BMI The Priory Hospital

Quality Report

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

Ratings

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

Summary of findings

Letter from the Chief Inspector of Hospitals

We inspected BMI The Priory Hospital as an announced comprehensive inspection. We inspected the core services of medical, surgery and outpatient and diagnostic imaging services at The Priory on the 16 and 17 of February. We also visited unannounced on the 18 and 25 of February 2016.

The hospital provides a range of services, which include Medicine, Surgery, Outpatients and diagnostics. In addition to this, they have a critical care unit we did not inspect due to the proportion of activity being only seven percent. The fertility service was not inspected as the Human Fertilisation and Embryology authority (HFEA) regulates it. NHS funded patients accounted for 16% of the patient population.

Children and young people were seen predominantly in outpatients, and were accompanied by a parent at all times.

Facilities at the hospital include a fertility clinic, on site pharmacy, imaging, nuclear medicine, oncology day centre, six bay intensive therapy unit, cardiac catheterisation lab, five theatres and 118 registered beds. In addition to the main hospital site, there are stand-alone buildings for outpatients, MRI, physiotherapy and health screening.

To meet the commitment we had made to inspect independent hospitals this service was a scheduled comprehensive inspection. We had no prior concerns to make this service high risk.

The hospital was rated requires improvement overall, we looked at three core services which were medicine, surgery and out patients and diagnostic imaging.

The area of most concern was diagnostic imaging relating to incident management and equipment.

Are services safe at this hospital

- X-ray incidents were reported and learning was shared.However, we did note a serious flaw in the process; Outpatients raised an incident where they did not follow process, which led to a serious incident not being acted on in a timely manner.
- Where investigations took place, they did not all follow the BMI corporate policy particularly in relation to route cause analysis (RCA). Some staff undertaking this role had not been trained to do so; although at the time of the inspection training had been arranged for staff to access. Action plan management was not evident either not written or monitored for completion therefore learning opportunities were missed.
- Staff received Duty of Candour training but their understanding was variable.(The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support to that person.); however staff had some understanding of parts of the regulation.We saw that the hospital could not demonstrate how they had met all the parts of the regulation when an incident had occurred which met the benchmark to trigger.
- Effective use of the '5 Steps to Safer Surgery' checklist was not consistently followed amongst the staff required to use it.
- Safeguarding training was delivered to staff. However, due to the way training was delivered staff could not readily identify what level of training they had received.
- The director of clinical services was trained to level 3 for safeguarding children.Another member of staff trained to level 3 safeguarding children was present when children were booked for consultations.

Summary of findings

- There was an infection control lead to support staff, who worked across sites at another local BMI hospital.We found that infection control practices were mostly good.However, we did observe some poor practice in theatres and on an inpatient suite.
- The equipment replacement programme was not ensuring the replacement of essential equipment when it was required.This led to a piece of equipment, which could not be used, on anyone aged 50 and under as it was unsafe to do so.
- Nurse staffing was well managed The Priory had a cohesive staff group, despite the staff turnover for all staff types at 27% (October 2014 – September 2015). There was a vacancy rate of 8% (October 2015).At the time of our inspection, a member of the senior management team told us there were seven outstanding posts for nursing staff.Staff sickness rate was 4% (February to September 2014).
- The hospital had two Resident Medical Officers (RMO's) one was for the hospital in general and one was specifically for the critical care unit on site.Staff was confident in the clinical support they received from the RMO's.They had good access to the consultant staff that reviewed their patients and were within 30 minutes of the hospital.
- Handover arrangements were effective and escalation processes were well understood by staff.

Are services effective at this hospital

- We noted that patients received care in line with national best practice and guidance. However, unlike surgical patients, medical patients pathways were not fully defined.
- We found that nutritional assessments were undertaken and patients had ample access to fluids.Arrangements to access a dietician was in place.
- Consultants used the American Society of Anaesthesiologists (ASA) physical status classification to determine that patients were well enough to have the required procedures.
- Polices were written corporately, we saw there was a process for ensuring staff were aware of new policies via the head of department meetings which took place regularly.Where there was local variation, a standard operating procedure would be produced.We did not see any localised policies during our inspection.Following the inspection the provider told us localised policies and standard operating procedures were in place.
- The audit activity that took place within hospital mostly related to joint surgery.The hospital submitted data to national audits such as PROMS, NJR and Oxford Knee, all results were higher (better) than the England average.
- Pain relief was managed well for patients.We did note that more than one method was in use for the assessment of pain.Physiotherapists used a 1-10 scale and on Highbury Suite it was a 1-3 scale.On the surgical suites NEWS pain recording was in use.
- Readmission rates for the hospital were below the national average.This did not appear to be an issue for the hospital.
- There was a comprehensive programme to ensure practising privilege criteria were met. The hospital undertook this role for itself and a nearby hospital, which was also in the BMI group. We reviewed the process in place, which appeared to be robust.
- Revalidation was undertaken by the NHS employer where the consultant held their substantive post.Where consultants only worked in the private sector their revalidation was undertaken by the Group Medical Director.
- Consent was sought for all procedures; patients were given sufficient information to make informed decisions.Staff sought verbal consent to deliver any care interactions.

Summary of findings

Staff had received mental capacity training, but had little opportunity to use the knowledge. Due to the process of access for patients to the hospital, there were few occasions where mental capacity testing was required.

Are services caring at this hospital

- Friends and family test recommender rates were good ranging from 95-100% (April-September 2015).For the same time period the response rates ranged from 18-38%.
- The staff we observed universally offered high levels of care, dignity and compassion to the patients
- We saw that staff interacted appropriately with patients and visitors.We observed good interactions with hostess staff taking time to ensure patients had all they required relating to food and drink. Visitors told us they received good information updates when they made contact with hospital staff.Patients who were regular users of the service wanted the inspection team to be aware that they thought the staff were very good.
- Patients were aware of their treatment plans, and were in partnership with the clinician relating to their plan of care. Patients told us they were given enough information and ample time to ask questions when they needed clarification.
- Emotional support was evident in particular for those patients who attended the Highbury suite.Patients had access to a psychologist when undergoing chemotherapy treatment.

Are services responsive at this hospital

- Service planning to meet the needs of the patients was evident as the majority of the service was elective.This meant that patients who were insured, self-funded and NHS had choices regarding accessing the service they required.
- Patients were able to access to appointments and treatments at times that suited them.Services were available outside of core business hours.
- The referral to treatment times for all groups of patients were all 100%, against national targets of 90%.
- Generally, patients attending their appointments had very little wait time. If there were any waits these were communicated to patients.The only exception was within diagnostic imaging where when delays occurred the reason was not shared with the patients.
- There was very little exposure to people living with dementia or learning disability within the service for staff.People were identified at the referral stage and usually recommended for care within an NHS setting.The patients attending the hospital were cared for in rooms rather than wards therefore this presented an elevated risk for vulnerable people.We were made aware of one vulnerable patient who preferred to wait in their car whilst waiting for their outpatient appointment.
- Translation services were available, both face to face and via a telephone service.We noted that patient information literature was available in English only.
- We saw that the number of complaints had risen compared to previous years, but the hospital actively sought feedback from patients using the service.Patients were made aware of their right to complain within all the core services we inspected.Learning from complaints had resulted in some change in practice, such as customer training given to nursing staff was as a result of complaints about staff attitude.

Are services well led at this hospital

- Vision and strategy was in place for the hospital, we noted that staff were committed to their areas of work.Staff were introduced to the BMI brand promise to be “serious about health, passionate about care” during induction.

Summary of findings

- The Priory hospital worked closely with another local BMI hospital and provided similar services.The two hospitals were looking at ways to collaborate and support each other.
- Patient notes were not always available on site.This occurred when consultants saw private patients as outpatients only.
- The Executive Director oversaw the practicing privilege process for both this hospital and another BMI hospital nearby.The ED was aware of a Verita report published March 2014.This had been commissioned by another group but had implications for independent health hospitals.We saw that the Medical Advisory Committee meetings were run largely in line with the recommendations in the report.The hospital took part in a meeting with other NHS and independent hospitals in the area as they shared a consultant body.This enabled them to share information that may be a trigger and enable them to start preliminary investigations / discussions with a consultant, if there was cause for concern relating to their practice.
- The governance structure was robust in the most part, having a committee structure in place.Meetings took place to share information such as daily 'Comm-Cells' which head of departments attended.However, the governance process relating to the investigation and sharing of learning was not consistent and did not follow the process in the corporate policy.
- The process for adding risks to the hospital risk register was not clear.The risk register was a combined document containing risks relating to the health and safety and clinical.The majority of the risks related to the fabric of the building and equipment.We noted that some of the equipment used for clinical work was obsolete either due to its age or on a 'best effort' maintenance contracts.The status of the risk was to escalate, which meant the controls in place did not give full assurance. Some of the risks were classed as 'optimally controlled', but we found that some had been on the risk register for extended length of time such as 2013, with no resolution other than the mitigation put in place.Other 'optimally controlled' risks were rated the highest on the risk register with a score of 16, this was higher than all of the risks requiring escalation.This would not give assurance that the risk register was being used appropriately.
- We noted that the fabric of the building and some equipment needed replacing or updating.Some of the improvements required had plans in place such as the replacement of beds and where there was carpet in the clinical areas. However, for some there was no plan in place and staff were having to work around such as the Computed Tomography (CT) cardiac scans, not be able to use it for under 50's.
- There had been changes in the leadership that may have been unsettling for staff.At the time of the inspection both the Executive Director and the Director of Clinical services were quite new to the hospital.We saw good interaction between the leadership of the hospital this was evidenced by the staff feedback during the inspection and focus groups.
- We were not able to check the fit and proper compliance with regulations as all the senior management documents were held at BMI head office.
- We saw improvement work regarding patient feedback sought and acted on about meals for the chemotherapy patients.

Our key findings were as follows:

- Multidisciplinary working across the hospital was well embedded and patients benefitted from this coordinated approach.
- Outpatients and diagnostic imaging had significant issues relating to safety., where the surgical safety checklist was not in use for procedures taking place; we found that not all notes were present on the premises. In addition, the equipment replacement programme was having a detrimental effect on staff having to work around.

Summary of findings

- The fabric of the building and elderly nature of some of the equipment in use was impacting negatively on staff and meant that in some cases modifications of delivery had to be put in place.
- Governance processes relating to incidents needed to be strengthened. We saw that the hospital had identified the need itself, but at the time of the inspection it had not fully resolved all the issues.
- The risk register was not a well- managed document, which allowed the management to have assurance. The rationale used for risks present was not clear. We saw that risks for escalation had been rated lower than those that were classed as 'optimally controlled'.
- We found the hospital to be visibly clean. There were some issues relating to infection control in theatres, however these had not resulted in increase in infections. Some clinical areas were carpeted and as such did not comply with current guidelines. There was a plan for refurbishment but we were not given any timescales for this.
- Staff appeared to be part of a cohesive team. At the time of the inspection there were seven whole time equivalent posts vacant on the nursing suites. Agency was used to fill the uncovered shifts. The hospital was actively trying to recruit to these roles.

We saw several areas of outstanding practice including:

- Seven-day pharmacy service including on call service.
- Gold standard equipment for endoscopy.
- Award from the Macmillan Quality Environment Mark (MQEM); **a quality framework for assessing whether cancer care environments meet the standards required by people living with cancer.**

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

Importantly, the provider must:

- Improve the process for Duty of candour to ensure people are aware when they have received sub optimal treatment and suffered harm as a result.Then share the outcome of investigation with the person involved along with sharing learning with operational staff.
- Improve the governance process relating to incident management investigation, shared learning and risk management.
- Must ensure that equipment classified as obsolete has a programme in place that replaces such equipment in a timely fashion.

Please note that the other musts can be seen at the end of this report along with the requirement notices.

In addition the provider should:

- Ensure all patients are screened for the risk of malnutrition with documents completed in a timely manner.
- Ensure there are clear pathways on the surgical suites for medical patients.
- Ensure the management of medicines including storage, self-administering, identifying of a critical list of medicines as recommended by the NPSA, explanation of missed doses and clear documents used to identify the route for administration are in place.
- Ensure that all staff are familiar with policies for self-administration of drugs and introduce monitoring to ensure compliance.
- Ensure that barrier-nursing practise should be reviewed and staff reminded of their responsibilities.

Summary of findings

- Ensure that escalation procedures for NEWS outliers should be emphasised to staff and audit sheets should include actions taken to address anomalies.
- Ensure that theatre staff are reminded of the need to comply with IPC guidance.
- Ensure that compliance with the surgical safety checklist in use.Its use should be improved with attention to detail and auditing in order to ensure patient safety.

Professor Sir Mike Richards
Chief Inspector of Hospitals

Overall summary

This location is part of BMI Healthcare Limited.

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

The work undertaken is mostly elective. We inspected as a core service Medical care, Surgery, Outpatients & diagnostic imaging. We looked at but not as a stand-alone core service intensive care. We did not inspect the fertility clinic as that is regulated by the Human Fertilisation Embryology Authority (HFEA). We inspected the hospital as part of our commitment to inspect all independent health providers. We undertook this as a comprehensive inspection.

From October 2014 to September 2015, there were 1,316 medical procedures. There were 314 diagnostic endoscopic examinations such as colonoscopy and cystoscopy, between August 2015 and January 2016

Between October 2014 and September 2015 there were 6,773 surgical procedures completed at the hospital. The most common surgical procedures being; Multiple Arthroscopic Surgery – Knee (266 procedures), Phacoemulsification of lens with implant – unilateral (245 procedures) and Total prosthesis replacement knee joint (200 procedures).

- 16% of all patients were NHS funded (Oct 2014 to Sep 2015).
- There were 118 registered beds however, only 84 were in operation
- Five theatres
- The Registered Manager is Mrs Paula Naylor who had been in post for two months.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Medical care	Requires improvement 	• Incidents were raised appropriately but the investigation process did not always follow the corporate policy. • Hospital staff were not able to demonstrate that they were meeting duty of candour regulations when incidents occurred which triggered. • There was inappropriate documentation in use to support the prescribing and administration of medicines by syringe pump. • There were no clear pathways on the surgical suites for medical patients who deteriorated and were admitted as inpatients to those suites. • The endoscopy unit was not Joint Advisory Group (JAG) accredited and there was no assurance they were meeting set endoscopy standards, other than the tracking program. • The hospital had a vision and strategy but staff were not able to articulate what it was for the oncology unit. • The risk register management was not robust, and the investigation process needed improvement. The lack of audit activity restricted the service from identifying all improvement opportunities. However, we also saw that: • Care pathways for endoscopy were in place. Care was monitored to show compliance with standards there were good outcomes for patients' particularly for oncology patients'. • Seven day working was established for the majority of staff and multi-disciplinary working was evident to coordinate effective patient care. • Patients said staff were caring and friendly and their dignity and privacy were respected. We observed staff delivering kind and compassionate care.

Summary of findings

- Patients and their relatives were involved in their care and treatment and staff supported patient decision-making. Dietary and nutritional needs were met and patients were supported to choose food options.
- Consent was obtained prior to chemotherapy treatment and was recorded in patients' notes.

Surgery

Good

We rated surgical services overall as Good.
We rated the service good in the domains of Effective, Caring, Responsive and Well Led.

- We observed good multidisciplinary working between nursing staff, medical staff and allied health professionals.
- The service participated in national audits to record patient outcomes; outcomes demonstrated that patients received effective care and treatment. All patients were seen in a timely manner and exceeded national targets.
- Staff were caring and supportive of patients, protecting their privacy and dignity.
- Patients received individualised care based on their personal needs.
- Supervisors and managers understood their staff and supported them to provide good care.
- There was good support from the parent company BMI Healthcare in the form of Executive Directors reviews and action plans, and support for consultants who did not have a parent NHS hospital from which they received training and support.
  However, there were areas requiring improvement in the 'safe' domain.
- We saw issues in theatres and in the suites with compliance with infection prevention and control. Whilst the hospital had not experienced any infection outbreaks, we found some practise exposed patients to the risk of infection due to complacency of some staff.
- Governance of temperature sensitive medicines was poor. In one area we found three different forms or registers being used to record refrigerator temperatures. Where

Summary of findings

temperatures were outside normal levels there was no evidence of the issue being escalated and no assurance that stored medicines were still fit for use.

- We found that completion of World Health Organisation safer surgery checklists was inconsistent. Missing data from the checklists included signatures, dates and times. Observation of theatre practice during operations demonstrated that practice was safe; however, this was not reflected in the paperwork.
- National Early Warning Score (NEWS) was used to monitor patients. However, despite errors being identified during audits there was no learning evident to prevent re-occurrences.

Outpatients and diagnostic imaging

Requires improvement

We rated this this service as Requires Improvement overall.

We rated safe as Inadequate because;

- The progress of incidents could not be easily followed, we saw a serious incident that had not been investigated and the affected patients had not been notified.
- Details on all patient consultation were not kept onsite.
- The '5 steps to safer surgery' checklist was not embedded within Diagnostic imaging and did not take place in the outpatient department.
- The capital replacement programme for Diagnostic imaging was inadequate and radiology equipment was past its replacement date.
- Radiation doses delivered exceed the national dose reference levels for under 50's and the gamma camera was placed on the risk register seven years ago.

We have inspected but not rated this service for effective.

- We found that the referral and justification for exposure to medical exposure of radiation was unclear. Out of date protocol was still in circulation the diagnostic imaging department but discrepancy rates were less than the national target.

Summary of findings

We have rated responsive and well led as requires improvement;

- Computed Tomography CT cardiac scans for the
- The waiting times in diagnostic imaging were not communicated with patients.
- We were not assured that appropriate governance systems were in place to track incidents reported by staff.
- Feedback from the provider's corporate diagnostic imaging lead to the radiology manager regarding equipment replacement was poor. The equipment in the department was in urgent need of replacement with no vision of how BMI will be addressing the issues.
- The hospital risk register did not reflect the risks occurring in diagnostic imaging.
  However we did see some good practice:
- However we also saw that departments were clean. Adequate staffing levels ensured patient safety and medicine prescriptions were stored safely.
- Multi-disciplinary team working was seen throughout the hospital and staff appraisals were up to date. Extended working hours were evident to accommodate patient need.
- We have rated this service as good for caring. We observed kind, compassionate care, all patients we spoke to recommended the service. Patients were supported through their treatments.
- We also saw that learning from complaints was evident in the physiotherapy department.
- The provider was meeting it's referral to treatment targets and patients were provided with suitable appointments to reflect their needs.
- Staff were familiar with the vision and strategy for the service.
- Leadership was visible.
- Innovative practice was evident in physiotherapy and diagnostic imaging departments.

Summary of findings

Contents

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The Priory Hospital

Services we looked at

Medical care; Surgery; Outpatients and diagnostic imaging;

Summary of this inspection

Background to BMI The Priory Hospital

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- 16% of all patients were NHS funded (Oct 2014 to Sep 2015).
- There were 118 registered beds however, only 84 were in operation
- Five theatres
- The Registered Manager is Mrs Paula Naylor who had been in post for two months.

Our inspection team

Our inspection team was led by:

Donna Sammons, Inspection Manager, Care Quality Commission

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

How we carried out this inspection

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

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

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

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

Summary of this inspection

We undertook two unannounced visits following the announced component to check and substantiate outstanding areas of concern.

Information about BMI The Priory Hospital

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

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

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

The accountable officer for controlled drugs was Mrs Paula Naylor.

- 553 doctors with practising privileges.
- Staff employed by BMI The Priory included;
- 100.9 whole time equivalent (WTE) registered nurses,
- 46.6 WTE healthcare assistants,
- 27.5 allied health professionals
- 105.3 WTE support staff.

The core services offered are endoscopy, surgery (including cosmetic surgery and gynaecology), medical care and oncology. Additionally to these core services, the hospital also provides cardiac catheter laboratory, diagnostic imaging, dialysis, health screening, physiotherapy, refractive eye surgery critical care and children & young people's service and fertility.

Detailed findings from this inspection

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Medical care	Requires improvement	Requires improvement	Good	Good	Requires improvement	Requires improvement
Surgery	Requires improvement	Good	Good	Good	Good	Good
Outpatients and diagnostic imaging	Inadequate	Not rated	Good	Requires improvement	Requires improvement	Requires improvement
Overall	Requires improvement	Good	Good	Requires improvement	Requires improvement	Requires improvement

Notes

Requires improvement

Medical care

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

Information about the service

BMI The Priory is an independent hospital. Between October 2014 and September 2015, there were 1,316 medical procedures, between August 2015 and January 2016, 314 were diagnostic endoscopic examinations such as colonoscopy and cystoscopy.

The Priory offers oncology and haematology specialities within these, services included, outpatients, and day case inpatient surgery, chemotherapy and palliative care.

The Highbury suite is a dedicated day case unit for patients having oncology and haematology treatments, including chemotherapy and blood transfusions. The Highbury suite has one consulting room used for oncology and haematology outpatients and eight dedicated patient treatment rooms. The Priory also had two other suites Dudley suite and Bournville Suite. We visited both these suites as they had medical inpatients present, although they were primarily accommodated for surgical patients.

We inspected medical services at The Priory on the 16 and 17 February, 2016. We also visited unannounced on the 18 and 25 February 2016. We spoke with 26 staff members including: nurses, doctors, therapists, managers and healthcare assistants. We spoke with nine patients and three relatives. We reviewed six medical records on the suites and four on the day unit. We also observed interactions between staff and patients. We saw a handover take place and focus groups were held which were attended by staff who were working within medical care services.

Summary of findings

We have rated this service as requires improvement because:

- Incidents were raised appropriately but the investigation process did not always follow the corporate policy.
- Hospital staff were not able to demonstrate that they were meeting duty of candour regulations when incidents occurred which triggered.
- There was inappropriate documentation in use to support the prescribing and administration of medicines by syringe pump.
- There were no clear pathways on the surgical suites for medical patients who deteriorated and were admitted as inpatients to those suites.
- The endoscopy unit was not Joint Advisory Group (JAG) accredited and there was no assurance they were meeting set endoscopy standards, other than the tracking program.
- The hospital had a vision and strategy but staff were not able to articulate what it was for the oncology unit.
- The risk register management was not robust, and the investigation process needed improvement. The lack of audit activity restricted the service from identifying all improvement opportunities.

However, we also saw that:

Requires improvement

Medical care

- Care pathways for endoscopy were in place. Care was monitored to show compliance with standards there were good outcomes for patients' particularly for oncology patients'.
- Seven day working was established for the majority of staff and multi-disciplinary working was evident to coordinate effective patient care.
- Patients said staff were caring and friendly and their dignity and privacy were respected. We observed staff delivering kind and compassionate care.
- Patients and their relatives were involved in their care and treatment and staff supported patient decision-making. Dietary and nutritional needs were met and patients were supported to choose food options.
- Consent was obtained prior to chemotherapy treatment and was recorded in patients' notes.

Are medical care services safe?

Requires improvement

We have rated this service as requires improvement for the safe domain because:

- Incidents were raised appropriately but the investigation process did not always follow the corporate policy.
- Hospital staff were not able to demonstrate that they were meeting duty of candour regulations when incidents occurred which triggered.
- Patient record completion was variable.
- There was inappropriate documentation in use to support the prescribing and administration of medicines by syringe pump.

However, we also saw :

- Sufficient equipment was available to the staff to meet patient's needs.
- The suites visited were visibly clean and appropriate systems in place to minimise the risk of cross infection.
- There was an effective staff skill mix on the Highbury suite to enable staff to meet the needs of patients.

Incidents

- Staff told us that Mortality and Morbidity reviews were discussed regularly when a death occurred in a multi-disciplinary meetings.We saw minutes from meetings when deaths had occurred.
- Between October 2014 and September 2015, there were eight deaths at the hospital one of which was classed as unexpected. There was further unexpected death in 2016 which was still being investigated at the time of the inspection the other six were expected and planned and formed part of the hospital's end of life care service.
- The hospital had an incident reporting policy; the reporting process was in paper format. In the event of an incident, all employees were to report incidents to their line manager and record all facts on the incident report form which was passed to the patient safety team.The team, led by the Associate Director of Nursing,

investigated the incident to ensure learning and improvement was identified and disseminated across the hospital.The team was also required to provide assurance to the governance committee that the reporting arrangements were robust and appropriate.

- The investigation process did not always follow the corporate policy.This meant that some learning opportunities were at risk of not being identified.
- The governance team on receiving the paper incident form uploaded the information on to a software package to continue to work with the incident.
- Staff received feedback from incidents and learning was shared during team meetings on a monthly basis. Monthly meeting minutes were kept in a folder in the nurses' office and these were updated after each meeting we saw these minutes from the meetings.
- There was a variable understanding amongst staff about 'Duty of Candour' (The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support to that person.).Ward Sisters generally understood the principle. They told us it was about informing patients when mistakes had been made and knew about giving an apology.Other staff knew that Duty of Candour was to be open and honest, and the key was effective communication and being empathetic with patients and relatives examples were given such as the leaking central line we did not see a written apology to support this statement.

Safety thermometer or equivalent (how does the service monitor safety and use results)

- Safety thermometer is a snapshot audit of the prevalence of avoidable harms that included new pressure ulcers, catheter related urinary tract infections (C.UTIs), venous thromboembolism (VTE) and falls. The equivalent of the safety thermometer information was displayed at the entrance of each suite so staff and visitors were aware of their performance. This is a requirement for all NHS patients and the provider was required to share the results with the commissioners, we saw that they were undertaking this for all patients, not just NHS.
- Staff identified patients at high risk of pressure ulcers, falls or VTE and when necessary, actions were taken to reduce the risk. We saw documentation on medical care pathway forms scoring the patient high, medium or low risk.
- Staff were also monitoring the visual infusion phlebitis score (VIP). The VIP score is a tool recommended by the Royal College of Nursing (RCN) for monitoring infusion sites to check for infection and change the site when necessary, this was monitored on every visit and documented on patient records, and we saw audit result from February 2016 of 100%.

Cleanliness, infection control and hygiene

- We saw that suites were visibly clean and well-maintained and domestic staff were available throughout the day.Equipment was clean and marked as ready for use.Equipment was serviced and well maintained.
- Within the endoscopy suite, the cleaning of the scope equipment was in line with a m**audit**. This system enables the user to comply with medical device decontamination requirements when the instrument specification states that the item must be manually washed or ultrasonically cleaned.
- Staff were following the Infection Control Policy 'bare below the elbow'.Staff had access to personal protective equipment that included aprons and gloves to minimise the risk of infection patients were protected from any cross contamination.
- Patients who required urinary catheter insertion had their risk of infection minimised by having a clear plan for insertion, maintenance and removal of the catheter
- Cytotoxic is a group of medicines that contain chemicals, which are toxic to living cells. We saw staff using correct PPE when handling cytotoxic waste and were disposed of appropriately. Cytotoxic drugs are hazardous substances, as defined by the Control of Substances Hazardous to Health Regulations 2002 (COSHH).Under COSHH, employers must assess the risks from handling cytotoxic drugs for employees and anyone else affected by this type of work, and take suitable precautions to protect them. We found these requirements were met by the hospital.

- Staff had access to appropriate gloves for extra protection when administering chemotherapy.Extravasation kits and cytotoxic spillage (protection equipment against toxic waste) kits were easily accessed and were always available for staff to use.
- Hand sanitising gel was available at the entrance to each suite and throughout the department.Hand hygiene signs were displayed throughout the suites we visited to remind staff and visitors of the importance of handwashing to protect patients from the risk of cross infection.
- We observed staff washing their hands appropriately between patients.
- Between November 2015 and February 2016, hand hygiene audit results had been at 100%.
- We saw that shoe covers were used by endoscopy staff in theatres.
- There were no incidences September 2015 to February 2016 of Methicillin-resistant Staphylococcus aureus (MRSA), or clostridium difficile (C.diff).
- Patients who required protection against the risk of infection were nursed in individual rooms with personal protection equipment (PPE) available to use outside their rooms.
- The hospital had appropriate policies and procedures in place to manage infection prevention and control (IPC).An IPC policies and procedures file was accessible on the ward and in theatres.Staff were aware of and showed us the location of these policies.

Environment and equipment

- We visited the Highbury suite and the chemotherapy day unit and noted that the nurses call bell and the emergency call bell both had the same sound. The design of the unit meant staff could see patients from the nurses office.The unit was also small enough to shout for help if required. The unit has been open for over 10 years and had had emergencies but no cardiac arrests.
- Pressure relieving equipment was available for patients' who were at risk of pressure skin damage.We saw these being used by staff.
- We saw resuscitation equipment on the suites we visited had been checked regularly, trolley check records were updated and they were appropriately packaged and ready for use.However, on the Highbury suite we noted the resuscitation trolley checklist had been missed on one day.All electrical equipment in the Highbury suite had been safety checked and labelled to demonstrate this and all were in date to be used.

Medicines

- Medicines were stored safely and securely including those requiring extra controls (controlled drugs).Room temperatures were monitored to ensure medicines were stored so not to compromise their effectiveness.Medicines requiring cold storage were kept in refrigerators.
- During our inspection, inpatient suites had good processes in place to obtain medicines and weekly checks by an appropriate member of staff to ensure medicines remained safe to use.All medicines were within date and items supplied for individuals to take home were appropriately labelled.
- Medicine recalls and alerts were dealt with appropriately.
- There was inappropriate documentation in use to support the prescribing and administration of subcutaneous medicines via syringe pumps.The provider did not have a specific prescription chart, so medical staff used another prescription chart printed specifically for oral medication.The design did not have all the prompts required for the prescribing of subcutaneous medicines via syringe pumps, which could lead to mistakes and put patients at risk.
- Emergency medications were available on the resuscitation trolley for the treatment of cardiac arrest and anaphylaxis.Emergency kits were available in the relevant clinical areas, staff were checking these daily and recording using a checklist
- Patients were not given the choice to self -administer their own medication if they wished to do so.We did see some people continuing to administer their own medicines but there was no self-administration policy in

place.We went back for an unannounced visit and we saw that this had been addressed and patients' were not to self-medicate.We saw clear signs on medication cupboards and medication trolleys to remind staff.

- Medications reconciliation is the process of verifying the most accurate list of all potential patient medications. The procedure for medications reconciliation did not involve a member of the pharmacy team nor was there any record of this being undertaken routinely by another health care professional.
- Some medicines were being given under patient group directions (PGDs) which enabled the nursing staff to respond in a timely way without the need for a prescription.On the Highbury suite, these documents had recently expired in January 2016 and there had been no process identified to review them.
- Medicines were administered appropriately.Although, there was no identified list of critical medicines as recommended by the NPSA for r. This list should identify medicines where the timeliness of administration is crucial.
- Reference materials for staff to use regarding the use of medicines such as the British National Formulary were available either in hard copy or online.
- There was a system in place to report medicines incidents and following investigation to share learning amongst staff, via staff meetings
- On the Bournville suite, there were no body maps in use to show where medicines administered such as transdermal patches had been applied or to confirm that the site of application had been rotated as recommended by the manufacturer.
- Allergies were clearly documented on the treatment and prescription charts.
- Nursing staff are aware of the procedures and policies on the management of controlled drugs.
- Staff used local antimicrobial guidelines, prescription charts did not indicate any concern with prescribing of antimicrobials.There was a bi annual antimicrobial audit
- On the Highbury suite, staff were fully competent within chemotherapy and were trained to administer bolus chemotherapy which is a vesicant chemotherapy.This chemical agent causes burns and destruction of tissue, and is given via syringe or via gravity and requires additional competency training. Staff on Highbury Suite had completed the relevant chemotherapy training.
- Only consultants prescribed chemotherapy and advised the RMO if required, about pre-chemotherapy symptom management medications.

Records

- Medical records we observed were all in paper format, this included prescriptions.
- Patients had one set of records in which doctors, nurses and other professionals recorded information.Records included the treatment plan, the patients' condition and results of any investigations or tests the patient had received.We looked at five medical patients out of eight records on the Dudley suite and found the medical records were dated, and the name of the health professional that had completed the record was legible.However, this was inconsistence throughout the wards.
- We saw that patients had two hourly patient care rounds checks which included offering patients a drink, pain management, ensuring the patients comfort and checking that the nurses call bell was nearby.
- Patients' daily care charts were in patients' rooms, these included information such as records of observations and an early warning score to identify any deterioration in their health these were completed and were escalated to senior level for support if required.
- Chemotherapy patients were given a 'Red booklet' where they recorded their blood test results, medications such as anti-sickness and steroids, information on chemotherapy cycle including all side effects and when they should seek emergency advice.Patients were advised to bring this booklet with them for every treatment day at the suite.
- We saw a discharge letter to a GP demonstrating treatment given and their updated medication list.We saw that pre-chemotherapy assessment forms on the Highbury suite included detailed information on the patient, including any identified allergies.

Safeguarding

- Staff were aware of safeguarding procedure, Staff felt supported when they needed advice about safeguarding.
- Staff on the Highbury suite met the targets for the children safeguardingtraining up to level 2of 96%. Adult safeguarding up to level 2was 95%, this was a combined result.
- Training was role specific and delivered via e-learning, when staff were undertaking the training it was badged as just safeguarding. This was the reason why when we initially asked staff about the level attained they were unable to tell us.
- The Director of Clinical Services held the position of executive lead for safeguarding to support staff to recognise a safeguarding and support with referrals they had received level 3 training for both adults and children.

Mandatory training

- The hospital as a whole had 100% competency in medicines management training from October 2015 to December 2015.
- Mandatory training included blood transfusion, collection of blood products, oxygen therapy, infection control, moving and handling and information governance 89.4% of staff had completed their mandatory training.
- Mandatory training had to be completed online via an e-learning system.Three staff told us this was difficult to manage at times if the unit was busy and we saw 89.4% of staff had completed their mandatory training on the Highbury Suite.

Assessing and responding to patient risk

- Staff told us that when patients deteriorated they were transferred to an inpatient suite.An oncology nurse would accompany them if they were receiving chemotherapy.
- Medical services within the hospital used a National Early Warning Score (NEWS).NEWS was introduced by the Royal College of Physicians as a tool to quickly identify acutely ill adult patients.
- A patients' early warning score was calculated from each observation recorded within their records.The score was then used to identify deteriorating patients who required further medical team input.The team/ doctor then assessed the patient and a decision was made in relation to their ongoing management this was being done consistently.
- In the Endoscopy theatre, staff followed and completed a surgical checklist based on the World Health Organisation (WHO) surgical safety checklist used in operating theatre environments. The checklist is a tool for the relevant clinical teams to improve the safety of surgery.This includes improving anaesthetic safety practices, ensuring correct site surgery, avoiding surgical site infections and improving communication within the team.
- We observed a nursing handover on the Highbury suite which included the Macmillan nurse; she was also the pain management nurse and a nurse prescriber who offered support for the oncology inpatients on the other suites.We observed discussions about pain and sickness management.
- During handover, information was shared about new patients attending the unit that day who required blood tests.Patients who needed the 'first patient talk' (where patients were given all the information about their own treatment regime from their consultant) were identified.This was evidence of a thorough handover and was good practice.
- The nurses on Highbury Suite used the United Kingdom Oncology Nursing Society (UKONS) triage tool.This is a risk assessment tool that, if used correctly, standardises and supports excellent practice, improving quality and safety and providing evidence of service provision.The tool provides a robust framework for triage assessment, action and audit, and as a result leads to improved quality and safety in patient care.
- Risk assessments were completed and we saw a checklist available within the care plan to ensure these were filled in but not all were checked and signed off.
- On the Highbury suite staff, patients were regular attenders, due to the treatments patients required.This enabled staff build good relationships with them.On arrival, patients were assessed and vital signs were checked.Staff knew when to seek medical advice and they could determine if there had been any changes since their last admission.

Requires improvement

Medical care

Nursing staffing

- The Highbury suite had 14 staff in total.There were eight qualified nurses including three sisters, two health care assistants; one being level three trained, two administrators, two bank nurses (who were chemotherapy trained).The sister on the Highbury suite told us there were three full time vacancies: one lead cancer nurse, one senior oncology chemotherapy nurse and one registered nurse.
- Staff on the Highbury suite had an inpatient oncology sister who also worked with patients receiving chemotherapy on Dudley or Bournville suites. Staff told us the majority of oncology inpatients were admitted onto the Dudley suite that required inpatient chemotherapy regimens.
- The Highbury suite cared for mixed tumour base cancers including haematology and renal.The suite had appropriate skill mix of staff to accommodate these patients.
- The Highbury suite also had two breast care nurses who covered seven and half hours a day, Monday to Friday.There was one student nurse on placement at the time of our inspection, but during training students were not included in staffing numbers.For Endoscopy, there was one lead nurse and one technician who worked as part of the theatre team.
- On Bournville and Dudley suites if an inpatient required chemotherapy treatment, staff from the Highbury suite were rostered on the off duty rota to cover these inpatients during their chemotherapy treatment.
- They did not use agency staff and we saw evidence of this on the off duty rota on the Highbury suite.This was confirmed by the nurse in charge who completed the rota.
- Staff told us if there was just one patient in the Highbury suite there would always be two members of staff on duty.
- We saw that staffing tool was used to plan the skill mix five days in advance, with continuous review on a daily basis. The actual hours worked also entered retrospectively to understand variances from the planned hours and the reasoning.

Medical staffing

- Nursing staff reported excellent medical cover across the hospital, with minimal delays when they requested assessment of patients whose condition had deteriorated. Staff contacted the 'named consultant' for individual patients' and RMO and the consultant would work together to manage these patients'. Staff said that the consultants would visit daily and more often if the patient's condition required it.
- There was RMO cover the inpatients suite and the chemotherapy day unit for a week at a time; there was a second RMO for the Intensive Care Unit.
- The RMO said they were a 'preventative worker'.This involved visiting all the areas between 10-11pm to review patients as required.They said they did not get disturbed overnight unless it was an emergency this was closely monitored and was logged each time they were called at night time. We did not see evidence of this but RMO said it is only in emergency circumstances they are ever called out.
- On the Highbury suite, staff were concerned they did not have an oncology trained Resident Medical Officer (RMO) for an immediate oncology support, therefore staff said they had to seek first hand advice from the Consultant.We spoke with the RMO whose background was as a General Practitioner (GP). They told us they had minimal oncology experience but was more than competent in supporting patients who required full general medical examination and was able to work with consultants when required to do so.They gave us examples of where they were capable of dealing with oncology patients one being a patient who required stronger anti-sickness intravenously the RMO was aware of the variety that was available to manage their symptoms.Another example was a patient who became breathless RMO was able to provide appropriate care and treatment for this patient with his GP experiences.
- BMI The Priory prioritise its Healthcare Practising Privileges policy; that consultants remain available (both by phone and, if required, in person) or arrange appropriate alternative named cover if they were unavailable when they had inpatients in the hospital.

Major incident awareness and training

Requires improvement

Medical care

- Emergency plans and evacuation procedures were in place and arrangements were displayed on noticeboards. Staff were trained in how to respond to fire and evacuation procedures.
- The hospital had numerous contingency plans in place which detailed escalation and workaround practices.These were available for staff on the intranet.

Are medical care services effective?

Requires improvement

Overall we rated the medical care services as requires improvements for the effective domain because:

- There were no clear pathways on the surgical suites for medical patients who deteriorated and were admitted as inpatients to those suites.
- The endoscopy unit was not Joint Advisory Group (JAG) accredited and there was no assurance they were meeting set endoscopy standards, other than the tracking program.
- Patients were screened for the risk of malnutrition but they were not completed in a timely manner
- We found that there was a lack of audit activity to determine the quality of patient outcomes relating to oncology effectiveness.

However we also saw:

- Pain management was effective.
- Appraisal rates were 98% for the Highbury Suite which was very good.
- There were good links with a local hospice.
- There good arrangements relating to seven day working, for example the RMO cover and two pharmacists providing an on call service.
- Multidisciplinary working was evident to coordinate patient care and provide different types of support for medical patients mainly in oncology.

Evidence-based care and treatment

- There were care pathways in place based on the National Institute of Health and Care Excellence (NICE) for oncology patients. All policies on the Highbury suite were in date and adhered to local National Health Services protocols.
- Staff adhered to the Neutropenic sepsis NICE guidelines. Staff sought advice from the consultant and would refer patients to relevant services either within the hospital or via Emergency department within NHS. However, we were made aware that some patients deteriorated and needed to be admitted to an inpatient suite. The hospital did not collect data on the number of times this occurred.
- Staff within the medical services were encouraged to take part in audits to improve practice for example Hand Hygiene audits, Record Keeping audits. Staff told us in endoscopy they used a manual tracking, traceability and quality **audit** trail system twice a year. This system enables the user to comply with medical device decontamination requirements when the instrument specification states that the item must be manually washed or ultrasonically cleaned.
- Patients had their needs assessed; however, on the surgical suites staff were not using the medical pathway for patients. Instead, they used the surgical ones and left blank the sections that did not apply to the medical patients. However, they did add patients medical history for example.
- We saw endoscopy pathways were available however, as there were no patients we could not see them in use at the time of the inspection.
- The Director of Clinical Services is responsible for overseeing the audit results. This is done once the leads for each clinical area has reviewed them and identified an improvement plan is necessary.

Pain relief

- There was a specific scoring scale for pain; zero being no pain and three being the highest level of severe pain. We saw nurses asking patients if they were in pain and if so pain relief was provided as per the prescription chart.
- Patients said they received pain relief when they needed it. We looked at patient records and found they had received pain relief regularly as prescribed we did not see any missed doses in patient prescription charts.

Nutrition and hydration

- The Malnutrition Universal Tool (MUST) was used to assess and record a patient's risk of malnutrition and hydration on admission but some records were missing the completed risk assessment.

- We saw fluid balance charts and food charts in use; three were incomplete. However, patients were weighed and a dietician was informed when advice was required.
- On the Bournville suite, we looked at one medical record of the one medical patient present during the time of our inspection. The weight of the patient was regularly checked but the Body Mass index chart was not fully completed however, staff had contacted the dietician for support.
- We saw that patients had access to drink by their bedside. Catering staff offered drinks regularly and menus throughout the day.

Patient outcomes

- The Priory Endoscopy unit was not JAG accredited Joint Advisory Group on gastrointestinal endoscopy. JAG Accreditation is the formal recognition that an endoscopy service has demonstrated that it has the competence to deliver. Staff told us it could not be accredited as it was not 'a stand-alone unit'. Staff were not aware of nor did we see future plans for development of an endoscopy suite.
- Information provided by the provider relating to audit activity did not cover any activity within medicine or oncology. Monthly dashboard information was collected and reviewed across the hospital, the only data relating to medicines effectiveness was mortality rates, unplanned readmissions and transfers out.
- There was some local audit activity undertaken. However, a member of the senior management team shared their concern that more clinical audit could be undertaken to demonstrate their effectiveness.

Competent staff

- 98% of staff on the Highbury suite had completed their appraisals; one member of staff had not yet completed their appraisal as they were on annual leave.
- We observed clinical practices and attended staff handovers. We saw staff working across medical services were competent and knowledgeable within their chosen area of work. This was demonstrated in their clinical practices and communication within the team and with patients.
- We spoke with a bank nurse who said they had completed online e-learning including all mandatory training. She was supernumerary for two out of four shifts until she was competent and confident to work alone with close support from the team. She also said she completed an induction workbook before commencing any duties.
- Staff were actively encouraged to follow specialist interest within the service. Staff felt supported to develop in their career, they were encouraged to attend training within their speciality, i.e. oncology training staff were encouraged to attend update courses involving oncology, other examples included becoming a link lead for other health concerns such as Diabetes, infection protection control and were given protected time with enough notice to attend these courses.
- Staff competency assessments were in place to show staff had been assessed and were proficient within their respective specialist roles
- Most of the chemotherapy was prepared by pharmacy staff off the unit but on site of the hospital. This ensured staff familiarity with the work and reduced the opportunities for mistakes.
- Resident Medical Officers (RMOs) (supplied by an agency) provided a twenty-four hour seven day a week service on a rotational basis. All RMOs working at the hospital were selected on their experience specifically to enable them to manage the mix of patients usually attending the hospital. All RMO's had experience in Advanced Life Support (ALS) and Paediatric Advanced Life Support (PALS).
- Consultants shared with the provider details of appraisal and revalidation as part of their practicing privileges requirements. This enabled the provider to assure itself that the consultants experience was relevant to the service offered.

Multidisciplinary working (in relation to this core service)

- We saw good Multidisciplinary working within medical care. The Macmillan Nurse, physiotherapist, occupational therapist, speech and language therapist, breast specialist nurse, dietician, lymphedema nurse, tissue viability nurse (who was based on the Intensive Care Unit) and the psychologist were accessible for patients. Along with pathology, theatres, intensive therapy units (ITU) intensivists, radiology, pharmacy, materials and engineering staff.

- Only the Macmillan nurse was in attendance when we observed the handover at shift change on the Highbury Suite, but we were assured by the nurses that other services were available and were easily accessible for patients.
- Patients had access to a dietician, physiotherapist and occupational therapist if and when required. We saw that the dietician and physiotherapist were often on site according to patient medical notes and patients' feedback.
- We saw good MDT working between consultant and nursing staff including the Macmillan nurse where they discussed individual patients and what steps to take to manage symptoms.
- We saw a pharmacist explaining to patients about their medication and giving them a thorough instruction how to take their medicine.
- They had effective Multidisciplinary working links with hospices. Patients who required respite, pain management or end of life care were given options to be transferred to a local hospice. The hospice offered support and advice for ward staff to manage and care for palliative patients. This included other services involved in holistic care of patients such a Lymphedema nurse, dieticians, physiotherapist, occupational therapist (OT) and Speech and Language Therapy Team (SALT.

Seven day services

- There was a seven-day service provided by the pharmacy department and a provision for supply of medicines out-of-hours in an emergency.
- Nurses said that consultants were available for nurses to seek advice 24 hours a day, seven days a week. The day to day medical services was provided by the RMO's who dealt with any routine and emergency situation in consultation with the relevant consultant assigned to the patient.
- The Highbury Suite was a consultant led day case chemotherapy service. Nursing staff said they contacted the patients' consultant if they needed advice. This was also confirmed by the inpatient suite staff who said consultants were available for nurses to seek advice 24 hours a day, seven days a week.
- Staff said patients were supported by 24-hour expert medical and clinical care, provided through a combination of 'on-site' and 'on-call' arrangements. There was a senior nurse on duty twenty four hours a day this nurse was supernumerary and was available to provide support to both inpatients and staff on duty, also dealing with outside enquiries, including patients, relatives, and other healthcare providers and to accept any out of hours admissions.
- There was an intensive care RMO available on site twenty-four hours a day seven days a week to provide support for ITU and other patients requiring critical care. ITU consultant intensivists were also available on call twenty-four hours a day seven days a week.

Access to information

- Patients' observation charts were kept in their rooms or at the nurse's station and were accessible at all times.
- Patients' records were in a multidisciplinary single unified format. This ensured the relevant information was easy to follow and accessible; each patient also had bedside nursing notes. These were not always completed but were transferred to patients' multidisciplinary records and always accompanied a patient if they were attending other treatments in another area within the hospital.
- Staff had monthly bulletins and newsletters for any updates such as NICE guidelines or other updates within BMI Healthcare.
- We saw that the suites had whiteboards with updated information relevant to staff and their role, i.e. updates on new roles available, new lead roles within chemotherapy services.
- Consultant concerns are discussed by the Hospital management team with the Medical Advisory Committee Chair, and if considered serious enough, with the BMI Group Medical Director. Concerns that relate to standards of practice, quality or patient safety are also shared with the consultant's Responsible Officer.
- Care summaries of patient treatment were sent to their general practitioner (GP) to keep them up to date such as what medications patients were discharged with and what treatment had been given.
- There is a process for discharge with letters for their GP, which included treatment received and medications. Patients were provided with a copy of their discharge letter

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Requires improvement

Medical care

- Patients consent for treatment contained clear and concise information on the Highbury suite and patients were given booklets with all relevant information before starting their treatment.
- On the Highbury suite, we saw consent forms for commencement of patients chemotherapy treatment. Patients were given contact details and on call contact details to seek advice from an oncology nurse. All forms we saw were completed; we looked at eleven copies.

Are medical care services caring?

Good

Overall we rated the medical care services as good for the effective domain because:

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- The Highbury Suite was a consultant led day case chemotherapy service. Nursing staff said they contacted the patients' consultant if they needed advice. This was also confirmed by the inpatient suite staff who said consultants were available for nurses to seek advice 24 hours a day, seven days a week.
- Staff said patients were supported by 24-hour expert medical and clinical care, provided through a combination of 'on-site' and 'on-call' arrangements. There was a senior nurse on duty twenty four hours a day this nurse was supernumerary and was available to provide support to both inpatients and staff on duty, also dealing with outside enquiries, including patients, relatives, and other healthcare providers and to accept any out of hours admissions.
- There was an intensive care RMO available on site twenty-four hours a day seven days a week to provide support for ITU and other patients requiring critical care. ITU consultant intensivists were also available on call twenty-four hours a day seven days a week.

Access to information

- Patients' observation charts were kept in their rooms or at the nurse's station and were accessible at all times.
- Patients' records were in a multidisciplinary single unified format. This ensured the relevant information was easy to follow and accessible; each patient also had bedside nursing notes. These were not always completed but were transferred to patients' multidisciplinary records and always accompanied a patient if they were attending other treatments in another area within the hospital.
- Staff had monthly bulletins and newsletters for any updates such as NICE guidelines or other updates within BMI Healthcare.
- We saw that the suites had whiteboards with updated information relevant to staff and their role, i.e. updates on new roles available, new lead roles within chemotherapy services.
- Consultant concerns are discussed by the Hospital management team with the Medical Advisory Committee Chair, and if considered serious enough, with the BMI Group Medical Director. Concerns that relate to standards of practice, quality or patient safety are also shared with the consultant's Responsible Officer.
- Care summaries of patient treatment were sent to their general practitioner (GP) to keep them up to date such as what medications patients were discharged with and what treatment had been given.
- There is a process for discharge with letters for their GP, which included treatment received and medications. Patients were provided with a copy of their discharge letter

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Medical care

- Patients consent for treatment contained clear and concise information on the Highbury suite and patients were given booklets with all relevant information before starting their treatment.
- On the Highbury suite, we saw consent forms for commencement of patients chemotherapy treatment. Patients were given contact details and on call contact details to seek advice from an oncology nurse. All forms we saw were completed; we looked at eleven copies.

Are medical care services responsive?

Good

We have rated the medical care services as good for the responsive domain because:

- Expansion plans were in place to meet the extra demand for Highbury suite services.
- The Highbury Suite had been awarded the Macmillan quality environment mark.
- There was efficient working within the oncology services that were responsive to patient's needs.
- Good information was available for patients undergoing chemotherapy treatment. People could access the right care at the right time. Access to care was managed for patients individual needs.
- Waiting times, delays and cancellations were minimal and were managed appropriately. Patients were kept informed of any disruption to their care or treatment.
- Facilities and premises were appropriate for the services being delivered.

Service planning and delivery to meet the needs of local people

- The Highbury suite had been awarded for the Macmillan Quality Environment Mark (MQEM).The MQEM is a detailed quality framework used for assessing whether cancer care environments meet the standards required by people living with cancer.
- The Highbury suite was open Monday to Friday with Monday, Tuesday, Wednesday and Friday having late clinics until 8pm. Catering were available until 6pm and would prepare sandwiches for patients who had later treatment. We saw water and hot beverages machines were available for patients to help themselves.
- Plans were in place to increase the size of the service offered by Highbury suite and this would involve a move to a larger footprint within the hospital.
- The endoscopy clinic was open Monday to Friday, and had later appointments available; this gave patient choice around work commitments.
- To Take Out medications (TTO's) out-of-hours services were in place resulting in less delay for patient discharge.
- Patients were given leaflets about their specific chemotherapy regime relating to their type of cancer. They were given extra information such as the wig and scarves services for those who were anxious about losing their hair.
- There was an oncology on call rota for patients who required advice outside of their working hours this was provided by the oncology sisters who worked on Highbury suite.
- Patients were advised to contact the advice line that was run by the Highbury Suite staff if at all unwell or call emergency services if they were deteriorating rapidly.

Access and flow

- On the Highbury Suite patients we spoke with said they did not wait too long for administration of their chemotherapy following their blood tests, medications were prepared in the correct order to match people's arrival times on the unit.
- In the event that a patient deteriorates they were only accepted for admission by their named consultant once the patient has discussed their condition with either the on call nurse or RMO. They would advise the patient what course of action to take such as attend the nearest emergency department NHS hospital or attend The Priory.
- The hospital had systems in place to ensure length of stay was well managed. The booking system onto Highbury suite was effective; with the support of pharmacy to ensure treatments were ready on time to administer. In addition, patients needing medication to take home process was supported by the accessibility of pharmacy staff.

Meeting people's individual needs

Requires improvement

Medical care

- Patients understood the impact of oncology treatment on their wellbeing and on those close to them, physically emotionally and socially. Staff offered wig services including scarf services for those who were undergoing treatment that would result in hair loss.
- There were interpretation services available for patients and families who did not have English as their first language this could be arranged either using the telephone or face to face depending on what the patient required.
- Highbury suite used a wide range of information available for patients undergoing chemotherapy treatment, endoscopy and other services that kept them informed and would assist in reducing anxiety. This included information regarding nutrition, blood/ platelets transfusion, information on their cancer and engagement with local Macmillan support. A private room was available for relatives and carers of patients being cared for on the inpatient suites. This room was comfortably furnished, had information about patients wellbeing and different services available. There were no private rooms for endoscopy patients, they were initially admitted to a ward, walked to theatre and were transferred to recovery then back to the ward until they felt ready to go home.
- They had an oncology on call rota for patients who required advice outside their working hours we saw this on the rota; this was covered by the senior staff on Highbury suite.
- One patient said they were happy to have their own room for treatment. They told us they were able to spend time working on their laptop during their chemotherapy treatment. They were able to choose their treatment times, which meant they could still work around their treatment.
- The oncology lead for the whole of BMI said they were hoping to expand the Highbury suite to support the rising demand for this service.
- Patients are supplied with a wallet card to inform other healthcare professionals that they currently receiving chemotherapy in case patients deteriorated and required an emergency service.
- They had patient support workers who offered snacks, drinks and individual food menus of their choice.
- There was no dedicated room for relatives or carers to stay overnight if they wanted to however, there were sofas in some rooms on the suites so a relative could stay.

Learning from complaints and concerns

- Information was displayed on noticeboards about how to raise concerns or complaints, and leaflets were available throughout the hospital. Patients had received relevant leaflets about how to make a complaint. Nursing staff told us that feedback from patients was shared in a variety of ways: in staff meetings, emails and in person we saw minutes from their meetings.
- We were told by staff that clinical complaints are discussed at the hospital governance meeting. Any consultant related complaints are presented at the hospital Medical Advisory Committee. We saw these in minutes of meetings.
- Corporate protocols (as set out in the BMI Healthcare complaints policy) required that complaints should be acknowledged in writing to the complainant within two working days and a formal substantive response sent back to the complainant within 20 working days.
- Staff said they are encouraged to escalate complaints to their Head of Department, so that issues can be resolved promptly and lessons could be learned. If the issue was more serious, then the relevant senior management team member would be contacted. If the patient or their relative was still at the hospital staff would discuss the issue to avoid it developing into a formal complaint.
- CQC had received four complaints about the provider from the period of Oct 2014 to Sep 2015; staff said that they had not received any formal complaints this year.

Are medical care services well-led?

Requires improvement

Overall, we rated this service as requires improvement for the well-led domain because:

- The hospital had a vision and strategy but staff were not able to articulate what it was for the oncology unit.
- There was no plans to achieve JAG accreditation, but we saw no other mitigation to demonstrate achievement of working towards better standards.
- The nurse oncology lead role on the Highbury suite was vacant and nursing staff said they missed this 'extra' support'.

- The risk register management was not robust, and the investigation process needed improvement. The lack of audit activity restricted the service from identifying all improvement opportunities.

However we also saw:

- We saw staff demonstrating the core hospital values in the care they provided. Staff were positive about the standard of care they provided. There was a culture of collective responsibility between teams and services.
- There was strong collaboration and support across all staff functions and a common focus on improving the quality of care and people's experiences.
- We saw good leadership from senior staff and good communication amongst the team on the Highbury suite.
- The public voice was actively sought with service development and improvement.

Vision and strategy for this this core service

- The hospital value was the same as the corporate one, which was; 'best quality, best practice and best outcomes in everything that we do'. However, we did not see sufficient clinical outcome monitoring to see how they could assess achievement of best outcomes.
- The hospital had a clear statement of vision and values within the oncology service. They were aware of the patient turnarounds and were in the process of putting a business case in place to expand the Highbury Suite this meant they could accommodate and treat more patients. Following the inspection the provider confirmed that the business case had been completed and was in the review process.
- Driving patient experience within oncology and safety through a holistic approach was at the heart of the service.
- Endoscopy staff we spoke with said there were no plans for the endoscopy service to be JAG accredited. To achieve accreditation an endoscopy suite must evidence demonstration of agreed levels of clinical quality, quality of patient experience, workforce and training. JAG accreditation would provide increased confidence of the service provided.
- Due to there being two BMI's in closed proximity executive and corporate managers were considering options to site individual specialist services at one or other of the hospitals. The long-term vision being improved levels of specialist equipment and support for particular procedures, attracting more consultants and improving outcomes for patients.

Governance, risk management and quality measurement for this core service

- The hospital held regular Medical Advisory Meetings (MAC), a safeguarding committee, clinical governance meeting and quality health meeting. All of these meetings were held monthly and quarterly and we saw the meeting minutes.
- Senior management team meetings were held on a monthly basis. They discussed incidents and never events, complaints, staff appraisals with deadline action plans outlined. However, structure and investigation into incidents and complaints were weak and staff were not always informed of investigation results.
- Within Highbury suite the call bell issue was planned to be addressed by the relocation of the suite to another part of the hospital. Managers were aware that that would resolve the potential risk.

Leadership and culture of service

- They were advertising a new oncology lead post and were in the interview stages during our inspection, this being a valuable source for the rest of the oncology nursing staff for that immediate support within oncology services. Following the inspection the provider confirmed that the post had been recruited to.
- Senior management recognised that medical services within oncology required an oncology lead and the vacancy needed to be filled as soon as possible to stabilise the oncology service. Interviews for this vacancy had already been arranged for March 2016.
- There was good collaboration with pharmacy managers across the BMI group to enable shared learning to take place.
- Staff said they felt supported by the senior staff and were confident in escalating complaints and concerns. Matrons felt supported by the head of clinical services; senior sisters on the Highbury suite could contact the head of oncology within BMI if required to do so.
- Staff in several areas commented that they were 'a good team. 'Many staff had worked within oncology and

endoscopy for several years. New starters within their first couple of years were all proud of their strong team work ethic and the quality of care they were giving on their units.
- The Senior Management team were visible; they facilitated monthly meetings for all employees to attend. The meetings were recorded and available for those who could not attend.
- Strong team working, with medical staff and surgical working cooperatively and with respect for each other's roles and staff respectfully challenged each other clinical decision to ensure patient safety.
- All staff spoke positively and were proud of the quality of care they delivered.
- Staff repeatedly told us about the fantastic team work within the service that kept people going even when the unit was busy.

Staff engagement

- The hospital used a combination of email, intranet messages and newsletters to engage with staff.
- We repeatedly heard from staff at all levels that they felt engaged and involved in service development within oncology services.

Public engagement

- The hospital had used patient feedback to identify that the food offered was not meeting the needs of patients undergoing chemotherapy. Because of this patients were involved in developing a menu that better suited their needs.

Innovation, improvement and sustainability

- The Highbury Suite is hoping to expand their oncology day unit service due to high demand for this service. A business plan in place and hoping to work towards this in the near future of 2016.

Good

Surgery

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

Information about the service

BMI The Priory Hospital is part of BMI Healthcare. The group has a nationwide network of private hospitals, which included a nearby sister hospital. Some administrative and managerial functions were shared between the two hospitals. Policies and procedures were for the most part set corporately.

The Priory hospital has 72 inpatient beds and 34 day-case beds. The majority of patients using the services were surgical patients and were accommodated on Bournville and Dudley suites.

The site had five theatres. Theatres were available between 8am and 8pm Monday to Saturday, with occasional use of the local anaesthetic theatres between 8am and 4pm Sundays.

Between October 2014 and September 2015 there were 6,773 surgical procedures completed at the hospital. The most common surgical procedures being;

Multiple Arthroscopic Surgery – Knee (266 procedures)

Phacoemulsification of lens with implant – unilateral (245 procedures) and

Total prosthesis replacement knee joint (200 procedures)

The hospital does not employ any doctors. Consultants who have applied for and been granted practising privileges used the facilities of the hospital to provide services to their private patients. A small number of NHS patients were also seen. We saw documentation, which showed that the Priory Hospital has 553 consultants registered as having practising privileges at the hospital.

Resident medical officers (RMO) are provided under contract from an external company. RMO's provide 24/7 medical cover for the suites.

Nurses, healthcare workers and theatre staff were employed by the hospital.

During the inspection and in order to make our judgements, we visited a number of suites and treatment areas. We observed practice on suites, theatres and recovery areas. We spoke with 13 patients, relatives or carers about their experiences at the hospital. We spoke with 24 staff regarding their work and the hospital in general. We reviewed documentation in relation to the general running of the services, maintenance of equipment and buildings; we also reviewed eight patient records and reviewed information provided to us prior to and during the inspection.

Good

Surgery

Summary of findings

We rated surgical services overall as Good.

- We rated the service good in the domains of Effective, Caring, Responsive and Well Led.
- We observed good multidisciplinary working between nursing staff, medical staff and allied health professionals.
- The service participated in national audits to record patient outcomes; outcomes demonstrated that patients received effective care and treatment. All patients were seen in a timely manner and exceeded national targets.
- Staff were caring and supportive of patients, protecting their privacy and dignity.
- Patients received individualised care based on their personal needs.
- Supervisors and managers understood their staff and supported them to provide good care.
- There was good support from the parent company BMI Healthcare in the form of Executive Directors reviews and action plans, and support for consultants who did not have a parent NHS hospital from which they received training and support.

However

- There were areas requiring improvement in the 'safe' domain.
- We saw issues in theatres and in the suites with compliance with infection prevention and control. Whilst the hospital had not experienced any infection outbreaks, we found some practise exposed patients to the risk of infection due to complacency of some staff.
- Governance of temperature sensitive medicines was poor. In one area, we found three different forms or registers being used to record refrigerator temperatures. Where temperatures were outside normal levels there was no evidence of the issue being escalated and no assurance that stored medicines were still fit for use.
- We found that completion of World Health Organisation safer surgery checklists was inconsistent. Missing data from the checklists included signatures, dates and times. Observation of theatre practice during operations demonstrated that practice was safe; however, this was not reflected in the paperwork.
- National Early Warning Score (NEWS) was used to monitor patients. However, despite errors being identified during audits there was no learning evident to prevent re-occurrences.

Good

Surgery

Are surgery services safe?

Requires improvement

We rated this service as requires improvement for safe.

Because;

- Infection control practices needed to improve on both the suite and theatres. A patient who was immune-suppressed was put at risk as staff did not follow best practice. We also observed poor standards within theatres.
- We found some equipment that required replacement mainly in theatres. The hospital was aware of the risks, but at the time, there were no plans to replace them.
- Senior nursing staff in one area described how patients self-medicated. The provider's medication policy stated that patients would not be allowed to self-medicate unless local provision has been made. No such provision existed at the Priory site.
- We found that temperature sensitive medication was not stored in a way, which guaranteed its safety.
- The surgery checklist was not used accurately to reduce the risk of surgery for patients.

However;

- Staff were encouraged to report incidents using the electronic incident reporting system. There were good systems in place to ensure that staff were able to learn from incidents throughout the surgical core service.

Incidents

- BMI Priory had an electronic incident reporting system, although the initial step required staff to complete a paper form. Staff completed an initial paper report that was then transferred to the electronic system. Policies were available to staff to enable them to identify when they needed to report incidents, and how to do so. Incidents were graded according to their severity and impact on individuals and or services.
- We spoke with staff who told us that they were encouraged to report incidents and were aware of the need to do so.
- Never events are serious, wholly preventable patient safety incidents that should not occur if the available preventative measures have been implemented. No never events had occurred in the reporting period (October 2014 to September 2015).
- There had been an incident where the learning was that doors to the rooms were to remain open when patients returned from theatres. This practice had been shared with the inpatient staff and was regularly audited for compliance.
- Between October 2014 and September 2015, there were eight deaths at the hospital one of which was classed as unexpected. There was further unexpected death in 2016, which was still being investigated at the time of the inspection. All of which had been investigated with one still awaiting the conclusion of the investigation at the time of the inspection. Because of one of the investigations post- operative patients doors are left open. The hospital made us aware they continually spot check for compliance and found staff are following this change in practice.
- The hospital reported six serious incidents during the reporting period although the provider did not use the same reporting criterion as the NHS.
- We saw evidence of how incidents in other parts of the hospital or at other hospitals within BMI Healthcare were shared. We saw details itemising the incidents and guidance on how they could be prevented or reduced, these were displayed on the CommCell boards in staff rooms. The CommCell boards acted as a one-stop location for information to staff to be displayed. Senior nursing staff also showed us minutes of team meetings where these issues had been raised and staff directed to the CommCell boards for additional information.
- Staff confirmed that they were made aware of hospital wide incidents in various formats, for example, through team meetings, governance meetings and emails from line managers.
- Duty of Candour is regulatory duty that requires providers of health and social care services to notify patients (or relevant persons) of safety incidents involving their care. Providers are also required to provide reasonable support to those involved. During interviews, staff were able to describe their obligations under Duty of Candour, however not all staff understood the trigger points when this would come into effect.

Safety thermometer

- The NHS Safety Thermometer provides a quick and simple method for surveying patient harms and analysing results so that you can measure and monitor local improvement and harm free care. The system is designed to monitor the number of instances where patients who had been admitted to hospital experience hospital acquired: pressure ulcers, falls, catheter acquired urinary tract infections (UTI's) and venous thromboembolism (VTE).
- The hospital followed the guidance of the NHS Safety Thermometer scheme and we saw that information about harm free care was displayed on boards at the entry to wards and departments. They submitted information nationally in relation to their NHS patients.
- Between October 2014 and September 2015, figures showed that there had been no hospital acquired pressure ulcers.
- All patients were screened to assess their risk of acquiring a venous thromboembolism (VTE) whilst in the hospital. Between October 2014 and September 2015 only one patient suffered a hospital acquired VTE during that period.

Cleanliness, infection control and hygiene

- All areas of the hospital appeared visibly clean and relatively tidy. We did see some equipment left in corridors but we noted that this did not impede patient's visitors or staff and would not have impacted on any emergency access or evacuation.
- We observed staff in many locations washing their hands and making use of hand gel. However, we observed poor practice in some areas of theatres at Priory hospital. On four occasions, we saw staff opening waste bins by hand and not washing afterwards. We saw that not all staff complied with bare below the elbow, which is considered best practice in preventing and controlling infections. We also noted staff wearing facemasks pulled down around their neck between procedures.
- We saw one theatre had bloodstains on the lights and ceiling from the previous days use. Staff we spoke with were uncertain whose responsibility it was to clean these areas. However, the theatre manager arranged for the area to be cleaned immediately and assured us that cleaning of difficult to reach areas would be reviewed.
- We saw that whilst hand gel was available at the entrance to all suites there was no signage to alert people to the presence of the gel and encourage its use. We did not see any visitors using hand gel.
- We saw that personal protective equipment was available to staff in the form of aprons and gloves. However, we observed that a patient in one suite had been identified as requiring barrier nursing. A notice was displayed on the door of their room to that effect. Barrier nursing may be required because a patient has an infection and extra precautions were required to prevent the spread, or because a patient has reduced immunology and needs to be protected from external contamination. We saw staff entered and left the room without using any protective equipment. When we checked the room, we saw that there was no contaminated waste bin inside the room for staff to dispose of personal protective equipment (PPE) before exiting.
- We asked theatre staff at the hospital to show us their hand hygiene audits and we were told that they did not have any within theatres.
- Hand hygiene audits in the suites indicated that they were 100% compliant.
- Despite seeing instances of poor practice, records showed that the hospital had not had any outbreaks of Clostridium Difficile (C.diff), Methicillin-resistant Staphylococcus aureus (MRSA) or methicillin-susceptible Staphylococcus aureus for over 16 months.
- We observed that the National Institute for Health and Care Excellence (NICE) guideline CG74, Surgical site infection: prevention and treatment of surgical site infections (2008) was followed by staff in the theatres. This included skin preparation and management of post-operative wounds.
- Surgical site infection incidents were low from December 2014- December 2015 there were zero related to orthopaedic surgery. All other surgery for the same time was very low. March 2015 was the highest with five incidents; four months including October to December 2015 had zero occurrences.

Environment and equipment

- Emergency resuscitation equipment, for use in operating theatres and ward areas, was regularly

checked, and documented as complete and ready for use. Resuscitation trolleys were secured with tags, which were removed daily to check the trolley, and contents were in date.

- A number of pieces of surgical equipment used in theatres were aging and as such were present on the risk register. These needed to be replaced but at the time of the inspection, there were no plans to update the equipment.
- We saw evidence that equipment was maintained in accordance with manufacturers recommendations. We saw that safety checks had been completed on all portable equipment. Stickers were used to show when equipment had been tested and when the next test was due. This enabled staff to see that equipment was safe to use. There was good management and segregation of waste. All bins were labelled to indicate the type of waste to be disposed of Staff described how porters emptied bins regularly throughout the day.
- The hospital buildings were old and some external areas looked tired and in need of refurbishment One area of the hospital was being renovated and we saw that workers had left potentially dangerous materials in a car park area without any cordon or fencing to prevent patients, visitors or staff approaching the materials. We pointed this out and the materials were removed immediately.

Medicines

- General medicines were stored safely and securely including those requiring extra controls (Controlled drugs). Room temperatures were monitored to ensure medicines did not become too warm.
- Medicines requiring cold storage were kept in refrigerators. However, the refrigerators were not adequately monitored; we saw that there were two record sheets and a logbook on one suite, which indicated that staff were unsure where they needed to record information. The refrigerators were not being maintained within the recommended range and there were no indications of what actions had been taken to ensure that the medicines kept within the refrigerator were still suitable for use.
- A pharmacist visited inpatient suites daily. There were good processes in place to obtain medicines and weekly checks by an appropriate member of staff to ensure medicines were within their use by date. Medicines provided to patients on discharge were appropriately labelled.
- Medicine recalls and alerts were dealt with appropriately.
- Emergency medications were available on the resus trolley for the treatment of cardiac arrest and anaphylaxis. The resuscitation trolleys were checked daily.
- People were not given the choice to self –administer their own medication if they wished to do so. We did see some people continuing to do their own medicines but there was no self-administration policy in place. This is important to make sure that people were assessed appropriately and risks were minimised when people were allowed to self-administer their own medicines. We discussed this with senior staff and they assured us that self-medication should not have been taking place and they took steps whilst we were on site to stop the practice and ensure staff complied with corporate policy.
- On 25 February 2016, we conducted an unannounced visit to the hospital. We saw that self-medication on the surgical suites had ceased and notices had been placed on drug trolleys.
- The procedure for medications reconciliation did not involve a member of the pharmacy team. Medications reconciliation is the process of verifying the most accurate list possible of all medications a patient is taking. There was no documented evidence that other health care professionals were undertaking this routinely.
- There was no list of critical medicines that had been identified as recommended by the NPSA/2010/RRR09. This list identifies medicines where the timeliness of administration is crucial, such cases include patients with sepsis or those with pulmonary embolisms. However, we did not see anybody missing doses of critical medicines during our inspection.
- Reference materials for staff to use regarding the use of medicines such as British National Formulary were available either in hard copy or online.
- There was a system in place to report medicines incidents and following investigation to share learning amongst staff.

Records

- In suites and theatres, we examined eight sets of patient medical and nursing records, which included assessments for patients treated in operating theatres. There were detailed and comprehensive pre-assessments made on patients prior to admission.
- Records included details of the patient's admission, risk assessments, treatment plans and records of therapies provided. We looked at preoperative records, including completed preoperative assessment forms. Records were legible, accurate and up to date.
- Medical records were seen to be stored in secure cabinets in suite areas.
- 'Five steps to safer surgery' surgical safety checklist should be used for every patient undergoing a surgical procedure. We saw that the guidance was followed in the Priory theatres however in checking records for the period of our inspection and for a similar period in November 2015, we saw that the checklists contained a significant number of omissions, or had been overwritten. Most of the omissions related to the time of different aspects of procedures. It is important that all aspects of the checklists were completed accurately which enables better analysis and learning if procedures go wrong.
- When reviewed 35 records for 18 November 2015, we saw a total of 88 errors or omissions. These included nine signatures missing; eight dates missing, and 71 times omitted. Records for 17 February 2016 showed an improvement. Of 21 records reviewed, we found four signatures, three dates and six times omitted.
- Patients were provided with a copy of their discharge letter, which included a list of medicines.

Safeguarding

- The hospital had safeguarding policies and procedures available to staff on the intranet, including out of hours contact details.
- Consultants were required to evidence their safeguarding training as part of their practising privileges.
- The hospital wide compliance rate for all levels for both adult and child safeguarding at the time of the inspection was 95%. The target was 85%. However, we reviewed the policies in place and found they did not stipulate which staff required what level of training. The lead clinical commissioning group had recommended the policy required local contact details and training levels identified by staff. Information supplied demonstrated that 24 identified staff had received training to level two for both adult and child safeguarding. However, we noted that there was 101 full time equivalents (FTE) qualified nursing staff.
- The hospital had two members of staff trained to level 3 in adult and children's safeguarding.

Mandatory training

- Staff had access to both on-line and face-to-face training. We saw records, which showed compliance with mandatory training for nursing, and care assistants on the suites averaged 91%. Many staff had achieved 100% compliance, however overall compliance was reduced as a result of some staff falling behind due to sickness or other absence.
- Staff had individual training programmes relative to their role. We saw that there were between 17 and 22 mandatory subjects dependent upon role. Senior staff were able to review which subjects individual staff had attended and which were outstanding.
- Induction processes ensured that new staff or temporary staff understood their role and were supported.
- Theatre staff average compliance was 92.8%; again, a large number of staff 27 had achieved 100% compliance. Only nine members of staff had less than 75% this included one new starter who was not included in the average figure, as they had only started to work through their training.

Assessing and responding to patient risk

- The National Early Warning Score tool (NEWS) which demonstrated whether a patient's condition was deteriorating was used in all surgical wards.
- We saw that NEWS audits were completed each month on Bournville and Dudley suites. The audits identified that other discrepancies had been found, but they did not show how learning had been shared to prevent re-occurrences. Managers told us that results were displayed on the CommCell boards and if individual staff were identified, they would be spoken to and given advice.

Good

Surgery

- Risk assessments were undertaken in areas such as venous thromboembolism (VTE), falls, malnutrition and pressure sores. These were documented in the patient's records and included actions to mitigate the risks identified.
- A theatre communications meeting took place each morning at 7.30am where any issues were discussed which might affect the proposed procedures that day.
- Policy for transferring patients between suites and theatres stated that a qualified member of staff should accompany patients between theatres and suites. However, we saw that practice was that none of the qualified staff were completing the transfers.

Nursing staffing

- We saw that staffing levels in theatres and on the individual suites were good.
- Staff in theatres did highlight that they were expected to work very flexibly to fit in with demand from consultants, however they told us that the hospital responded by being flexible towards any requests they made for leave or time off.
- Staffing consisted of six nurse team leaders, 27.5 whole time equivalent (WTE) nurses and 18.3 WTE care assistants, and 10 operating department practitioners (ODP's).
- Agency staff were used on occasions to cover vacancies. Theatres had an arrangement with the agency which ensured that any staff used were 'critical care unit' trained, managers explained that this ensured agency staff could deal with any eventuality they might face.

Surgical staffing

- Individual consultants made their own arrangements to visit patients at Priory hospital. Staff told us that surgeons with inpatients attended the suites at least once per day to meet with and review their patients; some attended twice per day.
- Nursing staff explained that consultants also left contact details and requested that they be contacted if any of their patients were unwell. They were also happy to be contacted for advice.
- In the absence of consultants, medical cover was provided through a contract between BMI Priory and a private firm which provided an on-site Resident Medical Officer on a 24/7 basis.
- We did speak with a resident medical officer (RMO) during the inspection. They described their role and told us they felt supported by the hospital staff and felt able to approach individual consultants for advice or guidance if this was required.
- Consultant staff were within 30 minutes of the hospital so they could attend to patients in a timely manner.

Major incident

- Emergency plans and evacuation procedures were in place and arrangements were displayed on noticeboards. Staff were trained in how to respond to fire and evacuation procedures.
- The hospital had numerous contingency plans in place that detailed escalation and workaround practices. These were available for staff on the intranet.

Are surgery services effective?

Good

Surgical services were effective.

- Patients received care and treatment in line with national guidance and good practice.
- Arrangements for nutrition and hydration met people's needs.
- The hospital engaged with national audit, for eligible procedures the hospital scored higher than the England average for all measures.
- We observed good multi-disciplinary working between nursing staff, and allied health professionals.
- Staff were competent to undertake their roles and were able to access additional training.
- Seven day working was well embedded in the organisation.

Evidence-based care and treatment

- BMI Priory did not admit emergency patients. All surgical procedures were elective, which meant that patients had chosen to have an operation to deal with their condition.
- Patients were required to be relatively well before being suitable for surgery at BMI Priory. Patients were assessed in line with the American Society of Anaesthesiologists (ASA) physical status classification

system. ASA scores range from 1-6. ASA1 is a normal healthy patient; health and wellbeing reduce as the ASA number increases. Consultants did not use the hospitals services if patients ASA level was above ASA3.

- We saw from records that comprehensive pre assessments had been completed prior to patients being admitted.
- Assessments for patients were comprehensive and holistic. Patients' care and treatment was planned and delivered in line with evidence-based guidelines.
- Policies and guidelines were readily available for staff on the hospital's intranet These were seen to be up to date. Policies followed guidance with National Institute for Health and Care Excellence (NICE) and other professional associations.
- Venous thromboembolism (VTE) assessments were completed on patients and results / score were recorded on the patients drug charts. These were clear and evidence-based, ensuring best practice in assessment and prevention.
- The preoperative assessment clinic assessed and tested patients in accordance with NICE guidance for someone due to have a planned (elective) surgical operation. Examples included MRSA testing.

Pain relief

- Patients' pain was assessed and managed effectively in most cases. The NEWS chart was used to record patient pain score and medication was given as prescribed.
- Patients we spoke with all told us that their pain was effectively controlled.

Nutrition and hydration

- The Malnutrition Universal Screening Tool (MUST) was used to assess and record patient's nutrition and hydration. The MUST tool is a five step screening tool to help identify patients who were underweight and at risk of malnutrition.
- Support was available for patients who required assistance to eat or drink. Relatives and carers were able to attend and assist patients if they wished and were able to do so.

Patient outcomes

- The hospital engaged with national Patient Recorded Outcome Measures (PROMs) audit for its NHS patients. PROMs data measures the general health and wellbeing of patients before certain operations and again at intervals after the operation to assess any positive or negative effect.
- Eligible procedures are; groin hernia, hip replacement, knee replacement and varicose vein operations. In order to protect the anonymity of patients and ensure accurate analysis PROMs data is not published on numbers below 30 in each category. The hospital provided documentation to show that during the reporting period April 2014 and March 2015, they had 29 eligible procedures consisting of; six groin hernias, eight hip replacements and 15 knee replacements.
- PROMs outcomes were listed under two headings EQ-5D which is calculated based on the patients response to five questions and EQ-VAS which is the patients estimate of wellbeing based on a single sliding scale.
- For knee replacement seven of the fifteen patients were suitable for analysis.
  - EQ- 5D results showed that six (85.7%) of the seven patients had seen improvements in health. The England average was 81.1%.
  - EQ-VAS results showed that five (83.3%) of the seven patients found an improvement in their wellbeing. The England average was 55.7%.
- Knee replacement operations were also measured using the Oxford knee score. The seven procedures at Priory hospital had all reported improvement in health (100%). The England average during the reporting period was 93.8%.
- The National Joint Registry (NJR) collects information on all hip, knee, ankle, elbow and shoulder replacement operations. The latest published data from the NJR covers data on operations completed during 2014. Data in the report showed that during 2014, twelve consultants completed 263 qualifying operations at BMI Priory Hospital. The data showed that the average ASA level for patients was 1.8; 97% of patients had evidence of confirmed consent, and 87% of patients had identifiable link to their NHS patient number.
- The register identifies providers that have been classified as outliers since 2003, and 2010 for hip or knee revisions (re-do operations) and for mortality within 90 days of surgery. BMI Priory had not been an outlier in any of the recorded categories.
- In a 12 month period between July 2014 and June 2015 there were 24 (0.3%) unplanned returns to theatre which was below national averages.

- There was a seven-day service provided by the pharmacy department and a provision for supply of medicines out of hours in an emergency.

Competent staff

- Registration of nurses, allied health professionals and doctors with practising privileges at the hospital had been verified. This meant that 100% of staff had the appropriate registrations to practice.
- We reviewed documentation and records which showed the process the hospital used to ensure that consultants requesting or renewing their practising privileges were properly assessed. This included evidence from the consultants NHS hospital. Where consultants did not have an NHS practise we saw that comprehensive validation processes were in place within BMI which ensured they had maintained their level of competence and completed all appropriate training.
- Nursing staff that we spoke with stated they were supported by senior staff to access training Staff accessed both mandatory training and additional training for which they could request funding.

Multidisciplinary working

- Multidisciplinary working took place between nursing staff and allied health professionals. Consultant input was less obvious as most clinical decisions had been completed prior to patients being admitted to the hospital.
- We observed good working relationships between the residential medical officer (RMO)'s, nursing staff and theatres staff.
- Morning briefings in theatres included all staff, outlined all procedures to be carried out, and highlighted risks or issues for each patient on the list.
- Allied Health professionals such as occupational health, physiotherapists and dieticians worked closely with medical teams to support patients recovery and provide advice before discharge.

Seven-day services

- Nursing and care assistant staff worked 24/7 and were supported by the resident medical officer (RMO).
- The majority of operations were conducted on weekdays between 8am and 8pm, with a small number of procedures completed on Saturday mornings.
- Pharmacy and therapy support were available throughout the day on weekdays and operated a call out system overnight and at weekends.
- Services were provided to support the demands of consultants. At the time of our inspection we were told that there was no demand from consultants for extended hours or additional days.

Access to information

- Staff all had access to the hospitals computer systems. Guidelines and protocols and policies were all accessible. Staff were able to demonstrate how they accessed information on the electronic system.
- Portering services and engineering services had their own dedicated computer systems. They could see requests from staff to address environmental and equipment issues; they could be rated and addressed in order of need.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- All staff had received training in the Mental Capacity Act 2005 and mental health act; however understanding of the acts was very fragmented. Managers explained that although training had been given, the methods employed by consultants and the chose and book system used by GP's meant that it was very rare for patients who did not have capacity to be treated at the hospital.
- Systems were in place to ensure that best interest decisions were made where patients lacked capacity to make important decisions about their care.
- Patients we spoke with told us that they had been informed of the risks associated with their surgery before they signed the consent form. Staff discussed their treatment with them before commencing care. We saw that consent forms were completed, signed and available for staff to check prior to treatment being commenced.

Are surgery services caring?

Good

We found that staff were caring.

Good

Surgery

- We observed interactions between staff and patients and their family members. Staff were friendly, polite and professional.
- Patients told us that staff were attentive and had involved them in decisions about their care. Consent was sought prior to any procedure being completed or care provided.
- Patient's privacy and dignity were respected and protected. Patients were able to discuss their personal needs and wishes with staff. Patients told us that staff at all levels treated them as equals.

Compassionate care

- Patient's privacy and dignity were maintained when personal care was given or when any procedure or treatment was undertaken.
- We saw that patients in theatre were treated with respect even when unconscious.
- Patients we spoke with all confirmed that staff had been polite and friendly. This had included encounters with receptionists, nursing staff, doctors and staff such as porters and housekeepers.
- We observed many instances of staff talking with patients, and laughing and joking with them. Staff remained professional and took their lead from the particular patient they were dealing with.
- We overheard nursing staff asking patients if they needed assistance during meal times. This was done in a friendly non-condescending manner.
- We saw staff as they were stopped by visiting relatives who wanted information about the patient they were visiting. Staff always provided polite responses and if they were busy promised to return and provide answers. We saw two instances where staff returned to relatives after completing the task they were involved in.
- We did not hear call bells being used; patients told us that staff were always calling in so they didn't need to call them which they thought reflected the level of care that was provided.
- Patients told us that they were able to speak with all staff, from porters to senior clinicians and felt they were always treated as equals.

Understanding and involvement of patients and those close to them

- Patients told us that they had been able to discuss their care and treatment with their consultant and with nursing staff. They said they had been able question different options and they had been given information which they could understand. Some patients described how they had been provided leaflets describing their procedure so they understood what to expect.
- Patients told us that their relative or carer had been able to attend meetings and consultation's and had been able to take a full part, asking and answering questions
- Patients who were paying for their treatment told us that they had been provided with all the information they needed to make financial decisions relating to their health.
- Consultants spoke to patients appropriately; all patients we spoke with confirmed this. We did see that one formal complaint had been made about a consultant's attitude towards a patient.

Emotional support

- Patients and their families were able to speak privately with consultants or managers regarding the costs of their care and any concerns they had.
- Nursing staff explained that consultants usually dealt with patients and their relatives if bad news had to be given. Occasionally nurses had to speak with relatives or friends who visited when consultants were not on site. Quiet rooms were available for staff to speak with relatives. They could also be used for self-funding patients sensitive discussions.
- There was a chaplaincy service available for patients' religious or spiritual needs.

Are surgery services responsive?

Good

Surgical services were responsive to people's needs.

- Surgery at BMI Priory was all elective planned procedures, so very few procedures were cancelled.
- Referral to treatment times were excellent.
- Translation services were readily available to support patients and staff.
- Patients knew how to make complaints. We saw evidence that where learning was identified as a result this was shared with the staff.

However;

- Staff could not describe how they would make adjustments for vulnerable people such as those living with a learning disability.

Service planning and delivery to meet the needs of local people

- The hospital worked with consultants to provide them with the equipment, facilities and support which in turn enabled them to provide surgical services to patients who preferred to pay for their treatment or to patients who had chosen to have their NHS procedure carried out at the hospital using the choose and book system.
- Private patients were able to approach consultants based on their speciality. Each surgeon might work at a number of hospitals in different areas, but might only perform certain procedures at certain hospitals. This meant that patients came from the local community, and from outside the area and also from abroad to have their needs met.
- Services were planned to meet clinical need of the procedures carried out rather than local population needs.
- The hospital provided an intensive care unit for patients attending.

Access and flow

- Referral to treatment times for all groups of patients were all 100%, against national targets of 90%. This was achieved partly because there was spare capacity in the hospital. Staffing levels and availability of theatres and equipment was greater than the demand which meant patients did not have long waits to commence treatments.
- Between August 2015 and January 2016 the hospital had 20 (0.4%) patients who required an unplanned readmission within 31 days of discharge.
- The service had a six-bedded intensive care unit. Between October 2014 and September 2015 the unit was only used to 7% of its capacity. This meant that the service had capacity to provide specialist care whenever it was required. Whilst this unit met the requirements of an NHS acute hospital intensive care unit, the acuity of most patients was such that the level of support available from such a unit was only required in a small number of cases. Some medical staff told us they would like to see the acuity of patients able to use the hospital increase as they had the facilities to provide appropriate care at that level.

Meeting people's individual needs

- Patients had good access to consultants within core hours, evenings and weekends. Consultants made the provider aware of their availability, especially if they had a substantive post in the NHS. This did not impact negatively on patients experience.
- Translation services could be arranged if required and as patients were all elective, such issues were usually identified in advance of the patient attending.
- There were facilities available for relatives or carers to remain on the suites if they needed to.
- We did not see and staff were unable to describe any adjustments which had been made to accommodate patients, carers or visitors who had a disability.

Learning from complaints and concerns

- The hospital followed the BMI complaints policy when formal complaints were made.
- Staff understood how to support people who complained. They told us that the majority of issues patients raised were dealt with at the time, preventing issues escalating to formal complaints. These issues were recorded in individual patients care records but no separate record was kept which might assist the hospital to identify trends and prevent the issue reoccurring. We were told that some minor complaints were discussed informally in team meetings or at handovers.
- Formal complaints were recorded and responded to appropriately. Between September 2015 and March 2016 the hospital received five formal complaints. At the time of our inspection three of the complaints had been finalised and the remaining two were progressing through the complaints system.
- Learning from formal complaints was shared locally to staff at team meetings, which was evidenced through minutes of meetings. Minutes were available to staff on the suites CommCell boards.

Are surgery services well-led?

Good

We rated this service as good for well led.

- The local vision related to the Priory and the local sister hospital identifying areas of expertise to diversify.

- Systems were in place to ensure that consultant's performance was monitored and reviewed through the Medical Advisory Committee.
- Corporate oversight ensured that systems were monitored and issues addressed. Annual reviews were completed of services and comprehensive reports shared with the executive team outlining areas for improvement.
- Senior managers were visible and approachable. We saw strong local leadership on the suites, within theatres and the intensive care unit.

However;

- We saw complacency relating to a lack of challenge for some poor practice such as entering and leaving theatres.
- Lack of process of self-medication procedures and poor recording of refrigerated medication. These had the potential to negatively impact on the services provided.

Vision and strategy for this service

- BMI Priory Hospital is part of the BMI Healthcare group which has 59 hospitals throughout the UK. All locations including the surgery core service shared the BMI corporate identity and the company moto of 'Serious about health. Passionate about care'.
- Priory hospital is based in Birmingham and is geographically close to and shares some administrative and managerial roles with the nearby BMI Hospital. The two hospitals provide similar services and to some degree compete with each other for work. The two hospitals were looking at ways to collaborate and support each other rather than competing. Executive and corporate managers were considering options to site individual specialist services at one or other of the hospitals. The long term vision being improved levels of specialist equipment and support for particular procedures, attracting more consultants and improving outcomes for patients.

Governance, risk management and quality measurement

- Systems were in place to monitor performance which fed back to board level. Regular quality and performance meetings took place in which audit outcomes were reviewed and agreement of improvement next steps.
- Risks were identified and where required placed on the hospital risk register. However, review of the risk register was not always evident. Some risks had remained on the register for a number of years. We did see evidence of some risks being progressed.
- The theatres at Priory hospital did not have an uninterrupted power supply (UPS) battery back-up. This had been identified and was on the risk register. We asked the hospital to evidence how this issue was being progressed. We were provided with minutes of meetings and a copy of the capital investment plan for 2016 which showed provision had been made for the purchase of a UPS system during the next financial year.
- The service had a Medical Advisory Committee (MAC) which oversaw governance of consultants working in the hospital. Part of the role was also to review performance data of the hospital. The committee met every four to six weeks. We saw minutes of the MAC meetings which showed how issues were debated and information shared between consultants, the committee and the executives of the hospital. We met with the Chair of the MAC who was able to describe the governance process and gave examples of how the committee had been effective in management of adverse incidents and management of consultant performance.
- We saw minutes of team meetings, which contained feedback on incidents, complaints and compliments. Medical alerts and information of note was shared during meetings in addition to being published on the hospital intranet site for staff to access.
- There was good collaboration with pharmacy managers across the BMI group to enable shared learning to take place. We saw evidence of how incidents in one of the company's other hospitals had been circulated to enable staff to understand how to prevent similar incidents occurring locally.
- BMI conducted Executive Director (ED) advisor visits of the hospital. The last visit occurred in late 2015 but the report had not been produced at the time of our inspection. The hospital provided us with a copy of the March 2015 action plan 'EDs Action Plan from Provider Visit Completion'. We saw that the plan consisted of 33 pages highlighting over 170 issues, with actions and target dates. We saw how the issues had been addressed and services improved.

Leadership of service

Good

Surgery

- Supervisors and managers understood their staff skills and abilities of individual members of their team. Managers and supervisors treated staff with respect and supported them in their work.
- Staff confirmed that they were able to approach managers and felt supported.
- Consultants told us that nursing staff were responsive to their needs; in particular they were complimentary of the theatre staff, who they described as first class.
- Consultants believed the Medical Advisory Committee (MAC) process supported them and was part of the process for continued improvement of the services offered to patients.
- There were areas where closer observation by senior management would improve services. Many of the issues identified in the safe domain as requiring improvement could be addressed by supervisors reinforcing national good practice or hospital or corporate policies. These include theatre discipline, staff knowledge and implementation of self-medication procedures and oversight of temperature sensitive medication storage.

Culture within the service

- The staff were a close knit and friendly team who obviously supported one another. There was an open culture within the staff and management teams at the hospital. During our inspection we found staff of all levels to be approachable and polite. However this environment may have led to the complacency demonstrated by some staff.

Public engagement

- BMI Healthcare has a comprehensive website which enables patients to review the Priory Hospital. Details of the services available and the consultants registered with the hospital were all available.
- A patient newsletter is published on the website with news items and general information.

Staff engagement

- Staff had access to the hospital intranet system with emails, news feeds and access to policies procedures and working practice.
- Regular team meetings took place which fed into management meetings. We saw evidence in minutes of meetings of issues being escalated and responded to.

Innovation, improvement and sustainability

- The hospital were reviewing services provided at BMI Priory and the nearby BMI hospital with a view to providing specialist treatments at individual sites. This may lead to more advanced services; the ability to provide more intensive treatments; attract additional and more specialist consultants.
- The hospital shares some management and governance systems with a nearby BMI hospital, which reduce costs and improve liaison between the sites. For example all consultants practising privileges were filed at and reviewed by Priory Hospital staff, and the Medical Advisory Committee cover both sites.

Requires improvement

Outpatients and diagnostic imaging

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

Information about the service

The outpatients and diagnostic imaging services at The BMI Priory Hospital offers a wide range of specialties including ophthalmology, orthopaedics, ear nose and throat (ENT), general medicine, physiotherapy, urology, cosmetic surgery and general surgery.

From February 2015 to January 2016, there was a total of 41,354 outpatient episodes. Out of these 17,454 were first appointments and 23,900 were follow up appointments. Ninety percent of the activity was self-paying or insured patients, ten percent was NHS funded care

The department comprises of a CT scanner, an MRI scanner, a Computed Radiography x-ray room, a fluoroscopy room, a mammography room, an ultrasound room, an interventional room, a nuclear medicine gamma camera, mobile x-ray units and image intensifiers for theatre imaging.

The service mostly saw adults; however children over the age of three were also accepted as patients for consultations. From February 2015 to January 2016, there was 266 children appointments.

The service is open from 8am to 8pm Monday to Friday with some additional clinics on Saturdays.

The outpatients department includes a number of consultation and treatment rooms, a physiotherapy department with a gym and the diagnostic and imaging suite. Patients were referred by their GP, through consultants' private practice or as self-referrals. NHS services are commissioned by local clinical commissioning group.

As part of our inspection we spoke with eight patients and a range of staff including the senior staff nurse, a consultant, clinical lead nurse for outpatients, healthcare assistants, physiotherapists, radiology managers, radiographers, the physiotherapy manager and team leader and reception staff. We observed care and looked at 12 patient medical records.

Requires improvement

Outpatients and diagnostic imaging

Summary of findings

We rated this this service as Requires Improvement overall.

We rated safe as Inadequate because;

- Details on all patient consultation were not kept onsite.
- The '5 steps to safer surgery' check list was not embedded within Diagnostic imaging and did not take place in the outpatient department.
- The capital replacement programme for Diagnostic imaging was inadequate and radiology equipment was past its replacement date.
- Radiation doses delivered exceed the national dose reference levels for under 50's and the gamma camera was placed on the risk register seven years ago.
- The progress of incidents could not be easily followed, we saw a serious incident that had not been investigated and the affected patients had not been notified. This also resulted in a failure to recognise that duty of candour needed to be considered.

We have inspected but not rated this service for effective.

- We found that the referral and justification for exposure to medical exposure of radiation was unclear.Out of date protocol was still in circulation the diagnostic imaging department but discrepancy rates were less than the national target.

We have rated responsive and well led as requires improvement;

- Computed Tomography CT cardiac scans for the
- The waiting times in diagnostic imaging were not communicated with patients.
- We were not assured that appropriate governance systems were in place to track incidents reported by staff.
- Feedback from the provider's corporate diagnostic imaging lead to the radiology manager regarding equipment replacement was poor.The equipment in the department was in urgent need of replacement with no vision of how BMI will be addressing the issues.
- The hospital risk register did not reflect the risks occurring in diagnostic imaging.

However we did see some good practice:

- However we also saw that departments were clean.Adequate staffing levels ensured patient safety and medicine prescriptions were stored safely.
- Multi-disciplinary team working was seen throughout the hospital and staff appraisals were up to date.Extended working hours were evident to accommodate patient need.
- We have rated this service as good for caring.We observed kind, compassionate care, all patients we spoke to recommended the service.Patients were supported through their treatments.
- We also saw that learning from complaints was evident in the physiotherapy department.
- The provider was meeting it's referral to treatment targets and patients were provided with suitable appointments to reflect their needs.
- Staff were familiar with the vision and strategy for the service.
- Leadership was visible.
- Innovative practice was evident in physiotherapy and diagnostic imaging departments.

Requires improvement

Outpatients and diagnostic imaging

Are outpatients and diagnostic imaging services safe?

Inadequate

We have rated this service as Inadequate for safe because;

- Details of all patient consultations were not kept onsite, which put patients at risk of not receiving the most appropriate care.
- The '5 steps to safer surgery' check list was not embedded within Diagnostic imaging and did not take place in the outpatient department.
- The capital replacement programme for Diagnostic imaging was inadequate.
- The radiology equipment was past its replacement date. Radiation doses delivered exceeded the national dose reference levels.
- The gamma camera was placed on the risk register seven years ago but was removed from the risk register without communication with relevant staff.
- The progress of incidents could not be easily followed, we saw a serious incident that had not been investigated and the affected patients had not been notified.

However we also saw that:

- Departments were visibly clean, with good housekeeping arrangements.
- Staffing levels were maintained to ensure patient safety.
- Medicines and medicine prescriptions were stored safely.

Incidents

- Incidents were reported using a paper based system. The staff member would complete a paper incident report form, this would be handed to an administration lead to grade the incident and input the details onto a computer system. The department did not keep a log or duplicate of the incident form completed. This could make following the progression of an incident difficult.
- During discussions with outpatient department staff we were made aware of an incident that had occurred four weeks prior to our inspection. We attempted to follow the process in place for this incident. We found that even though staff said they had reported the incident, the incident report form could not be located and the incident had not been inputted on the computer system. The incident form was eventually located in the outpatient department. Due to this delay no learning from the incident had been initiated and the patients involved in the incident had not been informed. Senior management were informed of this at the time of inspection. During our unannounced inspection we saw that the incident investigation had been commenced however, the patient had not been contacted.
- We saw evidence of how incidents in other parts of the hospital or at other hospitals within BMI Healthcare were shared. We saw details of incidents and guidance on how they could be prevented or reduced, these were displayed on the CommCell boards in staff rooms. We observed minutes of team meetings where these issues had been raised.
- Staff confirmed that they were made aware of hospital wide incidents in various formats, for example, through team meetings, governance meetings and emails from line managers.
- Physiotherapy staff said they always had feedback from incidents they reported from their manager personally and in team meetings.
- We saw that incidences that had occurred in the hospital were discussed at staff team meetings. Meetings were minuted so staff who were not present could view the discussion that had taken place.
- Staff were not familiar with the term 'Duty of Candour' The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support to that person. Staff had some understanding of being open and honest but could not provide examples of when Duty of Candour would be applied. We observed an incident investigation that had been commenced requiring openness and honesty however; the patient had not been contacted.

Diagnostic Imaging

- Incident management within radiology was embedded. Staff were aware of how to report incidents and there was a culture of openness when errors occur. In

radiology, one reportable Ionising Radiation (Medical Exposure) Regulations [IR (ME) R] had occurred in the previous 12 months and this was under investigation locally.

- The radiology services manager (RSM) informed us that they investigated incidents locally. All paper documentation was submitted to the executive director's clinical governance team for population onto the electronic system. Feedback was given through the clinical governance forum.
- Diagnostic imaging staff were aware of the Duty of Candour policy. We saw posters displayed which demonstrated the policy and we were informed that within radiology all errors were communicated to the patient by the RSM either verbally at the time of the error or via a letter as part of their own departmental processes.

Cleanliness, infection control and hygiene

- The areas we inspected were visibly clean and tidy. Cleaning schedules were in place with clearly defined roles and responsibilities for cleaning the environment and decontaminating equipment.
- Staff were aware of current infection prevention and control guidelines. Arrangements were in place for the handling, storage and disposal of clinical waste, including sharps.
- Staff followed the 'bare below the elbow' guidance and used appropriate protective personal equipment, such as gloves and aprons, whilst delivering care.
- All of the consulting and imaging rooms we inspected had hand-washing facilities, antibacterial hand gel and cleaning wipes available. Hand hygiene posters were displayed.
- The hospital had an infection control nurse who worked jointly with another local BMI hospital. They conducted environmental and hand hygiene audits. The most recent environmental hand hygiene audit was carried out in October 2015. It demonstrated compliance in 23 out of 25 areas. Target for the audit was complete compliance; we observed an action plan in place to address the non- compliant areas.
- No healthcare-associated infections such as Methicillin Resistant Staphylococcus Aureus (MRSA), clostridium difficile (C.diff) or, Methicillin Sensitive Staphylococcus Aureus (MSSA) were attributed to the outpatients and diagnostic imaging department for the 12 months preceding the inspection, February 2015 to February 2016.
- We saw 'I am clean' stickers on all unused equipment in the department. This meant that staff could be confident that equipment they were using had been cleaned prior to use.
- Used linen bags in the outpatients department sluice were not over-full and notices were displayed stating when and how they should be changed.

Diagnostic Imaging

- The cleaning of computed radiography cassette is important as it ensures that dust and debris do not appear on patients images, which degrade the quality and can mimic pathology. This cleaning regime should be a regular and routine task but there was no evidence that this was occurring.
- The radiography assistant was aware of the requirement to clean the ultrasound probe with the appropriate wipes after intimate examinations. There was evidence of documentation relating to this cleaning schedule of ultra-sonography equipment.
- Quality assurance of the ultrasound machine occurred when the unit was serviced. If the radiology assistant was not present at the time of servicing, quality assurance was not documented.
- Changing rooms were clean with a good supply of fresh gowns available.

Environment and equipment

- The building was well maintained and free from clutter. It provided a suitable environment for treating patients, despite the challenges of being a Grade 2 listed building.
- Outpatients had 12 consulting rooms. There was a recently refurbished treatment room where minor operations or procedures were conducted.
- The sluice was not fit for purpose because it did not comply with Department of Heath recommendations. Detailed plans were in place for the redesign and development of the sluice to make it safe and compliant. Work was due to start in the week following our inspection.
- The stair safety rails were not complaint with health and safety guidelines for recommended height and space between balustrades. This was due to building restrictions. This risk had been reduced by ensuring

equipment and seating was not kept on the landing area to reduce trip hazards and discourage patients from waiting in the area. If children were seen for consultation on the second floor, the lift would be used.

- Conversations could not be heard from outside consulting room doors.
- Equipment was well maintained, appropriately checked and decontaminated regularly with checklists in use for daily, weekly and monthly monitoring. Resuscitation equipment was readily available on each floor of the department. The resuscitation equipment had one piece of equipment that was out of date, this was replaced immediately.
- Separate paediatric resuscitation equipment was available, this equipment was checked daily, checking lists were complete and all equipment was in date.
- Systems were in-place to ensure that consultants' own equipment that they brought onsite to use was safe to use with appropriate servicing and safety checks. If consultants had not provided the required documentation to prove safety, the equipment would be stored securely to ensure it was not used.
- The physiotherapy department had a non-slip floor surface; the treadmill equipment also had a nonslip surface.
- All equipment requested from the physiotherapy management had been granted in a timely way.
- The physiotherapy department used an electronic exercise prescription programme which ensured consistency between practitioners.
- Staff had access to the equipment and instruments they needed to meet patients' needs and confirmed any faulty equipment was either repaired or replaced promptly.
- The organisation used an outside company for equipment maintenance and an individual within the provider acted as on oversight and liaised with the company. We observed documentation that all equipment was up to date on servicing.
- We saw two pieces of equipment that did not have a label in place to indicate when they were last serviced. We alerted the senior staff to this. The next day the correct labelling was in place indicating the equipment had been serviced appropriately.
- Lasers were used for ophthalmology procedures in the outpatient department. A laser protection officer was in place and laser protection advisor reports had been conducted in June 2015 to ensure safety. An action arising from the report was to cover a mirror in the laser room during laser use; we observed that this had been actioned.

Diagnostic Imaging

- The department was supported by a medical physics team contracted to the hospital for radiation protection services. The provider had a contractual agreement for the provision of a radiation protection advisor (RPA), radiation waste advisor (RWA) and medical physics experts (MPE).
- The capital replacement programme for equipment was inadequate. Annually ageing equipment was escalated to the director of imaging at the corporate organisation level. The corporate organisation level gave little feedback to the radiology services manager regarding the review and risk management of equipment.
- The CT scanner was unable to maintain a dose level or below national reference levels which means that for some examinations including CT cardiac scans of the under 50's are no longer offered. The radiology equipment was past its replacement date. This was assessed through risk assessment and dose audit. The MRI scanner was at the end of its asset life and staff were waiting confirmation that it would be replaced in 2016 / 2017. Following the inspection the hospital told us the business case for replacement had been approved.
- The gamma camera was placed on the risk register seven years ago due to its age and the risk of the unavailability of parts. It had been removed from the risk register at some point unbeknown to the radiology services manager (RSM) and it is unclear as to who removed this item.
- There were several consultants who practice in the interventional suite who had concerns over the image quality of the image intensifier compared to the units they work with within the NHS. This was predominantly due to the age of the equipment.
- The lead computerised tomography (CT) radiographer acted as the quality assurance (QA) lead for CT equipment. An additional member of staff was in the training process to assist in this role. We saw evidence of routine QA documents.
- All x-ray equipment was regularly serviced. We saw evidence of service records, maintenance handover forms and medical physics checks after servicing.

Requires improvement

Outpatients and diagnostic imaging

- Specialist personal protective equipment made from lead was regularly checked; these checks were recorded.
- In 2014, there was an urgent recommendation by the appointed radiation service. It recommended that examination protocols were improved across a number of procedures. This had not been achieved. There has been insufficient priority given to the replacement of equipment and there were safety concerns over performance, doses and future safety.
- The Ionising Radiation (Medical Exposure) Regulations (IR(ME)R) employer's procedures, standard operating procedures and examination protocols for individual examinations had not been sufficiently reviewed. A mix of current and historical paper documents dating back to 1999 were found in the IR(ME)R folders in both radiology and cardiology. This had the potential to cause confusion for staff.
- There was not a robust referral criterion. The guidance for radiographers to authorise medical exposures was out of date and unclear.
- The provider had a radiation safety policy but although it had been recently reviewed, historic and current documentation were stored in paper folders together which made it difficult to ascertain the most up to date information.
- There were concerns over radiologist and cardiologist dose monitoring. Clinicians had to use dosimeters they used in local NHS trust work as these were not provided by the hospital. A radiation dosimeter is a device that measures exposure to ionising radiation.
- If a high dose was recorded for an individual there was no way to identify where the increased dose arose from. This has been discussed at the Radiation Protection Committee (RPC).
- There was no system of eye or finger dose monitoring for individuals undertaking interventional procedures.
- A number of examinations exceeded the national reference levels for dose of radiation delivered to patients. This had been highlighted by the appointed RPA as requiring urgent attention. Priority had not been given to this requirement.
- Local diagnostic reference levels which reflected the high dose practice had been developed.
- Staff were aware of their responsibilities under the radiation regulations, however there was a lack of understanding of some aspects. Dose awareness and diagnostic reference levels (DRL's) was an area that lacked understanding; this is a requirement under IR(ME)R . Staff were unaware of how to access the policy which identifies what steps should be taken if DRL's are consistently exceeded.
- Staff working in computerised tomography (CT) had a good understanding of expected dose values for specific examinations.
- Signage around the hospital was poor and patients that we spoke to said that they had difficulty in locating departments.
- The waiting area for main x-ray was small and overcrowded; however, it was clean and well lit. We saw a young female patient being brought to the department on her bed and had to wait in a busy waiting area with little awareness of the need to protect her privacy. The RSM informed us that the waiting area was a concern and needed addressing.
- The estate was old and in places the department looked tired. Space was restricted, especially to manoeuvre beds and wheelchairs.

Medicines

- Up to date policies and procedures were accessible to staff and medicines were stored, managed, administered and recorded securely and safely.
- Prescription forms were kept secure in locked cabinets and individual forms were issued to consultants when required. The number of the prescription forms issued was recorded in a log book along with details of the patient for whom it was used.
- Medicines that required refrigeration were stored correctly and temperatures were checked and recorded daily. The outpatients department or radiology did not hold any stock of controlled drugs.
- The on-site pharmacy had sufficient stock for the number of treatments being carried out. Staff told us the outpatient prescriptions were turned around immediately.

Diagnostic Imaging

- Contrast media, a type of medicine used during diagnostic imaging procedures, was kept in a locked cabinet in the radiology department.
- A patient group directive existed in diagnostic imaging for contrast media as part of a CT scan. Patient Group Directions (PGDs) are written instructions for the supply or administration of medicines to groups of patients.

Records were inconsistent. Individuals' names and dates of medication administration were missing from documents. There was no formal document for this medication administration.

Records

- The hospital kept records for anyone who was treated as an in-patient; however they did not hold records of consultations for everyone seen in the outpatients department. There were five onsite medical secretaries who each co-ordinated the notes for two to five consultants. If a consultant used one of these secretaries or saw an NHS funded patient then notes were kept on site. Approximately 500 consultants with practising privileges used their own secretary to transport notes to the hospital ready for consultation and to collect them afterwards. For patients seen by these consultants details of the consultation was not kept in the hospital.
- Consultants were registered with the Commissioner's Office (ICO) (a publically accessible online register, which meant they had to comply with The Data Protection Act 1998).
- The outpatient department did not use the 'five steps to safer surgery' despite conducting minor operative procedures and laser ophthalmology procedures. When we raised this staff stated they did not think it was necessary. The surgical safety checklist is designed to reduce the number of errors and complications resulting from surgical procedures by improving team communication and by verifying and checking essential perioperative care interventions even in minor outpatient and diagnostic imaging procedures.
- We reviewed 12 sets of patient records that were available on site. The notes were legible and contained all the relevant information including letters to the patient's General Practitioner (GP). The paper documents were not secured within the patients folders this meant that information could easily fall out.
- Physiotherapy patient notes were available for 100% of patients. They were stored on site for six to 12 months before being electronically scanned and stored.
- Patient test results were reported on paper and were stored securely under their consultants' name pending review in the outpatient department.
- Patient records were stored securely in all areas either in locked cabinets or rooms with keypads. Notes were signed in and out by secretaries.
- Health care assistants took the notes from clinical rooms and then back to the medical records store at the end of each clinic.
- If a patient used the chaperoning service while being examined by a consultant, a rubber stamp was used in the patient records. This read 'Chaperoned by' followed by space for the name of the chaperone. It was also documented if a chaperone was declined.

Diagnostic Imaging

- The World Health Organisation surgical checklist or a variation of it was not routinely completed or audited. We observed less than 50% of interventional procedures had the safety checklist documented. Management said the safety checklist was carried out but notes were often removed by Consultants prior to them being scanned into the patients electronic radiological record.
- The radiology service manager (RSM) acted as the picture archiving communication system (PACS) lead for the hospital. There was a contingency plan in place if the PACS or radiology information system (RIS) was unable to function.
- The justification of medical exposures was not robust. Practitioner's signatures were not always visible or legible.
- Signatures on referral forms to the diagnostic imaging department were sometimes illegible. The clinician could not always be identified. Reception staff had learnt to recognise the signature of the consultant or RMO on the referral form in order to process the request.
- The imaging department received the clinical history from the referring consultant. If required, patient images were passed to referring hospitals via a secure portal.

Safeguarding

- Safeguarding policies and procedures were accessible to staff including, a domestic abuse and a Female Genital Mutilation policy. Staff were aware of the actions and process to follow and how to escalate safeguarding concerns. There was a named lead for safeguarding to support this process.
- The hospital wide compliance rate for all levels for both adult and child safeguarding at the time of the inspection was 95%. The target was 85%. However, we reviewed the policies in place and found they did not stipulate which staff required what level of training. The lead clinical commissioning group had recommended

the policy required local contact details and training levels identified by staff. Information supplied demonstrated that 24 identified staff had received training to level 2 for both adult and child safeguarding..
- There was one senior nurse in the outpatient department that has completed level 3 safeguarding for adults and children. They were the lead for safeguarding within the department.

Mandatory training

- Mandatory training content and frequency differed for clinical and non-clinical staff and included training in safeguarding of vulnerable adults and children, equality and diversity, information security and infection control.
- The hospital had changed the system used for recording mandatory training and new modules had been added. Therefore when we requested information on mandatory compliance the most recent data was December 2015.
- As part of their mandatory training, all staff attended basic life support training annually.
- Training was delivered via a structured programme with face to face sessions and e-learning modules.
- Compliance with mandatory training was high. Data up until December 2015 showed 100% of staff in the diagnostic imaging department, 100% of staff in the physiotherapy department and 100% of the outpatient department nursing staff had completed their mandatory training.
- All bank staff also completed the provider's mandatory training.

Assessing and responding to patient risk

- An emergency bleep system was available for staff to call in case of emergency or a deteriorating patient. An emergency response team led by the resident medical officer (RMO) would attend to the patient. The RMOs utilised by this hospital were appropriately trained in Immediate Life Support (ILS) and Advanced Life Support (ALS).
- Emergency resuscitation equipment was available throughout the outpatient and physiotherapy areas. A paediatric 'grab bag' was available which contained equipment especially for children.
- Systems to promote safety were in place and well managed for example alarm systems, key coding access to consulting corridors, fire alarm procedures and checked fire extinguishers.
- The physiotherapy department conducted risk assessments on patients before they could use the equipment.
- Designated staff from the physiotherapy department were on call in the evenings and at the weekends in order to provide post-operative assessments such as for falls.

Diagnostic Imagining

- In 2010, an IR(ME)R inspection took place in the cardiology department, one of the recommendations in this report was that training records were available for cardiologists with practicing privileges undertaking cardiac catheter procedures. These records were not available. This has been identified as an IR(ME)R breach of Regulation 11(1). The IR(ME)R enforcement authority were serving an improvement notice on the provider.
- In the employer's procedures, cardiologists were not entitled to act in the capacity of practitioner or operator however, this was occurring. This is a breach of IR(ME)R Regulation 5(3).
- Interventional radiographers were acting as practitioners for some interventional procedures. They did not have adequate training or entitlement to do so.
- The protocol for women of a childbearing age undergoing medical exposures between the diaphragm and the knees, state that operators must indicate on the referral if the woman has been asked about potential pregnancy. In the interventional rooms this was not routinely being carried out. Less than half of the patients records viewed had the associated documentation. This is an operator task under IR(ME)R.
- The referral and booking process was a mix method of referrals. The reception staff were extremely adept at using the IT systems but the lack of communication between the hospital and radiology department made the process complex and time consuming.
- The justification for CT scans was unclear. A multiple stage booking and vetting process was in place via the IT system, and a paper based system. Historically, the CT lead acted as the practitioner for the justification of CT scans but this practice was changed a number of years ago to ensure only radiologists acted in this capacity. The CT lead is still cited in the employer's procedures as acting as a practitioner and therefore practice does not match procedure. The diagnostic imaging management were unaware that some discontinued practice was still occurring.

Requires improvement

Outpatients and diagnostic imaging

- There was an on call service for general, mobile and theatre radiography for urgent night and weekend imaging. All radiographers participate in the on call service. However, there was no radiologist on call rota. This operated on a goodwill basis.
- There were no delays in reporting times.
- A minor interventional service is offered by radiologists at the hospital during department opening hours. There was not an on call rota if the patient became unwell. The patient would be transferred to the NHS.
- A skin dose policy has been adopted by the interventional suite with a trigger threshold for reporting to medical physics and assessment of skin erythema following high dose radiation exposure. The trigger has not been reached locally since the implementation of the policy.
- Fertility patients could access the ultrasound service as an integral part of their pathway and care. Ultrasound could be accessed in a timely manner.
- There were no specific paediatric waiting areas.

Nursing staffing

- There were sufficient staff to deliver care.
- Nurse staffing rotas were held electronically on a roster management system. The system allowed heads of departments to manage rotas, skill mix, and staff requirements including senior cover and to manage sickness and annual leave absences.
- Nurses were on shift from 7:30am to 21:00 Monday to Friday with Saturday timings dependant on the clinics running. There was always a senior nurse on each shift with support from a number of nurses and a healthcare assistant. The rota showed mix of 50% qualified and 50% unqualified staff on duty per day.
- The number of nurses varied per day according to the size of the clinics and number of clinics running, it was usually two qualified nurses and two health care assistants.
- The outpatient department had one whole time equivalent nurse vacancy in the pre-assessment area
- Sickness and extra clinical need was covered by nursing bank staff. All of the bank staff were regularly used and familiar with the environment.
- From February 2015 to January 2016 there were 266 children appointments. A bank paediatric nurse was available for these clinics.
- Staffing levels met the calculated levels as per the rota during our inspection.

Medical staffing

- Medical staff were employed by other organisations (usually in the NHS) in substantive posts with practising privileges with The BMI Priory Hospital.
- If a consultant could not attend a clinic, appointments would be rearranged.
- There was a Resident Medical Officer (RMO) within the hospital 24 hours a day with immediate telephone access to the responsible consultant if required. Under the conditions of their practising privileges, consultants working at the hospital had to be accessible 24 hours a day, seven days a week.
- Alternatively consultants had to arrange appropriate alternative named cover if they were unavailable. Staff confirmed they were able to contact consultants when required and had not experienced any problems.

Diagnostic Imaging

- The department had a low sickness and turnover rate. One whole time equivalent vacancy existed for a radiographer which was advertised.
- The department employed eight full time radiographers and one part time, three radiology department assistants, one technologist and three nurses; two of which were part time.
- Staffing levels met the need of the patients. .
- There were twenty cardiologists with practicing privileges for cardiac imaging and intervention.

Allied Health Professional Staffing

- The physiotherapy department consisted of 11.8 whole time equivalent (WTE) physiotherapists and 2.15 WTE bank staff. The department was sufficiently staffed for patient safety. Bank staff were employed to increase capacity when required.

Major incident awareness and training

- A business continuity plan identified responses to manage any risks in case of a disaster or a major event.
- Staff were aware of the emergency procedures for a major incident such as a fire or adverse weather conditions.
- The provider commissioned an outside company to perform an unannounced adult cardiac arrest drill in

Requires improvement

Outpatients and diagnostic imaging

2015. The company chose the physiotherapy department. The report detailed that the providers emergency team performed very well, were efficient and demonstrated good team work.

Diagnostic imaging

- There was not a contingency arrangement if power supply to the interventional radiology room was interrupted.

Are outpatients and diagnostic imaging services effective?

Not sufficient evidence to rate

We have inspected but not rated this service for effective.

In summary our findings were:

- The referral and justification for exposure to medical exposure of radiation was unclear.
- Out of date protocols were still in circulation within the diagnostic imaging department.
- Discrepancy rates were less than the national target.
- Multi-disciplinary team working was seen throughout the hospital.
- Staff appraisals were up to date.
- Extended working hours were evident to accommodate patient need.

Evidence-based care and treatment

- Care and treatment was provided in line guidance from the National Institute for Health and Care Excellence (NICE) and the Chartered Society for Physiotherapy.
- Clinical staff were aware and practiced in accordance with national and local guidelines relevant to their specialist areas.
- Clinical care pathways had been developed in line with best practice and were put into action, for example physiotherapy pathways.

Diagnostic Imaging

- The Royal College of Radiologists guidelines recommend the use of i-Refer (an imagining referrals guideline) for referrals. This was not routinely used. This meant there were unclear referral criteria for clinicians and authorisation of medical exposures.
- The hospital required consultant radiologists to participate in discrepancy audit. Discrepancy audits facilitate collective learning from radiology discrepancies and improve patient safety.
- Discrepancy audit figures were between 2-5% which was within the Royal college of Radiologists recommendations of 5% by 2018. If a discrepancy was found, it was raised directly with the original reporting radiologist. This was documented on an audit form which is retained locally.
- Protocols for examinations had not been reviewed. The protocol folders contained information for examinations no longer carried out at the hospital. There was a large number of out of date documents still held in active files.

Pain relief

- Patients were assessed for pain relief during consultations and supported in managing pain through prescriptions with the appropriate medication.
- Complimentary pain relief therapies were also available via the physiotherapists such as acupuncture, Pilates and massage.

Patient outcomes

- The physiotherapy department took part in a national audit for perceived patient improvement following physiotherapy treatment. For upper limb conditions, a 23% change in quality of life was demonstrated, lower limb demonstrated a 22% increase and spinal treatment an 18% increase.
- The physiotherapy department used a survey which measured pain on a scale of one to 10 before and after treatment and included areas such as mobility, anxiety and self-care.
- There was some local audit activity undertaken. However, a member of the senior management team shared their concern that more clinical audit could be undertaken to demonstrate their effectiveness.

Diagnostic imaging

- The diagnostic imaging department had a yearly audit schedule in place. Dose audits were conducted in line with IR(ME)R regarding the protection of patients from the risks of unnecessary exposure to x-rays.

- The department was also audited externally from its commissioners to ensure the quality standards were being met. The reports we viewed were all positive. The safety concerns over high dose radiation and ageing equipment were not detailed.

Competent staff

- All staff completed competency assessments and an induction to the department when they first started. We viewed the competency document for health care assistants that aided skill progression.
- All staff received a departmental induction before they began to work unsupervised.
- In outpatients, physiotherapy and diagnostic imaging, 100% of staff had received an appraisal for the previous financial year which ended in October 2015. 60% of outpatient staff and 100% of physiotherapy staff had had their appraisal for the current financial year.
- Staff told us they had opportunities to conduct further training if it was identified. An example was a physiotherapist that had recently completed an acupuncture course.
- Practising privileges were reviewed by the chairperson of the medical advisory committee (MAC). This included a review of appraisals, General Medical Council (GMC) registrations and medical indemnity insurance.
- The BMI appraisal involved checking the NHS appraisals and participating in re-validation of their practice. Any delay in submission of evidence of appraisal and revalidation was flagged by the employee compliance coordinator with oversight, and if necessary, intervention from the registered manager.

Diagnostic imaging

- The department had appointed three radiation protection supervisors (RPS). RPS were appointed under the ionising radiation regulations 1999 (IRR) but locally oversee radiation protection under the ionising radiation (medical exposure) regulations (IRMER) in addition.
- Local rules required under IRR were evidenced. These had been recently reviewed but not all staff who were bound by these rules had read the documentation.
- One technologist worked in the nuclear medicine department for the operation of the gamma camera. The department adhered to all radiation protection regulations and audits regularly its compliance. There were four appointed Administration of Radioactive Substances Advisory Committee (ARSAC) licence holders for the administration of radionuclides.
- Continuous professional development (CPD) was self-directed and records were kept by individuals. Staff were encouraged to undertake CPD.
- The appraisal rate was 100%.
- Radiologists undertook CPD but primarily at their NHS base.
- The hospital requires that the radiologists provide their NHS appraisal on an annual basis.
- The department was in the process of reviewing induction, preceptorship and training packages in line with BMI corporate requirements and training templates. Record keeping of training documentation was variable amongst radiographer's. Training records for radiologists and cardiologists working in the interventional rooms were incomplete, out of date or absent.
- A new twelve week BMI and local level induction programme has been introduced and new staff had a "buddy" during their preceptorship.
- Staff told us that they were trained to operate the equipment and application specialists had offered some radiologist training. We did not see evidence to support this. The equipment was of significant age but there had not been any review of competencies on specific equipment.

Multidisciplinary working

- A multi-disciplinary team (MDT) approach was evident across all of the areas we visited. We observed collaboration and communication amongst all members of the MDT to support the planning and delivery of care in the outpatients, physiotherapy and diagnostic imaging departments.
- The physiotherapists demonstrated effective MDT with the local NHS rapid orthopaedic community services for knee replacement patients.
- Details of assessments and treatments carried out were communicated to patients' GPs on their discharge from the hospital.
- Daily meetings, involving the nursing staff, managers, therapists and medical staff were conducted to ensure there were sufficient staffing levels for each clinic and that key messages were communicated.

Requires improvement

Outpatients and diagnostic imaging

- There were service level agreements in place with nearby NHS organisations which involved teamwork to ensure continuity of care for patients, for example the physiotherapy department liaised with the local district nurses and NHS physiotherapy team to discuss plans for patient care. There were also service level agreements with local BMI hospitals to ensure the patient was treated in the most appropriate location.

Diagnostic imaging

- Communication between diagnostic imaging and the wider hospital was good and services were easily accessible.
- There was a good multidisciplinary working within mammography. Effective communication between mammography and the consultant radiologist was evident.

Seven-day services

- Clinics operated between 8am and 9pm Monday to Friday with clinics scheduled on Saturdays when the demand was high but mostly from 8am to 2pm.
- Under their practising privileges, consultants practising within the hospital were responsible for the care of their patients 24 hours a day, seven days a week. There was a Resident Medical Officer (RMO) within the hospital 24 hours a day with immediate telephone access to the responsible consultant.
- The physiotherapy department provided services seven days a week for inpatients including an oncall service and an outpatient service with times to suit the patients is offered over five days a week.

Diagnostic Imaging

- The department offered an extended working day. Monday to Thursday the main imaging department open from 8.30am until 8pm and until 7.30pm on a Friday. On Saturday the department was open from 9am until 1pm.
- The MRI scanner ran Monday to Friday from 7am until 9pm and 9am until 5pm on Saturdays.
- The ultrasound service run a flexible day according to demand.

Access to information

- Patient records for the consultants that did not use the on-site medical secretaries were not available to view. These were only available 48 hours prior to the respective consultants' clinic.
- The documentation in the physiotherapy department was either electronic, such as booking information and patient notes, or scanned in such as the GP referral letters and consent forms.
- Data and appointment lists were collated daily and printed off for relevant staff to ensure they knew which patients were attending.
- Outpatient consultations within the hospital were consultant-led. All patients attending outpatients would either have an accompanying GP referral letter or their current medical records from a previous appointment or admission would be available at the hospital. For NHS patients a detailed referral letter would be available prior to their initial consultation at the hospital.
- All corporate policies were available on the hospital's intranet. We asked members of staff, separately, to show us where policies could be found and they were all able to do so quickly and easily.

Diagnostic Imaging

- The radiology service used a picture archiving and communication system (PACS). This was a central off-site server that clinicians with appropriate secure access could view images from. Report results were available promptly from the radiology management computer system.
- The department utilised an appointment system used provider wide and also a radiology information system (RIS) and picture archiving and communication system (PACS).
- All IT systems were password protected and records of patient's appointments, examinations and reports were securely stored.
- There was no electronic requesting; all referrals were paper based via an imaging request form or a referral letter.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff had the appropriate skills and knowledge to seek consent from patients or their legal representatives. Staff were clear about how they sought informed verbal and written consent before providing care or treatment.

Requires improvement

Outpatients and diagnostic imaging

- Consultants discussed details of surgery and recovery at the outpatient's appointment and told us this would be discussed again on the day of surgery.
- Training on Deprivation of Liberty Safeguards and Mental Capacity Act assessments formed part of the hospital's mandatory e-learning. Compliance was 100% the department.
- Staff had some understanding in terms of the legal requirements of the Mental Capacity Act 2005 (MCA) 2005 and deprivation of liberties safeguards (DOLS), however, patients groups requiring these legal requirements were rarely seen at the hospital. Staff could locate the hospital policy regarding MCA and DOLS.

Are outpatients and diagnostic imaging services caring?

Good

We have rated this service as good for caring because;

- We observed kind, compassionate care.
- All patients we spoke to recommended the service.
- Patients were supported through their treatments.

Compassionate care

- All the patients we spoke with said the care they received was of a very good standard and we observed many positive interactions between staff and patients throughout our inspection.
- Staff greeted patients appropriately and in a friendly manner. Staff treated patients with dignity and respect whilst ensuring patient confidentiality was maintained.
- Patient comments included: "They can't do enough for you, I always get looked after", "really kind doctors and nurses" and "the staff are professional and caring" "the physio was brilliant and really listened to me".
- A chaperone policy was in place and posters were observed in all consulting rooms and waiting areas to advertise the policy. A patient preference regarding request or decline of a chaperone and the chaperones names was documented in each set of notes. Where possible the department would make adjustment to ensure a same sex chaperone was present.
- The Friends and Family Test (FFT) (a survey which asks patients whether they would recommend the service they have received to friends and family who need similar treatment or care) showed that 98% out of 2409 patients who provided feedback would recommend this hospital.
- The hospital also asked patients to complete a patient satisfaction survey. This was administered by an independent third party organisation. Results from the survey for 2015 to date, consistently showed high levels of patient satisfaction in all areas surveyed including overall quality of care and nursing care.

Diagnostic imaging

- Staff were polite, friendly and informative of what examination they would be performing and how to access results and onward care.
- Staff protected the privacy and dignity of patients during all observations.
- There was excellent care and compassion demonstrated by the mammographer, as seen during the inspection.
- Staff were helpful and assisted patients promptly and courteously.
- Reception staff were helpful and considerate to patients and respected the privacy of patients when at the reception desk.

Understanding and involvement of patients and those close to them

- All of the patients we spoke with told us they had been kept informed about what would be happening at each stage of their assessment and treatment. Patient booked their next appointment or were given a date for test results to be communicated before they left the department.
- All patients stated their appointment slots gave sufficient time to discuss their conditions in a relaxed and dignified manner.
- Patients told us they felt involved in decisions about their care and had enough information about available options to allow them to make informed decisions.
- Patients said that treatment options, risks and benefits as well as prices had been explained to them thoroughly.

Emotional support

Requires improvement

Outpatients and diagnostic imaging

- Patients were supported throughout their treatments. We saw staff spending appropriate time talking to patients and responding to their questions in an appropriate manner.
- Nurses or healthcare assistants acted as chaperones for any patients who requested the service. The chaperoning facility was advertised on posters in all of the outpatients consulting rooms.
- All the treatment and consultation rooms were private and could be used to deliver bad news. Staff told us consultants and nurses would work together to relay this information and provide any additional support where appropriate such as information about the condition.

Are outpatients and diagnostic imaging services responsive?

Requires improvement

We have rated this service as requires improvement for responsive because;

- CT cardiac scans for the under 50s were no longer offered due to ageing equipment with high radiation doses.
- MRI scans for NHS patients were transferred a neighbouring hospital for an MRI scan due to the unavailability of booking slots.
- Waiting times in diagnostic imaging were not communicated with patients.

However we also saw :

- Learning from complaints was evident in the physiotherapy department.
- The provider was meeting its referral to treatment targets.
- Patients were provided with suitable appointments to reflect their needs.

Service planning and delivery to meet the needs of local people

- The environment for patients was comfortable with plenty of seating areas. Free hot and cold drinks were available to aid patient comfort.
- There was a sufficient amount of free car parking spaces available close to the outpatient and physiotherapy departments.
- All patients stated their appointment slots gave sufficient time to discuss their conditions.
- Patients accessed services via a GP referral through the NHS referral service, self-referral or self-funding or via their health care insurer. Patients were offered appointment times after work and at weekends to fit around their personal and work lives.
- Patients referred via the NHS used the electronic referral service that gives patients a choice of place, date and time for their first outpatient appointment in a hospital or clinic. Patients confirmed this worked well and told us there were no concerns as they were able to book slots to suit their needs.
- Patients reported being assisted to their appointment via the lift with a member of staff if required.
- The physiotherapy department had private changing rooms with secure lockers for patients to use.
- The physiotherapy department treated children three years and older. Children were treated with priority and always by a specialist paediatric physiotherapist.

Diagnostic Imaging

- The diagnostic and imaging department provided scans on the same day for patients who had attended clinics. This reduced waiting times in the long term and meant patients did not have to return another day.

Access and flow

- The hospital had scheduled clinics with set specialities on a weekly basis with open booking slots. This meant staff knew when they could book patients for specific specialities and ensured the appropriate support staff were present. If any slots were empty then consultants could move or rebook patients at their discretion.
- NHS patients were managed in line with other NHS patients who should start their treatment within 18 weeks of being referred by their GP.
- The hospital met the 'referral to treatment' (RTT) target of having at least 95% of non-admitted patients beginning treatment within 18 weeks of referral for each month from April 2014 to March 2015. Data showed the hospital achieved 100% in all 12 months.
- The provider monitored the ratio of contacts related to procedures to ensure that consultants were not outliers in terms of excessive patient contacts.

Requires improvement

Outpatients and diagnostic imaging

- The physiotherapy department offered appointments within 48 hours of referral if appropriate for the patient or the same day for emergency referrals.
- The physiotherapy department had met provider set targets of 1,240, 15-minute appointment slots per month for the last 3 months.
- Waiting times for patients once they had arrived in the department were usually short after being booked in at reception. Although this information was not audited, patients confirmed they did not wait long before they were seen. No waiting times were displayed in the waiting areas but staff told us they would let patients know individually if there were any unforeseen delays.
- If a clinic was cancelled at short notice, they would attempt to contact the patient and offer alternative times.
- From December 2015, information was being collected regarding consultants that ran late for clinics or cancelled clinics last minute. Trends from this audit could then be addressed at senior management level. At the time of our inspection very little data had been collected, staff and management reported that this was not usually a problem.
- The main outpatient department did not collect information on patients who did not attend (DNA) their appointments. All patients were called to rearrange appointments. Discretion was used regarding charging of missed appointments.
- The physiotherapy department collected DNA rates that were less than 1%.
- If NHS patients did not attend for any reason, they were discharged back to their GP via an automated process.
- During the inspection, we observed all the clinics were running to schedule with no delays. However, the hospital did not monitor patient wait times once arrived in clinic or the number of patient attendances.

Diagnostic imaging

- There is no appointment waiting times for diagnostic imaging services.
- NHS patients that required MRI scans were transferred to a neighbouring hospital due to the unavailability of booking slots. These slots were only every other Friday due to radiologist availability. This meant they potentially could access the MRI service earlier. The MRI slots in the hospital are protected for the self-funded patients.
- CT cardiac scans for the under 50s were no longer offered due to aging equipment with high radiation doses. The impact on this group of patients is down to unavailability of the procedure. Patients were referred back into the NHS.
- Following the inspection the hospital told us works were due to start in Q1 2017, included within the business case is a new MRI & CT unit.
- Waiting times once in the department were not communicated well to patients. Delays in the service were observed due to busy outpatient clinics. This was not discussed with patients who were waiting.
- There were no delays to reporting and all radiologist reports were undertaken almost in real time.
- Faulty equipment with the department was addressed quickly. The CT scanner required a tube replacement and the radiographer coordinated replacement, installation and medical physics testing over the weekend enabling the service to be resumed promptly.

Meeting people's individual needs

- A variety of information leaflets were available but only in English. Patients confirmed they had received information about their care and treatment in a manner they understood.
- Telephone or face-to-face interpreter services were available where English was not the patient's first language. However, this need for interpretation services may not always be evident until the patient's first appointment. Provisions were made at the time of the appointment as the service used a telephone interpretation service that could be accessed immediately.
- Wheelchair access was available via a ramp at the main entrance of the outpatient department, with automated doors. The physiotherapy suite also had wheelchair access.
- Vulnerable adults, such as patients with learning disabilities and those living with dementia were identified at the referral stage. It was rare for such patients to be treated at the hospital as they were usually seen at NHS establishments. We were given an example where a patient living with dementia preferred to wait in their car until their appointment time, staff accommodated this need and went into the car pack to call them at the appropriate time.

Requires improvement

Outpatients and diagnostic imaging

- The outpatients waiting area was comfortably furnished with a range of seats of different heights, with and without arms.
- Patient reported having contact numbers to call if they were concerned about any aspect of their care,
- Patient received copies of letters sent between the provider and their GP.

Learning from complaints and concerns

- The physiotherapy team recorded all complaints both formal complaints and those resolved at the time of the issue.
- Because of a complaint, the physiotherapy team now clearly discuss the need for post-operative walking aids and the fact that these walking aids are not usually covered by private medical insurance. The physiotherapy lead would liaise with the local social care agency if a patient needed assistance in getting a walking aid.
- Information on how to raise complaints or concerns were displayed in the waiting areas. Staff were aware of the complaints procedure and told us they would always talk to the patient if possible and ensure the matter was resolved.
- Complaints were discussed and minuted at team meetings. Lessons learned from complaints were implemented and cascaded to staff to improve patient experiences.
- There was one complaint for the outpatient department and one for the physiotherapy department for the previous year, January 2015 to January 2016. There were no particular trends in complaints.

Diagnostic imaging

- Radiology had a low number of complaints from patients and the wider hospital.

Are outpatients and diagnostic imaging services well-led?

Requires improvement

We have rated this service as requires improvement for well-led.

This is because:

- We were not assured that appropriate governance systems were in place to track incidents reported by staff.
- Feedback from the provider's corporate diagnostic imaging lead to the radiology manager regarding equipment replacement was poor. The equipment in the department was in urgent need of replacement with no vision of how BMI will be addressing the issues.
- The hospital risk register did not reflect the risks present in diagnostic imaging.

However we also saw that:

- Staff were familiar with the vision and strategy for the service.
- Leadership was visible.
- Innovative practice was evident in physiotherapy and diagnostic imaging departments.

Vision and strategy for this service

- The quality strategy articulated how the service would provide the best possible care; strive for continual improvement and live up to the BMI brand promise to be "serious about health, passionate about care". Its four core themes of safety, clinical effectiveness, patient experience and quality assurance provided staff with a platform to deliver consistent care.
- Staff were familiar with the vision and strategy.
- Staff were provided with a corporate induction that outlined the vision and values.
- Due to there being two BMI's in closed proximity executive and corporate managers were considering options to site individual specialist services at one or other of the hospitals. The long-term vision being improved levels of specialist equipment and support for particular procedures, attracting more consultants and improving outcomes for patients.

Governance, risk management and quality measurement

- We were not assured the hospital had a robust process in place to ensure there was a complete and up to date set of patient's records on site. If patients who had attended the hospital for a consultation returned unannounced in an emergency the hospital may not have had details of what had been done during their consultation, and this could affect any treatment given.
- We were not assured that appropriate systems were in place to track incidents reported by staff.

Requires improvement

Outpatients and diagnostic imaging

- There was not a surgical safety check list in place to reduce the risk of surgical errors or complications.
- The hospital wide risk register did not reflect the risks occurring departmentally. The risk of aging equipment in diagnostic imaging department was not on the risk register. Actions taken to control or minimise the risks were detailed but it did not detail what they were or the timeframe for completion. Following the inspection we were told by the hospital that a business case had been approved for replacement of an MRI and CT scanner for Q1 2017.
- The hospital's electronic appointment booking system held real-time records of consultants who had practising privileges, and would not allow appointments or rooms to be booked for consultants who were not on the system. This meant that managers and staff were assured that all consultants using the hospital's facilities had undergone proper checks and held current practising privileges.
- Monthly clinical governance committee meetings were attended by senior managers from the hospital and members of the medical advisory committee (MAC). They discussed clinical incidents, complaints, infection prevention and control, medicines, results of clinical tests and clinical practice development.
- Outpatients and diagnostic imaging services were appropriately represented at executive level by the director of clinical services.
- Clinical governance was part of the Medical Advisory Committee (MAC) agenda. Concerns or issues related to outpatient and diagnostic imaging services were discussed at the meeting.
- There was an infection prevention and control lead nurse who was responsible for coordinating audit, reviewing infection control incidents and providing training to staff.
- A member of staff on duty within each department attended the staff 'Comm cell' every morning. This meeting was an opportunity to share information relating to the hospital and across each department. As well as general hospital business, it included complaints, incidents, concerns and compliments. Each department had the opportunity to report on things relating to their area.

Diagnostic imaging

- The equipment replacement programme was managed by BMI's director of imaging. A yearly equipment spreadsheet including details of equipment issues were sent to the director. Finances and equipment replacement however were distributed across the whole group and not locally risk based. Feedback was poor and the radiology manager was concerned that the equipment in the department was in urgent need of replacement with no vision of how BMI will be addressing the issues. Safety and quality of equipment is compromised and requires immediate attention. This is not being addressed as a priority.
- There were areas of departmental policy review that had not been adequately addressed and some confusion over practices within the department the RSM was unaware of.
- There was no contingency arrangement in place if the gamma camera is taken out of service for either the patients or the technologist whose primary employment is to act as the operator for nuclear medicine procedures.
- The department had a lead radiologist who acted as a representative for radiology at the Radiation Protection Committee meeting and the Medical Advisory Committee.
- There was an established radiation protection committee (RPC) which meet annually to discuss radiation protection for staff and patients. Actions and recommendations from this group were fed into the provider's clinical governance forum.
- The RPC and the MAC ratified procedures, local rules and employer's procedures. The RPC comprises of the executive director, two governance leads, Radiation Protection Advisor, Radiation Service Manager, a representative from theatre, a radiologist.
- The risk register was held at hospital level and radiology fed into this overarching document.
- The RSM and medical physics formed part of the procurement process when equipment had been purchased. There was limited control over equipment choice; it is felt that local needs are not adequately reflected.
- There were numerous meetings that took place including the daily Comm cell, the radiology huddle, a bi-monthly clinical governance meeting and a monthly heads of department meeting. The RSM found these all to be productive meetings where the needs of radiology were heard. It was felt that beyond hospital level that communication was disjointed.

Requires improvement

Outpatients and diagnostic imaging

- There was a register of non-medical referrers including information around training and entitlement. A number of staff were identified as having left or were no longer acting in the capacity of a non-medical referrer. The register required updating to reflect current practice.

Leadership and Culture within the service

- There was a visible local leadership in the outpatients and diagnostic imaging areas. Senior staff in physiotherapy provided clear leadership and motivation to their teams.
- Staff told us the overall ethos was centred on the quality of care patients received. They spoke of an open culture where they could raise concerns or issues in relation to issues such as patient care, which would be acted upon.
- Staff morale was good and we observed staff from all specialties working well together. The team was visibly enthusiastic about the outpatient and diagnostic imaging services. Many of them had worked in the service for many years. Staff enjoyed working at the hospital and felt the company treated them with respect and valued their opinions.
- Staff retention was stable and turnover was low. This enabled continuity of care for patients.

Diagnostic imaging

- The RSM has been in post for a number of years and was well regarded by staff both within the radiology department and by hospital management and other departments in the hospital. There was good working relationship with consultants who practice at the hospital.
- Due to the size of the department the RSM was accessible and available for staff and was seen by staff as approachable.
- Staff felt well supported by the RSM.
- Radiographers were offered role development and the chance to shadow colleagues at other BMI sites to share knowledge and practice.
- Staff were motivated and enjoyed working at the hospital.
- Staff were cohesive and supportive of one another.
- The RSM reported being well supported by management.
- Regionally, radiology mangers meet in an attempt to get to know each other's department and to share information and move towards standardised radiological practices.

Public and staff engagement

- Newsletters were produced for staff and for consultants and distributed by email and as printed copies. Both newsletters contained items on developments at the hospital, staff achievements, and charity events, learning from incidents and training opportunities and requirements.

Innovation, improvement and sustainability

- Although the physical environment of the outpatient minor treatment room was a challenge and restricted the hospital's capability to provide the desired scope of activity, it posed no risk to the patients. A business plan had been developed to address this. This included a review of all the outpatient department available space and the suitability of it use for the required purpose.
- The physiotherapy department was in the process of implementing an exercise plan for oncology department. The aim of this was to improve overall health and wellbeing of patients undergoing cancer treatments.

Diagnostic imaging

- The mammographer discussed the research she had undertaken for breast cancer patients. She was developing a service where the clinician wrapped care around the patient's breast cancer pathway by training in nuclear medicine for sentinel nodes and bone scanning. The department was looking to develop this role and CPD has been directed to ensure the appropriate training is undertaken.
- Magnetic resonance angiography is now offered at the hospital by one radiologist. This was excellent example of local progress.

Outstanding practice and areas for improvement

Outstanding practice

- Seven day pharmacy service including on call service.
- Gold standard equipment for endoscopy.
- Award from the Macmillan Quality Environment Mark (MQEM); a quality framework for assessing whether cancer care environments meet the standards required by people living with cancer.

Areas for improvement

Action the provider MUST take to improve

Hospital wide

- The hospital must improve the process for Duty of candour to ensure people are aware when they have received sub optimal treatment and suffered harm as a result.Then share the outcome of investigation with the person involved along with sharing learning with operational staff.
- The hospital must improve the governance process relating to incident management investigation, shared learning and risk management.
- The provider must ensure that equipment classified as obsolete or for replacement has a programme in place that replaces such equipment in a timely fashion.

Medicine

- The hospital must ensure an appropriate and competent member of staff routinely undertakes medications reconciliation.
- The hospital must identify a process of governance to update and review PGDs.
- The hospital must ensure that governance systems were in place that ensures the safe storage of temperature sensitive medication.

Surgery

- The hospital must ensure that governance systems were in place that ensures the safe storage of temperature sensitive medication.

OPD DI

- The provider must ensure that the progress of incidents can be easily followed.
- The provider must ensure that patients are informed when investigations into their care are taking place.
- The provider must ensure that a surgical safety check list is used for all interventional procedures.

Action the provider SHOULD take to improve

Medicine

- The hospital should all patients are screened for the risk of malnutrition documents completed in a timely manner.
- The hospital should ensure there are clear pathways on the surgical suites for medical patients.
- The hospital should ensure that management of medicines includes storage, self-administration and identification of a critical list of medicines, as recommended by the NPSA is in place. Explanation of missed doses and clear documentation identifying the route of administration should be in place.

Outstanding practice and areas for improvement

Surgery

- The hospital should ensure that all staff are familiar with policies for self-administration of drugs and introduce monitoring to ensure compliance.
- The hospital should ensure that barrier nursing practise should be reviewed and staff reminded of their responsibilities.
- The hospital should ensure that escalation procedures for NEWS outliers should be emphasised to staff and audit sheets should include actions taken to address anomalies.
- The hospital should ensure that theatre staff are reminded of the need to comply with IPC guidance.
- The hospital should ensure that compliance with the surgical safety checklist should be improved with attention to detail and auditing in order to ensure patient safety.

OPD and DI

- The provider must ensure that details of all patient consultations are kept by the provider.
- The provider should improve signage around the hospital.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **Regulation 12: Safe care and treatment** 12.—(1) Care and treatment must be provided in a safe way for service users. (2) Without limiting paragraph (1), the things which a registered person must do to comply with that paragraph include— (a) assessing the risks to the health and safety of service users of receiving the care or treatment; (b) doing all that is reasonably practicable to mitigate any such risks; (e) ensuring that the equipment used by the service provider for providing care or treatment to a service user is safe for such use and is used in a safe way; (g) the proper and safe management of medicines; **How the regulation was not being met:** Medication temperatures needed to be maintained to ensure active ingredients were not compromised. A competent and skilled member of staff is required to reconcile medications. Patient Group Directions needed to be in date reviewed regularly for the safety of administration for staff and patients. The hospital had equipment, which was aged, and due for replacement, some maintenance contracts were not best effort, and some equipment parts were no longer available. Staff were having to work around to maintain patient safety. The provider needs to ensure the equipment is replaced in a timely fashion.

This section is primarily information for the provider

Requirement notices

The '5 steps to safer surgery' checklist should be used in interventional procedures, at present patients were at risk.

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance **Regulation 17: Good governance** 17.—(1) Systems or processes must be established and operated effectively to ensure compliance with the requirements in this Part. (2) Without limiting paragraph (1), such systems or processes must enable the registered person, in particular, to— (a) assess, monitor and improve the quality and safety of the services provided in the carrying on of the regulated activity (including the quality of the experience of service users in receiving those services); (b) assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk which arise from the carrying on of the regulated activity; (c) maintain securely an accurate, complete and contemporaneous record in respect of each service user, including a record of the care and treatment provided to the service user and of decisions taken in relation to the care and treatment provided; (d) maintain securely such other records as are necessary to be kept in relation to— (f) evaluate and improve their practice in respect of the processing of the information referred to in sub-paragraphs (a) to (e). **How the regulation was not being met:**

This section is primarily information for the provider

Requirement notices

The governance process relating to incident management was not robust from raising incidents (OPD) to investigation process and learning from incidents.

The risk management process was not robust, the process of identifying and rating of risks, plus the management of them in terms of mitigation did not give adequate assurance.