risk register. The manager told us this would be addressed at the time of the inspection.

Engagement

The service engaged well with patients and staff effectively.

The department gathered feedback from patients through the patient satisfaction survey.

Although there was no separate waiting area for children there was a section where there were some stickers on the wall and some toys. Staff told us the stickers had been placed by a child attending the department and following feedback that some toys would be helpful.

Staff had input into the development of the service. Staff told us they felt their ideas to improve the service were listened to and if they had a specific interest of idea to develop this was well supported. An example of this was

the team exploring more effective ways of working with changes to staff shift patterns. There was a working group putting together a strategy for the changes at the time of the inspection.

Regular newsletters and bulletins were distributed which included key information for staff including performance and updates. This also included a recognition section and staff in the department had been nominated for their achievements.

Learning, continuous improvement and innovation

The service was committed to improving services by learning from when things went well or wrong, promoting training and innovation. However, innovation was limited due to out-dated equipment.

There was a positive culture for training and development in the department. Staff told us, and we saw from planned sessions and records that learning was encouraged and support was provided.

Appropriate investigations and action was taken when incidents occurred. There had been significant changes and improvements in the department since the previous inspection.

Regular audit and review of performance led to changes within the department to improve the quality of service provided to patients.

Managers of the service aspired to drive innovation through the department and hospital however were limited to what they could achieve with this due to the amount of outdated equipment still in use.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

Action the provider MUST take to meet the regulations:

Diagnostic imaging:

- The provider must ensure all signage in the MRI area meets MHRA standards. This was a breach of the Health and Social Care Act, Regulation 12: Safe Care and Treatment.
- The provider must ensure patient records are stored securely. This was a breach of The Health and Social Care Act, Regulation 17: Good Governance.
- The provider must ensure staff completion of mandatory training. This was a breach of The Health and Social Care Act, Regulation 17: Good Governance.

Surgery:

- The service must ensure that there is a staff member trained to advanced life support level immediately available to attend the recovery area in theatres. This was a breach of The Health and Social Care Act, Regulation 12 (2c).
- The service must ensure that the world health organisation's (WHO) five steps to safety surgery checklist is completed fully for each patient. This was a breach of The Health and Social Care Act, Regulation 12 (1) (2b).
- The service must ensure that patients' records are stored securely at all times on the surgical wards. This was a breach of The Health and Social Care Act, Regulation 17 (c).
- The service must ensure staff complete the mandatory training assigned to them. This was a breach of The Health and Social Care Act, Regulation 12 (2c).

Critical Care:

- The service must ensure that the sluice area of the unit is locked and that COSHH should be locked away. This was a breach of The Health and Social Care Act, Regulation 12.
- There was no set space for staff to record consent or capacity concerns in patient notes. This was a breach of The Health and Social Care Act, Regulation 17.

Medical care:

- The provider must ensure that assessments on admission are comprehensive and include all patient needs, including health, personal care, emotional, social, cultural, religious and spiritual. This was a breach of The Health and Social Care Act, Regulation 9(3)(a)
- The provider must ensure it acts in accordance with the requirements of the Mental Capacity Act 2005 and associated legislation. This was a breach of The Health and Social Care Act, Regulation 12(2)(a)
- The provider must review its documentation to ensure it is reflective of current best practice, guidance and legislative requirements. This was a breach of The Health and Social Care Act, Regulation 12(2)(b)

Action the provider SHOULD take to improve Surgery:

- The provider should document clearly and consistently information that is key to assessing patient risk.
- The provider should formalise on call arrangements with radiologists to ensure out of hours cover is always available when required.
- The provider should make available information leaflets in accessible formats and languages.
- The provider should review and update all policies in a timely manner.
- The provider should consider ways to improve the x-ray waiting area to ensure the privacy and dignity needs of patients are always met.

Outstanding practice and areas for improvement

- The service should ensure that venous thromboembolism (VTE) risk assessments for surgical patients continue to be completed. Regulation 12 (a) (b) (h).
- The service should ensure that planned maintenance to the theatres goes ahead without delay to ensure the environment is suitable and safe for use. Regulation 15 (1e).
- The service should ensure the installation of an uninterruptable power supply in theatres as part of theatre upgrade programme. Regulation 12 (a) (b).

Critical Care:

- The unit should consider displaying information in the unit on how to make a complaint.
- The unit should consider improving that awareness and understanding about mental capacity act and Deprivation of Liberty Safeguards (DoLS). (Regulation 18)
- The unit should consider having a printed copy of the emergency policy in case of an electrical or technical failure.
- The unit should consider having a designated space where staff could deliver bad news to patients' families or where patients families could sit out of the unit.
- The unit should consider how patients are supported to use toilet facilities to ensure care is delivered in a dignified way.

- The unit should ensure that all equipment is cleaned thoroughly. (Regulation 15 (1a)).

Medical Care:

- The provider should consider the temperature within Dudley ward is safe, and staff and patients are not exposed to extremes of temperatures that could impact their health, safety and wellbeing.
- The provider should consider its approach to providing all new staff with timely mandatory training when commencing employment at BMI The Priory.
- The provider should review its data collection to ensure it supports patient outcomes in the future.
- The provider should consider its approach to taking consent from patient, ensuring it complies with best practice and national standards in relation to taking consent.
- The provider should provide an annual appraisal to all staff.
- The provider should review the process for recording risks related to medical care on the corporate risk register.
- The provider should consider how strategies and plans for improvement are clearly documented and measured and consider how staff are fully involved in forming and reviewing the strategies.

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 9 HSCA (RA) Regulations 2014 Person-centred care

Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2014 Person-centre care

Medical care

Regulation 9(3)(a)

Regulated activity

Regulation

Diagnostic and screening procedures

Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment

Regulation 12 HSCA 2008 (Regulated Activities) Regulations 2014 Safe care and treatment

Regulation 12 (1)(2)(d)

(Medical care)

Regulation 12 HSCA 2008 (Regulated Activities) Regulations 2014 Safe care and treatment

Regulation 12(2)(a)(b)

Regulated activity

Regulation

Diagnostic and screening procedures

Surgical procedures

Regulation 17 HSCA (RA) Regulations 2014 Good governance

Regulation 17 HSCA 2008 (Regulated Activities) Regulations 2014. Good governance.

Regulation 17 (2) (b)(c)(d)(ii)

This section is primarily information for the provider

Requirement notices

Regulated activity

Diagnostic and screening procedures

Surgical procedures

Regulation

Regulation 18 HSCA (RA) Regulations 2014 Staffing

Regulation 18 HSCA 2008 (Regulated Activities)
Regulations 2014. Staffing.

Regulation 18 (1)(a)