BMI The Edgbaston Hospital

Quality Report

22 Somerset Road
Edgbaston
Birmingham
B15 2QQ
Tel: Tel: 0121 456 2000
Website: www.bmihealthcare.co.uk

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

Ratings

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

Summary of findings

Letter from the Chief Inspector of Hospitals

BMI The Edgbaston Hospital is operated by BMI Healthcare Limited. The Edgbaston Hospital is registered for 55 beds, however at the time of submitting pre-inspection data to CQC in February 2019; only 31 of these were actively being used to care for patients. Facilities include four operating theatres, X-ray, outpatient and diagnostic facilities.

The hospital provides surgery (including cosmetic surgery), medical care including endoscopy, outpatients and diagnostic imaging. We inspected surgery (including cosmetic surgery) in July 2019.

We carried out the announced part of the inspection on 17 and 18 July 2019 and inspected the surgery core service. We did not inspect the medical care, outpatients or diagnostic imaging core services on this inspection. As we only inspected one core service on this inspection, we are not able to aggregate ratings at location level.

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

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

Services we rate

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

- The service did not make sure all staff completed their mandatory training. This was a breach of the Health and Social Care Act Regulation 18: Staffing.
- Not all staff had the right training on how to recognise and report abuse.
- We found staff compliance to training in care and communication of the deteriorating patient was low.
- Not all records had documented action plans to manage specific patient risks.
- Some intravenous fluids were not stored as per best practice guidelines from the Royal Pharmaceutical Society and the National Institute for Health and Care Excellence (NICE).
- The service did not always follow best practice guidance when administering anaesthesia.
- The service had limited outcome data about the effectiveness of surgical procedures.
- The service was not fully compliant with the Accessible Information Standard.
- The service did not always close complaints within the provider set timeframes.
- Not all leaders at all levels had the skills and abilities to run the service. They did not always understand or manage priorities and issues the service faced.
- Leaders did not always use or follow available governance processes effectively although these were in place. We raised concerns that had been undetected or unmonitored through provider and location wide processes.
- Leaders and teams did not always identify and escalate relevant risks and issues.
- Some individual audits were not well documented.
- Where potential risks to the service were identified; leaders did not take action to review and monitor it.
- Information about the service was not always collected or used to drive improvement.

Summary of findings

However, we also found:

- The service had access to enough staff to care for patients and keep them safe. The service controlled infection risk well. Staff assessed risks to patients and mostly acted on them. The service managed safety incidents well and learned lessons from them. Staff collected some safety information and used it to improve the service.
- Staff gave patients enough to eat and drink and gave them pain relief when they needed it. Managers made sure staff were competent. Staff worked well together for the benefit of patients, advised them on how to lead healthier lives, supported them to make decisions about their care, and had access to information. Key services were available seven days a week.
- Staff treated patients with compassion and kindness, respected their privacy and dignity, took account of their individual needs, and helped them understand their conditions. They provided emotional support to patients, families and carers.
- The service planned care to meet the needs of local people, took account of patients' individual needs, and made it easy for people to give feedback. People could access the service when they needed it and did not have to wait too long for treatment.
- Local leaders supported staff to develop their skills. Staff understood the service's vision and values, and how to apply them in their work. Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. Staff were clear about their roles and accountabilities. The service engaged well with patients and the community to plan and manage services.

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

Heidi Smoult

Deputy Chief Inspector of Hospitals (Midlands)

Overall summary

BMI The Edgbaston Hospital is operated by BMI Healthcare Limited. It is a private hospital in Birmingham, West Midlands. The hospital primarily serves the communities of Birmingham and the surrounding areas. It also accepts patient referrals from outside this area.

The hospital was opened in 1965 however ownership changed to BMI Healthcare in 2008; and was named BMI The Edgbaston Hospital. BMI Edgbaston shares a joint senior management team and cross-site shared management responsibilities for heads of department with BMI The Priory Hospital and has done since 2018. One registered manager oversees both locations. Although these two locations are registered separately with CQC; they work collaboratively together and are known to BMI Healthcare as 'BMI Birmingham'.

The service provides surgery (including cosmetic surgery), diagnostic imaging and medical care to adults over 18 years. The service also provides endoscopy and outpatient services to both adults and children and young people. During our inspection we looked at the core service of surgery (including cosmetic surgery) only.

The service is registered for:

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

BMI Edgbaston has been inspected by CQC on three separate occasions. The last inspection report was published in February 2017. During the previous inspection, the hospital was rated as 'requires

Summary of findings

improvement' overall. The surgery core service was also rated as 'requires improvement' overall. This core service achieved 'requires improvement' within the domains of safe and well led and good in effective, caring and responsive. During this inspection we found activity within the surgery core service breached three Health and Social Care Act regulations. Theses were Regulation 12: Safe Care and Treatment of the Health and Social Care Act (Regulated Activity) Regulations 2014, Regulation 18 HSCA 2008 (Regulated Activities) Regulations 2014, Staffing and Regulation 17 HSCA 2008 (Regulated Activities) Regulations 2014. Good Governance.

Further details are listed at the end of this report.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Surgery	**Requires improvement** 	Surgery was the main service and had the highest proportion of hospital activity. We rated this service as requires improvement as it was inadequate for well led and required improvement in safe and effective. However, we found it was good in caring and responsive.

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Service we looked at:
Surgery

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Background to BMI The Edgbaston Hospital

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Our inspection team

The team that inspected the service comprised a CQC lead inspector, and two specialist advisors with expertise in surgery. The inspection team was overseen by Zoe Robinson, Inspection Manager.

Information about BMI The Edgbaston Hospital

The BMI Edgbaston Hospital is registered for 55 beds, however at the time of submitting pre-inspection data to CQC in February 2019; only 31 of these were actively being used to care for patients. The reason for this was BMI Edgbaston has two wards; however, one was decommissioned at the time of submitting this information. In addition to the 31 patient beds available for use; a two-bed observation unit was situated on the ward to use as required. This made 33 available beds in total.

The hospital ran its operating theatres from 8am to 8pm Monday to Friday; and 8am to 5pm on Saturdays. Operations were not scheduled on Sundays although nursing and medical staff were on site 24 hours a day to care for inpatients.

Summary of this inspection

During the inspection, we visited the ward, operating theatres, and pre-assessment area. We spoke with 29 staff including registered nurses, health care assistants, reception staff, medical staff, operating department practitioners, and senior managers. We spoke with four patients and one relative. During our inspection, we reviewed nine sets of patient records.

Activity (January to December 2018)

- In the reporting period January to December 2018, there were 1,139 inpatient and 3,481 day case episodes of care recorded at the hospital. Young people aged 16 years and above were admitted for surgical procedures following a formal risk assessment completed as part of the pre-assessment appointment. They reported three 16 to 17 year olds were recorded as inpatients, and six were reported as day case patients in the reporting period. Updated figures showed that from January to June 2019; the service operated on five 16 to 17 year olds. Three of these were endoscopy patients and two were surgical patients in line with the surgery core service inspected on this occasion.
- Forty two percent of inpatients were funded by the NHS. Just under 73% of day case patients were funded by the NHS (2,535 out of 3,841).
- As of December 2018, 524 consultants were registered to work under practising privileges at the hospital. Of this number, 299 had not conducted any work at the hospital in the preceding 12 months. One hundred and ten medical staff had undertaken between one and nine episodes of care in the preceding 12 months. Ninety-one doctors had undertaken between 10 and 99 episodes of care, and 24 had undertaken over 100 episodes of care.
- A resident medical officer was on site 24 hours a day, every day of the year.
- The accountable officer for controlled drugs (CDs) was the registered manager.

Track record on safety:

- Zero never events.
- The hospital reported 142 clinical incidents from January to September 2018 as relating to surgical services.
- One serious injury was reported within the time period of April to June 2018.
- No incidences of hospital acquired Methicillin-resistant Staphylococcus aureus (MRSA) from January to September 2018.
- No incidences of hospital acquired Methicillin-sensitive staphylococcus aureus (MSSA) from January to September 2018.
- No incidences of hospital acquired Clostridium difficile (c.diff) from January to September 2018.
- No incidences of hospital acquired E-Coli from January to September 2018.
- The service reported 38 complaints were submitted from January to December 2018.
- Two hospital acquired venous thromboembolism.

Services provided at the hospital under service level agreement:

- Patient Reported Outcome Measures (PROMS)
- Microbiology advice for orthopaedics.
- Resident medical officers.
- Medical records storage.
- Grounds maintenance.
- Medical devices management.
- MRI mobile unit.
- Waste (commercial; mixed recycling: hazardous).
- Clinical waste.
- Agency staffing.
- Medical gases.
- Patient satisfaction surveys and analysis.
- Radiation protection.

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

Requires improvement

The overall hospital rating for safe remained as requires improvement.

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

- The service did not make sure all staff completed their mandatory training.
- Not all staff had the right training on how to recognise and report abuse.
- Not all records had documented action plans to manage specific patient risks.
- Some intravenous fluids were not stored as per best practice guidelines from the Royal Pharmaceutical Society and the National Institute for Health and Care Excellence (NICE).
- The service did not always follow best practice guidance when administering anaesthesia.

We found the following areas of good practice:

- The service had access to enough staff to care for patients and keep them safe. The service controlled infection risk well. Staff mostly assessed risks to patients, acted on them and kept good medical records. The service managed safety incidents well and learned lessons from them. Staff collected some safety information and used it to improve the service.

Are services effective?

Good

The overall hospital rating for effective remained as good.

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

- The service had limited outcome data about the effectiveness of surgical procedures.
- The service had low appraisal rates during the reporting period.

We found the following areas of good practice:

- Staff gave patients enough to eat and drink and gave them pain relief when they needed it. Managers made sure staff were competent. Staff worked well together for the benefit of

Summary of this inspection

patients, advised them on how to lead healthier lives, supported them to make decisions about their care, and had access to good information. Key services were available seven days a week.

Are services caring?

Good

The overall hospital rating for caring remained as good.

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

- Staff treated patients with compassion and kindness, respected their privacy and dignity, took account of their individual needs, and helped them understand their conditions. They provided emotional support to patients, families and carers.

Are services responsive?

Good

The overall hospital rating for responsive remained as good.

Our rating of responsive for surgery stayed the same. We rated it as **Good** because:

- The service planned care to meet the needs of local people, took account of patients' individual needs, and made it easy for people to give feedback. People could access the service when they needed it and did not have to wait too long for treatment.

However, we also found the following issues that the service provider needs to improve:

- The service was not fully compliant with the Accessible Information Standard.
- The service did not always close complaints within the provider set timeframes.

Are services well-led?

Requires improvement

The overall hospital rating for well-led remained as requires improvement.

Our rating of well-led for surgery went down. We rated it as **Inadequate** because:

- Not all leaders at all levels had the skills and abilities to run the service. They did not always understand or manage priorities and issues the service faced.
- Leaders did not always use or follow available governance processes effectively although these were in place. We raised concerns that had been undetected or unmonitored through provider and location wide processes.

Summary of this inspection

- Leaders and teams did not always identify and escalate relevant risks and issues.
- Some individual audits were not well documented.
- Where potential risks to the service were identified; leaders did not act to review and monitor these.
- Information about the service was not always collected or used to drive improvement.

However, we also found the following areas of good practice:

- Local leaders supported staff to develop their skills. Staff understood the service's vision and values, and how to apply them in their work. Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. Staff were clear about their roles and accountabilities. The service engaged well with patients and the community to plan and manage services.

Detailed findings from this inspection

Overview of ratings

Our ratings for this location are:

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

Notes

As we inspected one core service during this inspection we did not aggregate the overall hospital ratings. The overall ratings for the hospital remain from the previous inspection report published on 15 February 2017.

Requires improvement

Surgery

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

Information about the service

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Requires improvement

Surgery

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- Agency staffing.
- Medical gases.
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Summary of findings

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Requires improvement

Surgery

Are surgery services safe?

Requires improvement

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

Mandatory training

The service did not make sure all staff completed their mandatory training.

- Staff did not all receive or keep up-to-date with their mandatory training for certain modules. According to the mandatory training policy, provider targets for compliance to completion of training were as follows: The hospital key performance indicators to demonstrate compliance to training was defined as: "100% compliance with all mandatory training at any given time. This figure excludes individuals who are new to BMI / post. Or 90% compliance with all mandatory training at any given time if including individuals who are new to BMI / post."
- Data from the service dated June 2019 showed ward staff and theatre-based staff compliance to mandatory training topics. We saw this varied from 31% to 100%.
- Data provided in June 2019 showed ward-based staff were not meeting the provider targets for all training modules (either 100% or 90% dependant on the number of 'new in post' staff). Out of 24 training modules, 17 did not meet the service compliance rates.
- Modules where compliance were particularly low included fire safety (67%), care and communication of the deteriorating patient (31%), basic life support (50%), intermediate life support (67%) and information governance (66.7%).
- Theatre based staff were also under the provider target on significant modules. For example, compliance against care and communication of the deteriorating patient was 36.8%, basic life support was 62.5% and intermediate life support was 65.4%.
- Managers monitored mandatory training and alerted staff when they needed to update their training; however, this had not been effective to ensure all staff were compliant as per the data above. Individual staff members were knowledgeable about their compliance with mandatory training which meant they were aware of what was outstanding and when they should complete it. Mandatory training was a mix of e-learning and face to face training.
- Staff told us about a recent sepsis study day they had attended therefore enabling them to identify when and how to escalate if they discovered a patient was developing this.
- Staff working within the recovery area all had intermediate life support training (ILS) and two staff were working towards advanced life support training (ALS). The resident medical officers were all trained in ALS and relevant staff working with children were trained in paediatric life support.

Safeguarding

Not all staff had the right training on how to recognise and report abuse. Despite this, staff understood how to protect patients from abuse and the service worked well with other agencies to do so.

- Staff did not all receive training specific for their role on how to recognise and report abuse. We requested information for safeguarding children training compliance as of June 2019. Data from the service showed that of all theatre staff; 21 had completing safeguarding children level one, 12 had completed safeguarding children level two, and 17 staff had completed safeguarding children level three. The June 2019 training data was also available for ward staff. This showed that 18 ward-based staff had undertaken safeguarding children level one, 12 had undertaken safeguarding children level two and nine had undertaken safeguarding children level three. Again, we requested the specific number of staff who worked on the ward and were told this totalled 11 as of August 2019. This was less staff than previously reported working on the ward. Information sent post inspection reported that this discrepancy in staff numbers may be due to some staff being enrolled as working at BMI The Priory, rather than at BMI Edgbaston Hospital.
- The intercollegiate document; Safeguarding Children and Young People: Roles and Competencies for Healthcare Staff (2019) specifies that all non-clinical and clinical staff who have contact with children, young people, parents/ carers or those who may pose a risk to

children should have training in at least level two children's safeguarding. Data from the service in the above paragraph told us that all clinical and non-clinical staff who worked in pre-assessment, theatres and the ward area could potentially have contact with these groups. Therefore, all these staff should be trained to at least level two. The evidence above suggests this is not the case as not all staff are trained above level one.

- Data from the service showed 13 staff in total worked in the pre-assessment area; and 92% of them were trained in safeguarding children level two.
- The service also provided compliance data as below as of June 2019. However, please note this data relates to only those staff whom the service deemed eligible for training; not the total number of staff working within a set area.
- Safeguarding modules where compliance met or exceeded the provider target for ward staff:
- Safeguarding children level two (91.77%).Safeguarding adults level two (91.7%).
- Safeguarding modules where compliance for ward-based staff did not meet the provider target included:
- Safeguarding children level one (77.8%).
- Safeguarding adults level one (83.9%).
- Female genital mutilation (87.5%).
- Chaperoning (80%).
- Safeguarding modules where compliance met or exceeded the provider training for theatre staff:
- Safeguarding children level one (100%).
- Safeguarding adults level one (100%).
- Safeguarding children level two (91.7%).
- Safeguarding adults level two (91.7%).
- Chaperoning (100%).
- Safeguarding modules where compliance for theatre-based staff did not meet the provider target included:
- Female genital mutilation (73.7%).
- We received data specific to PREVENT: protecting people at risk of radicalisation training and safeguarding level three training compliance as of February 2019. At this time, PREVENT was 92% compliant for the hospital. Safeguarding children level three showed as 100% compliant at this time.
- We also requested additional data regarding safeguarding adults training figures as of June 2019. This confirmed that 21 theatre staff were trained to level one in safeguarding adults and 12 were trained to level two. For ward-based staff, 18 were trained in level on safeguarding adults, and 12 to level two. This data does not demonstrate whether the hospital has met either the provider target or the Intercollegiate Adult Safeguarding Guidance (2018) which states that all staff working in healthcare settings should be trained to level one, and all practitioners who have regular contact with patients, their families or carers, or the public should be trained to level two.
- We also requested the level of training undertaken by the service safeguarding leads to identify if this was in line with the intercollegiate document; Safeguarding Children and Young People: Roles and Competencies for Healthcare Staff (2019) and/ or Intercollegiate Adult Safeguarding Guidance (2018) which recommends named leads should be trained to level four. Data from the service confirmed of the two local safeguarding leads; one was trained to safeguarding children at level two and safeguarding adults at level three. The other local lead was trained to safeguarding children at level one and safeguarding adults level three. However, staff had access to a level four trained member of staff who worked at provider level which met the guidance requirements.
- A statement provided by the agency which supplied the resident medical officers clarified that RMOs were trained by them to child protection level three, and Safeguarding children level two which met the components required by the intercollegiate document; Safeguarding Children and Young People: Roles and Competencies for Healthcare Staff (2019).
- Data from the service confirmed that young people between 16 and 17 years of age could be admitted for surgical procedures following completion of a pre-assessment risk assessment. The director of clinical services checked all potential surgical admissions for

patients under 18 to ensure appropriateness as part of their lead safeguarding role. Staff and patients had access to paediatric nurses based at BMI The Priory Hospital.

- From January to June 2019; two 16 to 17 year old patients had been operated on at the service. We saw a risk assessment conducted for each patient. This ensured only those young people who were able to be cared for in an adult environment were progressed for surgery. Young people who met certain criteria were automatically screened out; such as if the young person was in receipt of a care package or was under a certain height or weight. These patients were referred back to their GP.
- Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. Staff we spoke with were familiar with their safeguarding requirements. Staff we spoke with had a good understanding of safeguarding concerns and how to escalate these. Staff told us of specific examples of where action had been taken to protect vulnerable individuals.
- Staff knew how to make a safeguarding referral and who to inform if they had concerns. Staff had access to a visual flow chart to follow if they were unsure of how to report a safeguarding concern; for example, a new or temporary member of staff.
- Staff followed safe procedures for vulnerable patients or visitors. Staff had access to policies about safeguarding adults and children. Each patient had an allocated private room for their inpatient stay.

Cleanliness, infection control and hygiene

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

- Ward areas were clean and had suitable furnishings which were clean and well-maintained. We checked a sample of patient bedrooms during our stay and found all were visibly clean.
- Shower curtains were in place in en-suite bathrooms. Data from the service reported that these were wiped down daily and replaced when necessary; although no set timescales for replacement were provided.
- All flooring within clinical areas such as wards, theatres and consultation room was easy to clean and in line with good practice relating to infection prevention and control. This was an improvement from our previous inspection.
- During our inspection we saw plentiful supplies of hand sanitiser. Each patient bedroom had a touch free sink so staff could wash their hands. We observed staff to wash their hands before and after patient contact.
- The service score for cleanliness was better than the England average. The 'patient led assessment of the care environment' (PLACE) audit for BMI Edgbaston Hospital from 2018 showed a score of 100% compliance for both cleanliness of the environment and the condition, appearance and maintenance of the environment.
- Staff followed Staff provided patients with information and guidance about infection prevention and control; and how patients could support this. Staff had access to a hand hygiene policy.
- We saw various posters and boards containing information about infection prevention and control for patients, staff and visitors. For example, posters advertising 'bare below the elbow' and 'clean as a whistle' promoted best practice for staff.
- Cleaning records were up-to-date and demonstrated We saw cleaning records displayed to confirm that cleanliness checks had taken place; and 'I am clean' seals were used around areas such as the toilet to confirm when this had been last cleaned. If the seal was broken staff would re-clean the area.
- The hospital had an in-house decontamination service with trained staff. Approximately 50% of surgical instruments could be decontaminated on site making a quicker turn around. The remaining re-usable instruments and equipment were sent to a third-party provider for decontamination. We saw that autoclaves and washers were scheduled to be checked on a daily basis; with other checks such as water testing, to be done weekly, monthly or annually as required.

Requires improvement

Surgery

- Data from the service provided before our inspection showed that a hospital wide infection prevention control audit had been undertaken in January 2019 which monitored areas such as hand hygiene, suitability of the environment and facilities, and cleanliness of clinical equipment. We saw that this audit scored 90% however we did not identify if there was a specific target for compliance. Where areas were not achieved or evidenced; such as infection prevention and control local leads not being resourced; actions were set to mitigate this. However, we noted within the audit documentation these actions were not always structured; nor was it clear who would lead on and monitor such actions. The service sent us minutes from an infection prevention and control committee meeting held after the inspection period, in August 2019. This showed actions were allocated to specific individuals.
- Staff worked effectively to prevent, identify and treat surgical site infections. From January to June 2019; the service reported four surgical site infections (SSIs) from a total of 2239 cases. This equated to 0.17%. National figures are collected but only for NHS locations; therefore, we have not compared this figure to national SSI rates. Despite this, this figure is considered a low rate of SSI. Data from the service confirmed none of these met the criteria for a serious incident and all were managed locally.
- Staff provided patients with information on managing surgical sites to reduce the risk of infection.
- The pre-assessment service completed audits to check that staff complied with the Methicillin-resistant Staphylococcus aureus (MRSA) protocol for appropriate pre-surgery testing. Managers checked ten patient records per month to check the risk assessment, and whether the guidance had been followed. We saw results for January 2019 which reported 100% compliance.

Environment and equipment

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

- Patients could reach call bells and staff responded quickly when called. Patient call bells were readily close to patients. However, in-patients told us they had not always needed to call for staff, as staff came around so regularly to check on them.
- The design of the environment followed national guidance. The hospital building was built in 1965. Therefore, this had been identified as a concern by the service; and had received updates and replacements. This included work to replace the hospital roof, and removal of carpeted areas to fit flooring that met infection prevention and control standards.
- We were told of forthcoming environment improvements including upgraded car park lighting to improve patient and staff safety.
- Data from the service reported that two theatres had doors replaced to meet required standards.
- The hospital had four operating theatres in use at the time of inspection; all with attached anaesthetic rooms. Three had laminar flow systems; and one was dedicated for the use of minor operations and endoscopy procedures. Laminar flow systems regulate the air in operating theatres by generating a continuous flow of bacteria free air. This ensures that infection prevention and control is maintained to a high standard.
- The service had a five bedded recovery area which was equipped as per Association of Anaesthetists of Great Britain and Ireland (AAGBI) guidelines.
- The service score for the environment was better than the England average. The 'patient led assessment of the care environment' (PLACE) audit for BMI Edgbaston Hospital from 2018 showed a score of 100% compliance for the condition, appearance and maintenance of the environment.
- Each patient had an allocated private room for their inpatient stay. These were en-suite. We saw each occupied patient room had a sign on the door with the patients' name; consultants name, latest vital signs score and when the next set of vital signs were due to be monitored. We saw patients could choose to not have their name displayed on the door to maintain privacy.
- Staff carried out regular safety checks of specialist equipment. We found that some equipment was older than recommended by manufacturers; this was

primarily the anaesthetic machines. Whilst they were serviced and safe to be used they were over 10 years old. This had previously been discussed with the site management team who showed us documentation and order forms for new machines which had not yet been delivered at the time of our inspection. This was on the service risk register and we saw that improvements had been made to mitigate the risk. For example, in February 2019 the service had no spare anaesthetic machine. However, by the time of our inspection we saw that a spare anaesthetic machine was available should a break down occur. We also saw there was no formal log book for checking the anaesthetic machines as per the AAGBI guidelines; however, the service was using a BMI provider produced checklist which we saw was updated daily.

- We saw that facilities for piped medical gases were available in patient rooms. Equipment to support this was stored next to the patient beds. We saw that these were due to be checked weekly. We checked three bedrooms and found in each room; this specific equipment had not been checked consistently. For example; our inspection commenced on the 17 July, and the last check was conducted on the 7 July. In April, only one week had a recorded check. Despite this, all equipment was in date and sealed appropriately. The checks that had been conducted clearly annotated this.
- The service had enough suitable equipment to help them to safely care for patients. However, an assisted bathroom was not in use at the time of the inspection. We saw an 'assisted bathroom' which was a separate larger bathroom for patients who may need this was being renovated at the time of inspection; with piping and a sink on the floor. This room was also being used to store out of service equipment. However, we noted this room was not secured or locked, or marked as out of order, which meant patients or visitors could enter which may pose a health and safety hazard. Following our inspection, the service confirmed a lock was now in place to ensure this room was secured to prevent unauthorised access.
- During the inspection, we sampled a range of equipment such as commodes, blood pressure machines and consumables to check for cleanliness and servicing (where required). All equipment we checked was clean and up to date with servicing requirements. In addition, all equipment was appropriately stored. We saw electrical items such as televisions were in date with safety testing.
- A patient kitchen was located on the ward where housekeeping staff prepared meals and drinks. This area was visibly clean and equipment which may pose a hazard, such as knives, were put away. The fridge used to store food displayed the temperature, so this could be monitored daily. Food allergen information was clearly displayed.
- We saw a first aid box in the kitchen which was due to be checked monthly; all checks for the year of 2019 so far were completed except for June.
- During the inspection we checked the resuscitation trolley on the ward. The emergency oxygen cylinder was full, in date and well secured. Appropriate daily and weekly checks were recorded, and we saw a sample of equipment was in date. The defibrillator battery had been checked the morning of our inspection and was found to be in working order.
- We saw a separate oxygen cylinder next to the resuscitation trolley. Whilst this was securely attached to an appropriate trolley; this was not secured to the wall so could potentially be wheeled away by an unauthorised person.
- Staff disposed of clinical waste safely. Staff had access to clinical waste and sharps storage bins which were appropriately labelled and stored. We saw these were used appropriately during our inspection. A third-party provider collected and disposed of clinical waste.

Assessing and responding to patient risk

Staff learnt from incidents when they had not escalated deteriorating patients and showed improvements in this. Staff completed and updated risk assessments for each patient and removed or minimised risks; although they did not always document action plans.

- Staff used a nationally recognised tool to identify deteriorating patients and escalated them appropriately. The service monitored deteriorating patients using the National Early Warning Score (NEWS2) which requires staff to check patients' vital

signs at specified intervals. During our inspection we reviewed how staff recorded patient observations within six patient records (we checked nine records overall; however, we checked observations specifically within six patient records). We found all six records showed that observations were recorded and completed at correct intervals. NEWS scores were calculated correctly, and any deterioration was escalated appropriately.

- From January to June 2019; the service had transferred one patient as an emergency to an NHS trust (March 2019). We reviewed the investigation report for this incident and saw that appropriate pathways had been followed including commencing the 'sepsis six' pathway; and calling an ambulance for the patient. However, the investigation report highlighted that a set of observations taken should have been escalated to the resident medical officer due to the raised scores indicating a deterioration in health. This was not escalated until the next set of observations were taken ten minutes later. The investigation report found this delay did not negatively impact upon the patient's subsequent care, treatment and recovery although an action was completed to remind staff to appropriately document and escalate NEWS where indicated.In addition, it was found that staff had not always recorded the patients' temperature which meant an accurate NEWS score could not be calculated. This was also included in the action plan as an area of improvement for all staff. As outlined in the paragraph above, during the inspection we found NEWS monitoring had improved and staff followed correct escalation procedures.
- All staff we spoke with including health care assistants and nurses were aware of how to escalate concerns regarding a patient's health. However, staff compliance to mandatory training of care and communication of the deteriorating patient, and basic and intermediate life support, did not meet the service target which meant not all staff were trained to respond to deteriorating patients or a medical emergency.
- As of December 2018; data from the service confirmed that the resident medical officer (RMO) who remained on site 24 hours per day, seven days a week was trained in advanced life support (ALS) and advanced paediatric life support (APLS). Nine additional staff were trained in either paediatric basic life support or paediatric intermediate life support (PILS).
- This was in line with the provider policy entitled 'adult resuscitation' which stated: "The Care Quality Commission requires a minimum of one ALS provider (current certification) on duty at any one time. In all BMI managed units, the Resident Medical Officer (RMO) will hold this qualification. There should be an ALS Provider (current certificate) working within the theatre/recovery area whilst theatres are running." This also met the Association of Anaesthetists of Great Britain and Ireland (AAGBI) guidelines for patients in recovery which state that an ALS trained member of staff should be available to attend immediately in the event of deterioration.
- The hospital used an on-call emergency theatre team should any patient require an urgent return to theatre.
- The service held a service level agreement with NHS Trusts located in Birmingham for support or emergency transfer.
- Staff told us they had recently undertaken a sepsis study day and could clearly outline the steps they would take if a patient's vital signs indicated they were at risk of sepsis. Staff provided an example of a patient who had suspected sepsis and was transferred out to a local NHS acute trust for urgent treatment.
- Staff told us they located patients closer to each other where risks of deterioration were identified so that they could monitor these patients more effectively. For example, staff told us that on particular days, some patients were at risk of fainting following their surgery due to the medicines given to them. These patients were in neighbouring bedrooms. Staff told us that if a patient did faint; the emergency call was put out and all required staff arrived quickly.
- Staff within the service took part in unannounced emergency scenarios approximately every six weeks; such as major haemorrhage or a collapsed patient. Managers planned these to occur in any part of the hospital, so all staff were familiar with potential emergencies and could practice their responses.We saw evidence to confirm this. The last scenario which was conducted two days prior to our inspection highlighted areas of improvement for the RMO. We saw that this was

referred to the RMO agency for extra training to be provided. This highlighted a positive approach to ensuring all staff were aware of their roles in a real emergency scenario.

- Where surgical patients chose to decline a potential blood transfusion due to cultural or religious preferences; the patient could 'donate' their own blood to be kept in the event of an emergency for personal use.
- Staff provided patients with clear information prior to discharge and supplied a pack of information. This contained phone numbers to call in the event of any concerns or complications and general advice about what to expect post-surgery. Additional information in how to prevent surgical site infections and VTE was provided to patients.
- Staff completed risk assessments for each patient on pre-assessment and updated them when necessary and used recognised tools. Prior to being accepted for surgery patients were risk assessed to ensure they were suitable to be operated on at BMI Edgbaston Hospital. This was due to the hospital not having the additional facilities to care for high risk patients, such as an intensive care unit. Patients who were screened out for surgery included patients with a body mass index (BMI) over 40, patients who scored over 'two' on the American Society of Anaesthesiologists (ASA) physical status classification system. The scale moves from one to six, with one being the lowest risk patient and six being the highest.
- All medical records we checked showed appropriate venous thromboembolism (VTE) assessments were undertaken; and where required 24 hour repeat assessments completed. We saw prophylaxis (preventative treatment) was prescribed; which included medicines and mechanical treatments; such as support stockings and intermittent pneumatic compression (leg pumps).
- Staff completed risk assessments for a range of potential clinical compilations or concerns. These included falls risk assessments, the Malnutrition Universal Screening Tool (MUST), and the Waterlow assessment for pressure ulcers. However, we found that of nine records checked; whilst all had completed risk assessments in place; not all had recorded plans to manage any identified risk. Therefore, other staff reviewing the patient would not immediately be able to understand the specific care plan for that patient as it was not documented.
- Where plans were recorded in the notes; these were comprehensive and reflected the level of risk identified. Although not all action plans were formally recorded within patient records, when we spoke with staff they were clearly aware of specific patient risks and were able to articulate actions taken to mitigate any identified risk. For example, a staff member described how a falls risk had been identified upon a patient admission; and explained the measures put in place including equipment and physiotherapist support.
- As part of the pre-assessment process, patients were seen either face to face or had a telephone appointment dependant on the procedure to be undertaken. Where appointments were face to face, tests were completed such as blood and urine tests. If required, additional appointments were made for example if a patient having a telephone appointment required a blood test. Through this any potential complications such as infections could be identified and treated prior to surgery. Therefore, minimising the risk of harm to patients. Patients we spoke with told us about unknown infections that the pre-operative assessment identified; and felt the treatment they received supported safe surgery.
- During our previous inspection in 2016, we found that the surgical service was not consistently adhering to the World Health Organisation (WHO) surgical safety requirements. This is a series of checks in theatre which much be done before, during and post-surgery to ensure patient safety is maximised. This was found to be a breach of the Health and Social Care Act at our last inspection. During this inspection we directly observed this process with five separate patients; and checked patient records to ensure this was documented appropriately. We found that that the safety checklist was being carried out to a good standard. A variety of staff were involved in the checks, and these were signed off by the surgeon undertaking the procedure. In addition, patients were given an information leaflet

pre-surgery which outlined the surgical safety checks which would be done; and clearly explained that if the patient felt these had not been adhered to; they could and should speak out to the surgical team.

- Data provided before our inspection showed the results of an audit of the WHO safer surgery checklist in December 2018. We saw that this was entitled an 'observational audit' implying the auditor had actively viewed the process. However, the audit also reported that 10 records were sampled indicating this was a documentation audit. Therefore, we were not sure of this audit process. Despite this; we noted high compliance against standards throughout all 10 checklists. This supported what we found on inspection. In addition, post inspection, the service reported that both observational audits and documentation audits were conducted at the hospital.
- We observed staff on the ward and within pre-operative assessment areas completed identification checks before discussing patient care. For example, they asked patients for their name, date of birth, address details and the nature of the procedure they were having.
- We observed staff regularly re-check patient allergies before providing medicines and as part of pre-operative checks.

Nursing and support staffing

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

- The service had access to enough staff of relevant grades to keep patients safe. Prior to our inspection, the service submitted data showing staffing levels as of December 2018. This showed that some areas were understaffed at this time which meant agency staff were used. For example, registered nurses working within inpatient areas (wards) were planned to have the whole time equivalent (WTE) of 16.4 established posts. As of December 2018; 11.4 WTE posts were filled which meant a vacancy rate of just over 30%.
- We saw nursing staff within theatre had 17.3 WTE posts filled as opposed to 19.3 WTE planned for which meant a vacancy rate of 10%.
- Operating department practitioner staffing (ODP) and health care assistants within theatres was also had vacancies; 6.9 WTE were in post as opposed to 7.9 WTE required to cover the workload. This worked out to a 13% vacancy rate; however, did represent one post.
- We saw that the health care assistant grade for ward areas was fully staffed as of December 2018 (seven staff worked the WTE of 4.7 posts).
- 'Other staff' (for example administration staff) across the hospital were staffed at a rate of 51.3 WTE in post compared with 55.7 available posts. This equated to a vacancy rate of 8%.
- From January to December 2018; we saw that bank and agency use ranged from 8.8% of the total ward based registered nurse use (January) to 20.9% (67 shifts; 64 agency filled and three bank filled) in October 2018. For theatre-based nursing staff; agency use ranged from 7.4% in January 2018 to 13.9% in April 2018. Data from the service reported that no shift went unfilled from October to December 2018.
- We saw no bank or agency health care assistants or operating department practitioners were used in theatre from January to December 2018; and minimal numbers of bank or agency health care assistants were used on the ward for this time period.
- We requested data from June 2019 which showed that ward based nursing staff, including bank staff made up 5.8 whole time equivalent roles; and agency staff usage made up 1.9 WTE posts. In theatres, 14.3 WTE staff covered shifts; with 2.4 WTE agency staff being used for the month. Therefore, the service was using bank and, more so, agency staff to keep patients safe.
- Data from the service told us that clinical staff recruitment had been difficult; however, actions taken to mitigate this included ongoing recruitment activity and using staff to work cross sites and both BMI The Edgbaston Hospital and BMI The Priory Hospital.
- We saw that from January to December 2018, turnover within theatres ranged between 0% for theatre based registered nurses, and 2.3% for ODP and healthcare assistants within theatres.

- Staff sickness was higher in theatres than on the ward from January to December 2018. In particular the last four months of the year saw an increase. For theatre-based nursing staff; an average of 4.7% was observed from September to December 2018. For ODPs and healthcare assistants based in theatres; a sickness rate of just over 3% was observed for the same four months. Ward based staff sickness rate of 0.4% was noted on average.
- Managers accurately calculated and reviewed the number and grade of nurses and healthcare assistants needed for each shift in accordance with national guidance. The service used a national tool 'care hours per patient day' (CHPPD) to calculate what staff they would need based on planned procedures and estimated in-patient length of stay. Staffing was formally reviewed at twice weekly capacity meetings held across both BMI Edgbaston Hospital and BMI The Priory Hospital to ensure a consistent level of safe staffing. Staffing was also reviewed locally daily at the 'comms cell' meeting (face-to -ace meeting) at which a representative of each department in the hospital attended.
- The number of staff on shift in all surgical areas matched the planned numbers. During our inspection all areas we checked were adequately staffed to keep patients safe. We saw agency staff were working in theatres and on the ward. These staff were regular agency staff who were familiar with patients and how the hospital worked.
- Theatres were staffed to the Association of Anaesthetists of Great Britain and Ireland (AAGBI) guidelines. The recovery area was also safely staffed with three nurses, a health care assistant and a porter who transferred patients from and to the ward.
- Staffing was planned by checking forthcoming operations and ensuring ward and theatre areas were staffed to manage this demand. Staff from both BMI The Priory Hospital and BMI Edgbaston Hospital were flexible to work across site to ensure safe staffing numbers.
- Shift changes and handovers included all necessary key information to keep patients safe. During our inspection we observed a ward nurse handover. Staff discussed inpatients' conditions, vital signs and allergies, and allocated work.
- Managers made sure all bank and agency staff had a full induction and understood the service. Agency staff were required to complete an induction checklist when first working at the service which covered local health and safety procedures. The managers recruited from one nursing agency and aimed to use the same staff to support consistency of care. Managers told us that where concerns had been raised about agency staff; these were escalated to the agency and those staff were not used again.

Medical staffing

The service had enough medical staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Consultants worked on a 'practising privileges' basis therefore were not directly employed by BMI Healthcare.

- The service only booked in patients for consultations and procedures where consultants were available to undertake the work. Therefore, there was always enough medical staff to support planned surgeries. As of December 2018, 524 consultants were registered to work under practising privileges at the hospital. Of this number, 299 had not conducted any work at the hospital in the preceding 12 months. One hundred and ten medical staff had undertaken between one and nine episodes of care in the preceding 12 months. Ninety-one doctors had undertaken between 10 and 99 episodes of care, and 24 had undertaken over 100 episodes of care.
- When consultants had a patient at the hospital; they were required to be contactable either on site or via phone. If a consultant was not going to be available; it was expected they would source cover from an alternative consultant who had practising privileges at the hospital.
- The hospital used resident medical officers (RMO) who stayed at the hospital on a 24-hour, seven day per week basis. RMOs 'lived in' at the hospital and worked on a

two-week rotation (one week off, one week on; or two weeks on, two weeks off). RMOs were supplied by a third-party agency who specialised in the provision of this type of staff.

- Medical staff undertook two ward rounds daily during the week. Each patients' named consultant conducted one ward round, and the RMO conducted another. At weekends the RMO undertook ward round duties.
- The RMOs attended handovers and interacted with nursing staff to be aware of the clinical requirements of patients on a daily basis.

Records

Not all records had documented action plans to manage specific patient risks. However, staff kept records of patients' care and treatment which were up-to-date, stored securely and available to all staff providing care.

- Patient records were kept on site. During our inspection we reviewed nine sets of patient records. This included both nursing and medical records. Both nursing and medical records were paper based; although some basic patient details were stored electronically such as appointment details. Records were stored securely in locked rooms when not in use.
- Medical records viewed contained enough information to keep patients safe. They contained clear diagnoses and management plans. The medical notes detailed patient consent for surgery, details of the procedure undertaken, and showed that surgical safety checklists had been completed. We saw medical records contained evidence of daily consultant reviews and daily RMO reviews.
- All records were legible with the name and grade of staff member completing an entry clearly documented. All notes were signed and dated.
- Nursing notes had sheets for staff to confirm when they had completed an hourly 'intentional rounding' check which is when a member of staff attends the patient to check comfort and fundamental care needs. We saw that these sheets had gaps in them where staff had not recorded that they completed these checks. However, we directly observed staff undertaking these checks. Patients also told us that staff attended at least every half an hour to check on their needs.
- Staff completed risk assessments for a range of potential clinical compilations or concerns. These included falls risk assessments, the Malnutrition Universal Screening Tool (MUST), and the Waterlow assessment for pressure ulcers. However, we found that of records checked; whilst all had completed risk assessments in place; not all had recorded plans to manage any identified risk. This meant that staff could not consistently evidence they had identified how to manage such risks.Where plans were recorded in the notes; these were comprehensive and reflected the level of risk identified.
- Administrative staff ensured patient records were ready and prepared prior to patients arriving. As patients could have outpatient consultations at BMI The Priory Hospital; but opt to have their surgery at BMI Edgbaston Hospital; records had to be transferred between sites. A dedicated member of staff worked to deliver records between sites as required daily following a request by a member of the administration team. Staff told us this process worked well to make sure patient records were available. Staff used an electronic system to identifies where patient records were. Staff told us that on rare occasions they were not able to access records when they were required; on these occasions administrative staff created a temporary record was created using any electronic notes available. Therefore, no scheduled appointments were cancelled for this reason.
- Senior nurses within departments monitored patient records monthly. For May 2019; 10 records were checked and a score of 91% compliance to record keeping standards was recorded. We asked managers what action they took when scores were less than 100%. They told us they would speak to staff directly to address any specific areas of error.

Medicines

The service did not store all medicines safely. Documentation was not always fully completed. However, the service used systems and processes to prescribe, administer and record medicines.

- Staff followed systems and processes when prescribing, administering, and recording medicines. Medicines were mostly securely stored as per best practice guidelines from the Royal Pharmaceutical Society and the National Institute for Health and Care Excellence (NICE). However, we did see two different concentrations of intravenous potassium stored next to each other, out of any box or container which could lead to the wrong concentration being selected by a staff member in error. Best practice guidance states that medicines that look alike should be segregated and stored separately to avoid this.
- We saw some medicines were stored safely within a locked cupboard, and in date however had been decanted out of their original packaging such as injectable glucose.
- Controlled drugs (medicines which are controlled under the Misuse of Drugs legislation (and subsequent amendments) were appropriately and securely stored on both the ward and in theatres.
- Post inspection we received data which showed that some patients had been exposed to unnecessarily long time of being under anaesthesia prior to procedures commencing. The service did monitor temperature, and act accordingly in line with the BMI policy around this. However, no audits were completed to ensure compliance to this policy was maintained. In addition, we found some patients were given anaesthetic by consultant anaesthetists via a route which was not recommended by current research; for example, a spinal block rather than general anaesthetic for hip or knee replacement surgery. However, no incidents of harm had been reported or identified in relation to these concerns at the time of the inspection. We raised this with the service following the inspection when the hospital began a review of this practice. The consultants concerned remained suspended until an outcome was determined.
- Staff recorded and monitored both fridge and ambient room temperatures appropriately.
- Staff reviewed patients' medicines and provided specific advice to patients and carers about their medicines. During the pre-assessment appointment, where required, patients were given advice about medicines they were already taking. For example, if a patient was taken a medicine that may prevent blood clotting they were advised if they needed to stop this prior to their operation.
- A sepsis kit and an emergency blood fridge were available on the ward in the event of a patient requiring either of these types of interventions. Emergency drugs were stored on the resuscitation trolley kept on the ward. However, there were no signs in the drug storage room to indicate this.
- Staff mostly stored and managed prescribing documents in line with the provider's policy. During our inspection we looked at six patient prescription charts. We found that all but one prescription was signed and dated; allergies were generally recorded and writing was legible. We found that two out of four of the records reflected omitted doses which did not have a reason documented.
- Staff mostly followed current national practice to check patients had the correct medicines. We found that medical staff prescribed prophylaxis medicine to all patients that required this. Anti-coagulation use was in line with The National Institute for Health and Care Excellence (NICE) guidance 89 (2018).
- During our inspection we found that 'pre-load' high carbohydrate feed supplements were prescribed to support a faster recovery from major surgery. This was given out by nurses undertaking the pre-assessment. We saw both nurses working here had in date patient group directives (training and a signed confirmation that the nurse is able to give this medicine on behalf of a doctor to a defined group of patients).
- We saw results from a medicines reconciliation audit which was conducted in July 2018. The overall score achieved was 90% although no target to work against was noted. We saw where areas fell less than 100% actions were set and completed. For example, out of 10 records checked, nine had patients' allergy status recorded but one record did not. An action to remind staff to complete this section fully was set and signed off as completed.

Incidents

The service managed patient safety incidents well. Staff recognised routine incidents and near misses

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

- Managers shared learning about never events with their staff. Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event. No never events were reported by the service in the 12 months prior to our inspection. However, we saw information bulletins were shared with staff which included provider wide incident information such as learning following never events at other BMI sites.
- From January to June 2019; the service reported 170 incidents. The highest number was cancellation of surgery (48) followed by 'clinical concern' incidents (28). One hundred and forty-four were classified as 'no harm', 25 as 'low harm' and seven as 'moderate harm'. We saw within minutes from a clinical governance meeting that clear descriptions and outcomes of incidents were recorded and staff could access this information.
- Staff knew what incidents to report and how to report them. Staff reported incidents using an electronic reporting system. Whilst all staff had access to this; staff could also report an incident to the nurse in charge who could submit an incident on their behalf.
- Staff received feedback from investigation of incidents, both internal and external to the service. Staff told us they received information about incidents and any subsequent learning via team meetings. Staff told us of shared learning following incidents and were open about times they had made mistakes and learnt from this.
- A representative from each area of the hospital attended a daily 'comms cell' or safety huddle where hospital wide issues were discussed. The representative in attendance was expected to feedback any relevant information to staff working within their area after this meeting.
- Staff understood the duty of candour. They were open and transparent and gave patients and families a full explanation if and when things went wrong. Patients and families were given an apology and informed of any actions as a result. The duty of candour is a duty that, as soon as reasonably practicable after becoming aware that a notifiable safety incident has occurred a health service body must notify the relevant person that the incident has occurred, provide reasonable support to the relevant person in relation to the incident and offer an apology.
- Staff we spoke with were aware of the duty of candour and gave examples of where this had been applied; for example, following an incident whereby a patient was transported to BMI The Priory Hospital following complications in surgery. Another example was provided from the week of our inspection whereby a patient experienced a delay going into theatre which meant their procedure was cancelled. The consultant and anaesthetist were involved in providing an apology and ensuring that they were transparent with the patient to organise an alternative date.
- From January to June 2019; the hospital had five unplanned returns to theatre to manage complications. These were reported as incidents. We reviewed an investigation report for one of these incidents which occurred in February 2019. We saw that although this incident had not been identified as a 'serious incident'; a clear timeline of events was produced, and several areas of general improvement were documented. An action plan was attached which showed actions to be completed in a timely manner.
- Three unplanned readmissions were recorded from January to June 2019. This is when patients have to be readmitted within 28 days of having their surgery. We saw all three cases were investigated and learning was identified.
- We noted on a separate incident investigation report from February 2019 that an area of general improvement was for staff to document NEWS scores in the patient records for ongoing monitoring and comparison of patient baselines from admission to recovery; and time spent on the ward. During our inspection; we saw that observations were completed as per national guidelines and were recorded in patient records.

Requires improvement

Surgery

- The service reported one serious incident from January to June 2019. This occurred in June 2019 and was a patient fall with harm. The investigation process was still underway at the time of our inspection. This was reported to CQC in line with Care Quality Commission (Registration) Regulations 2009; Regulation 18 Notification of Other Incidents.

Safety Thermometer

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

- Safety thermometer data was displayed on wards for staff and patients to see.
- The safety thermometer data showed, except for patient falls, the service achieved over 95% harm free care for the last 12 months. For example, from January to June 2019 the hospital reported no patients sustained a pressure ulcer during their stay.
- Patient falls rose above 5% for February 2019. For the remaining months of December 2018 and January 2019 there were no patient falls recorded. Staff told us of actions they were taking to mitigate falls where patients were identified as higher risk such as ensuring mobility aids were available.

Are surgery services effective?

Requires improvement

Our rating of effective went down. We rated it as **requires improvement.**

Evidence-based care and treatment

The service did not always provide care and treatment based on national guidance and best practice.

- Staff mostly followed up-to-date policies to plan and deliver high quality care according to best practice and national guidance. The service followed best practice guidelines such as those produced by National Institute for Health and Care Excellence (NICE). Changes to these guidelines were communicated to staff from provider level who communicated changes through clinical governance meetings and staff bulletins.
- However, we found examples where best practice guidance or current research was not followed. For example, using a spinal block for anaesthetising orthopaedic patients undergoing hip or knee replacements rather than a general anaesthetic.Some medicines were not stored in line with best practice guidelines.
- Staff used an enhanced recovery programme with patients, particularly those undergoing orthopaedic surgery, such as hip or knee replacements. Enhanced recovery is an evidence-based approach which helps patients recover more quickly after major surgery. We saw patients were fully involved with this. As part of the pre-assessment appointment, patients saw a physiotherapist to complete a health questionnaire and to develop a treatment plan for before and post-surgery. We saw patients were mobilised as soon as appropriate after surgery. Physiotherapists took an active part in working with patients as part of this and also prescribed a course of ongoing exercises to complete after discharge. Patients we spoke with spoke highly of this service and felt the support they received in hospital was to a high standard. In addition, patients told us their post discharge treatment plan from physiotherapists was clear, easy to understand and helped them to identify the benefit of each exercise.
- As part of the enhanced recovery process, patients were prescribed 'pre-load drinks' at their pre-assessment appointment. These were high carbohydrate drinks which, if the plan was followed, supported a faster recovery post-surgery.
- Patients were provided with in-depth information about enhanced recovery, 'carb loading' and other information relevant to their forthcoming procedure at the pre-assessment appointment. This information was based on up to date best practice and NICE guidelines. For example, leaflets were given about surgical site infections which reflected NICE Quality Standard 49 (2013).
- All breast prosthesis and implants used were recorded on the National Breast and Implant register.

Nutrition and hydration

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

necessary. The service made adjustments for patients' religious, cultural and other needs. Staff followed national guidelines to make sure patients fasting before surgery were not without food for long periods.

- Staff used a nationally recognised screening tool to monitor patients at risk of malnutrition. Nutritional state was assessed for each patient on admission using the Malnutrition Universal Screening Tool (MUST). Food and fluid intake were monitored using food charts and fluid balance charts.
- Staff made sure patients had enough to eat and drink, including those with specialist nutrition and hydration needs. Staff discussed dietary preferences with patients, including likes and dislikes, as well as any allergies or cultural preferences.
- We observed patients were given clear information about fasting times prior to their operation for both solid food and fluids. Trained staff could provide 'carb loading' sachets for patients to have prior to their operation to maximise recovery. We saw that this was clearly explained to patients and literature was provided.

Pain relief

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

- Pain was discussed at the pre-assessment stage to help manage patient expectations. Patients were asked about their current pain levels prior to the operation and were given advice about this. Pain relief during and post-operatively was discussed; and patients were provided with information to read about this.
- Staff prescribed, administered and recorded pain relief accurately. Patients pain control was managed by the anaesthetist for surgical patients. The resident medical officer (RMO) could support with any post-surgery pain that required a medical member of staff. Alternatively, the relevant consultant could be called to reassess patients and amend a medication prescription.
- Pain advice booklets were given to patients for use post operatively. Pain scores were documented on the NEWS chart and managed accordingly. We saw pain scores were clearly recorded on a whiteboard in the nurses' station so this was clearly visible to staff.
- The pharmacy team supported pain management at ward level providing advice and support to the patients and the clinical teams. All medications given on discharge were communicated to the patient and the patient's GP via the discharge letter.
- Staff asked patients to complete patient questionnaires upon discharge and through this monitored patient feedback on pain relief.
- Patients received pain relief soon after requesting it. We spoke with three in-patients after they had had an operation. All three told us that the pain management was excellent; and where any problems were identified such as unwanted side effects to specific pain killers; staff were quick to respond and provide alternatives. Patients told us, and we saw, staff regularly checked pain levels and ensured patients were comfortable.

Patient outcomes

The service had limited evidence provided to demonstrate how effective surgical procedures were. However, the service did participate in national programmes to monitor results.

- Prior to our inspection, the service provided data which reported several different methods used to monitor patient outcomes. One of these methods was participation in national reported patient outcome measures (PROMs) and were working towards EQ-5D, which is a patient-reported outcome measure (PROM) that captures five dimensions of health-related quality of life: mobility, self-care, usual activities, pain/discomfort, and anxiety/depression.
- We requested PROMs data from the service. They provided us with information from May 2019 which showed out of an eligible 34 patients, two had returned the self-report questionnaire.
- From April 2018 to March 2019, of the 137 eligible patients who completed their pre-operative questionnaire, 52 (59.8%) also completed their post-operative questionnaire. The difference in the

results between the two questionnaires saw that all patients reported an improvement in their health with those undertaking a total hip replacement or hip primary reporting the biggest improvement.

- The service did not provide us with any further detail from the PROMs data to demonstrate the effectiveness of surgical procedures undertaken. For example, the service did not provide a breakdown of how patients reported on the five dimensions of quality of life or any further analysis of the data.
- The service reported it participated in the National Joint Registry (NJR) to collect information on orthopaedic joint replacement operations, to monitor the performance of implants and the effectiveness of different types of surgery. Data from the service showed that the consent rate to be included in the NJR for 2018 was 77%, with an 80% rate recorded for 2019 as of July 2019. Data specifically for the month of July 2019 showed 19 procedures were undertaken with 89% of patients completing the consent paperwork. The service had an annual NJR compliance and data validation audit which covered from April 2017 to March 2018. As a result, several recommendations were made such as ensuring all outstanding NJR records are fully submitted and include the NJR as part of the hospital's internal audit plan. A post audit action plan showed that improvement and monitoring actions were in place.
- BMI Edgbaston Hospital management team submitted data to the Private Healthcare Information Network (PHIN). This provides a publicly accessible oversight of the hospital. We checked PHIN in August 2019 and found the hospital was ranked 'good' in terms of submitting information to PHIN including patient satisfaction and PROMS data.
- Due to the service only providing minimal outcome data; it was not possible for us to make full comment on how effective this service is; nor how this data was used to drive improvement.

Competent staff

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

- Managers gave all new staff a full induction tailored to their role before they started work. Newly employed nursing staff received an induction package which included a booklet to complete to demonstrate competency in required clinical skills. Part of the induction process was to work across different areas of the hospital, so staff were familiar with all areas.
- Newly employed nurses worked supernumerary for four weeks before being put on the staff rota. A local practice educator visited weekly to ensure new starters were supported and competent.
- Staff working with pre-assessment had access to a corporate course of training which was accredited by an external university. Senior nurses completed observational audits of staff practice within pre-assessment. This was done monthly. In May 2019, we saw two staff were observed and both achieved 100% compliance against requirements.
- Senior staff could access leadership courses via e-learning. Staff told us they felt well supported by local management and able to develop their skills.
- Staff on the ward undertook link nurse roles for infection prevention and control and health and safety. This is where staff undertake additional training, so they can support other staff in the team with questions and queries.
- Managers supported staff to develop through constructive appraisals of their work. Staff told us they received regular one to one meetings and twice yearly appraisals with their managers. These were an opportunity to identify good work and areas for development, and any ongoing training needs.
- A formal appraisal system was in place, however not all staff had received one. In the last full appraisal year from October 2017 to September 2018, 70% of registered nursing staff and 60% of healthcare assistants and operating department practitioners in surgery had received an appraisal.
- Resident medical officers (RMO) and agency nurses and health care assistants received a local induction upon commencing at the hospital.

- Managers made sure staff attended team meetings or had access to full notes when they could not attend. Departmental team meetings were held with staff who were on shift. We saw minutes were produced and distributed for all staff to review.

Multidisciplinary working

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

- Staff worked across health care disciplines and with other agencies when required to care for patients. Patients had a high level of access to physiotherapy support. Physiotherapists were actively involved in the pre-assessment processes and both pre and post-surgery. Physiotherapists attended daily to work with patient post operatively and to develop a treatment plan for after discharge.
- Staff held regular and effective multidisciplinary meetings to discuss patients and improve their care. We observed excellent working relationships between the pre-assessment nurse and health care assistants and the physiotherapy team to provide a co-ordinated and person-centred assessment package.
- The hospital management team held a daily 'comms cell' which was led by the duty manager. This was attended by a representative of each department within the hospital therefore encouraged a collaborative and multidisciplinary approach to managing the safety of the patients. This meeting was held at 12pm at BMI Edgbaston Hospital and followed on from a daily 9am meeting held at BMI The Priory Hospital. A manager working cross site attended both meetings to ensure consistency and cross site support.
- Staff at the service shared information with patients' GP if the patient consented to this. This ensured that relevant information was shared so the patient could receive holistic care.

Seven-day services

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

- Consultants led daily ward rounds including at weekends when they had an inpatient requiring review. Patients were reviewed by their named consultant. Patients were also reviewed daily by the resident medical officer, including weekends. Consultants provided on call cover for any patients under their care outside of working hours.
- A theatre team was available 24 hours per day, seven days per week for emergency returns to theatre. The ward was also open 24 hours seven days per week for inpatients.
- The pharmacy service at BMI Edgbaston Hospital was open from 9.30am to 4pm between Monday to Thursday, and 9am to 5pm on Friday. It was not open at weekends. Out of hours; a member of the on-call pharmacy team could attend if required.
- Physiotherapy services were available from 8.30am and 4.30pm daily. Outside of these hours an on-call physiotherapist was available and contracted to be available at the hospital within one hour if required.

Health promotion

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

- Staff assessed each patient's health when admitted and provided support for any individual needs to live a healthier lifestyle. Staff provided patients with a variety of leaflets including information on their specific condition, and more general information about maximising health and wellbeing.
- The service had agreed care quality indicators to work towards in collaboration with the clinical commissioning groups which supported health promotion. In particular focussing on smoking and alcohol use. We saw these topics formed part of the initial assessment process; and patients were asked to share information to be offered support where appropriate.
- The service had relevant information promoting healthy lifestyles and support on every area we visited. We saw this was widely available and accessible for patients and their visitors.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Nursing staff completed specific training in the Mental Capacity Act and Deprivation of Liberty Safeguards

(2005). Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients' consent. They knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health.

- Staff gained consent from patients for their care and treatment in line with legislation and guidance. Staff at the service had access to a comprehensive policy outlining consent; and how this could be obtained and documented. This policy included information about capacity to consent; and referred staff to other relevant policies where capacity to consent may be in question.
- Staff clearly recorded consent to care and treatment in the patients' records. We saw that consent to surgical procedure was obtained and signed by both patients and consultants prior to surgery in the two records where we checked consent forms. Where appropriate; staff talked through the consent form for the patient to be included on The National Joint Registry which provides outcome data in relation to hip, knee, shoulder, elbow and ankle replacements and asked patients to sign this.
- Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. Due to the facilities and design of the hospital, most of the patients treated had capacity to consent to treatment. Patients who had significant cognitive or neurological impairment would usually be treated in an NHS hospital which had more appropriate facilities to support patients with extensive additional needs around capacity to understand and consent to treatment. Despite this; we were told of examples where some patients had a reduced or fluctuating capacity to consent; such as patients with mild learning disabilities. Staff told us how they supported patients to understand their proposed treatment in collaboration with carers.
- Staff made sure patients consented to treatment based on all the information available. Staff provided information leaflets to patients about consent and what this meant. The leaflets provided guidance for patients should they have any questions.
- Nursing staff did not complete specific training in the Mental Capacity Act and Deprivation of Liberty Safeguards (2005). However, as above the service did not generally see patients who would require a DoLS application to be made (to deprive a patient of their liberty to provide care or treatment on the basis that that patient does not have the capacity to make such decisions). Data from the service reported they planned to introduce this training in the future.
- During our inspection, whilst reviewing patient records we saw one patient had an active 'do not attempt cardio pulmonary resuscitation' in place at the time of their procedure. This was appropriately filled out and recorded visibly on the patient record.

Are surgery services caring?

Good

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

Compassionate care

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

- Patients generally gave positive feedback about the service in the Friends and Family Test survey. From July to December 2018; the hospital scored an average of 94.8% in the family and friends test (FFT). This meant that on average, 94.8% of the patients who responded would recommend the hospital to their friends or family. We noted a decline in scores from August; this ranged from 98.5% in August 2018 to 84.6% in December 2018.
- However, we saw that the service response rate to the FFT was low therefore this needs to be considered. On average, from July to December 2018; under 21% of patients seen at the hospital completed an FFT response card. This ranged from 26.5% in November 2018 to 11.9% in December 2018.
- We requested more up to date figures from January to June 2019. We found that the response rate had increased ranging from 15.6% (57 responses) in June 2019 to 44.2% (77 responses) in April 2019. The scores ranged from 91% of patients who would recommend the hospital to family and friends in June 2019 to 99.2% in April 2019.

- The 'patient led assessment of the care environment' (PLACE) audit for BMI Edgbaston Hospital from 2018 showed a score of 92.4% compliance for privacy, dignity and wellbeing.
- During our inspection we observed slightly more up to date information from January 2019 which showed a patient satisfaction score of 98.5%.
- Patients said staff treated them well and with kindness. We spoke with four patients and one relative during our inspection. All five individuals told us they had received excellent care from all staff they had seen, including doctors, nurses, housekeeping and support staff. Patients reported that they had received a dignified service and felt that staff had time to listen to them and support their wellbeing whilst in hospital.
- Patients told us, and we saw, that staff engaged in open conversation and made time to learn out patients' likes, dislikes, hobbies and personal lives. This enabled a natural rapport to be built up so patients felt more comfortable whilst in hospital.
- Patients told us that staff consistently introduced themselves when they came to provide care or treatment.
- Staff were discreet and responsive when caring for patients. Staff took time to interact with patients and those close to them in a respectful and considerate way. During our inspection we saw that staff spoke to patients kindly and with respect. During physical examinations, curtains were drawn to promote privacy in the pre-assessment area. Patient bedroom doors were closed when patients were talking with staff to maintain confidentiality. We observed all staff to present as cheerful and caring throughout our visit.
- Patients could request a chaperone when seeing staff. Posters were displayed advertising this service.
- During our inspection we saw several comments and 'thank you' cards displayed which had been written by previous patients. These indicated that the patients had received a positive experience whilst at the hospital and commented on the kindness shown by staff.
- We observed that staff clearly identified where they felt patients may benefit from help or support and offered this in an open way. For example, we observed a patient who was struggling to walk. Staff identified the patient may benefit from a walking stick. They discussed this with the patient and as a result the patient was provided with a walking aid during their appointment.

Emotional support

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

- Staff offered patients and those close to them help, emotional support and advice when they needed it. Patients told us, and we saw, that emotional support was discussed and offered at pre-assessment. All patients we spoke with had not found this necessary however were aware they could access this.
- Staff understood the emotional and social impact that a person's care, treatment or condition had on their wellbeing and on those close to them. We saw that staff discussed with patients how they felt about their operation and if they had any concerns or worries. Staff gave patients time to talk about how they felt.

Understanding and involvement of patients and those close to them

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

- Staff made sure patients and those close to them understood their care and treatment. Patients told us, and we saw that the pre-operative assessments undertaken were thorough and ensured patient involvement. Patients were encouraged to pre-populate assessment documentation in advance where possible; and this was discussed and formed the basis for the assessment. Patients who had used the service before felt the pre-assessment and the amount of information they had been provided with was an improvement from previous years.
- Patients told us that all staff listened to them fully and answered any questions or queries. In-patients said that staff regularly checked in to see if patients or relatives needed anything.
- Patients and their families could give feedback on the service and their treatment and staff supported them to

do this. Patients told us if they had experienced a problem, the hospital were quick to resolve this regardless of where the problem had originated from; for example, where a pre-surgery prescription was not issued. Patients told us they felt confident to speak openly to staff and raise any concerns either whilst at the hospital or via telephone.

- Patients told us they felt staff were genuinely interested in their requirements and choices. In particular, one patient told us they felt their consultant had made an effort to read medical notes relating to past operations as well as the current procedure they had received. Further examples were given of very specific food requirements or past health needs which were discussed at pre-assessment. When the patient was later admitted for surgery; staff on the ward were aware of these requirements already without the patient having to repeat themselves.
- Patients told us that the hospital staff sought to work round them; for example, work or family commitments to plan surgery for the most appropriate time.
- We saw a recent staff bulletin which had a page with "advice from patients". This included quotes from patients to ensure that patients' voices were heard; and that staff kept patients at the centre of their work.

Are surgery services responsive?

Good

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

Service delivery to meet the needs of local people

The service planned and provided care in a way that met the needs of local people and the communities served. The service was also inclusive of those living further away, including patients from abroad. It also worked with others in the wider system and local organisations to plan care.

- BMI Edgbaston provided surgical services to both private (self-funded and through private health insurance) and NHS patients. The hospital generally served the local population; however, we saw that private patients travelled from further away within the UK and abroad to be seen and treated by specific consultants.
- The hospital provided solely elective procedures. The service worked with consultants who used the hospital under practising privileges agreements and would ensure facilities and equipment to meet patient demands was supplied.
- Two local clinical commissioning groups (CCG) contracted NHS services for local patients. Forty two percent of inpatients were funded by the NHS (367 out of 1,139). Just under 73% of day-case patients were funded by the NHS (2,535 out of 3,841).
- Data from the service showed that in the financial year of 2018 to 2019; a target of 'supporting proactive and safe discharge – preparing patients for discharge' had been set collaboratively between the CCG and the hospital. This was due to end in April 2019. Data from the service indicated they had met their set target for this; data was collected through patient satisfaction surveys.
- Facilities and premises were appropriate for the services being delivered. The hospital grounds offered free parking to patients and visitors. The building was suitable for patients with reduced mobility. Lifts were available for patient and visitor use in order to access the ward and theatre areas. The ward environment was suitable for the type of services provided. The area was bright and spacious.

Meeting people's individual needs

The service was inclusive and took account of patients' individual needs and preferences. Staff made reasonable adjustments to help patients access services, although implementation of the Accessible Information Standard required improvement.

- When staff undertook the pre-assessment with patients; in addition to recording clinical information, they also undertook a social and lifestyle assessment to make sure individual needs were met. This included identifying if any care or support would be required post discharge. Where this was required; staff could contact local authorities to support patients access community social care.

Requires improvement

Surgery

- Staff organised interpreters, so they could fully understand patients if English was not a first language. This included British Sign Language interpreters. All staff we spoke with were familiar with this and understood how to access it. A recent example was provided where a BSL interpreter attended theatre pre-surgery in addition to recovery post-surgery in order to ensure staff could explain the process to a patient who had learning disabilities and therefore required additional support.
- The service provided extensive amounts of leaflets and literature to support patients at each stage of their treatment. The majority of these could be translated into either languages other than English; or into accessible formats in line with the Accessible Information Standard. However, we did not see any information displayed to inform patients and visitors these were available.
- A loop recorder was available on reception to support patients who are hard of hearing and text messages are used to remind patients of appointments.
- We asked the service about any other measures to support the communication needs of patients who required alternative formats due to disability as per the Accessible Information Standard (AIS) which is a legal requirement of any healthcare providing organisation. The information provided indicated that the service did not fully understand their responsibilities under the AIS. For example, the information provided referenced translation services for non-English speakers; and how staff could identify patients with additional needs; rather than specific communication aids for patients with disabilities who may require this. Options available included a leaflet about consent being available in large print, and as above, hearing loops in reception areas and BSL interpreters.
- Staff made sure patients living with mental health problems, learning disabilities and dementia, received the necessary care to meet all their needs. Where patients had additional needs, such as dementia, family and friends were encouraged to attend to provide support and assistance. Visiting times were flexible to support the needs of patients.
- The service undertook an annual Patient Led Assessment of the Care Environment' (PLACE audit). The service reported that this helped to identify they could improve the care provided for patients with dementia.
- We saw the ward had an 'assisted bathroom' which was separate from individual patient rooms and was larger for easier access. However, at the time of the inspection this was being renovated and was partially being used as a store room.
- The 'patient led assessment of the care environment' (PLACE) audit for BMI Edgbaston Hospital from 2018 showed a score of 96.9% compliance for 'disability' which indicates that the service was suitable for patients who identified as disabled. The hospital was wheelchair accessible and the rooms and en-suite bathrooms were suitable for patients who had disabilities which required the use of wheelchairs.
- Housekeeping staff offered a variety of meals using the patient menu which was a provider wide document. We saw adapted menus for patients with additional needs. For example, a 'dragonfly menu' was an adapted menu for patients with dementia using pictures as well as words. This also gave guidance for staff to help patients choose and eat their meals. Different colour plates were recommended for patients with dementia to aid visual distinction for the location of food.
- Staff were able to describe how they would work with patients with cognitive or neurological impairment or acquired brain injury; for example, patients with learning disabilities or patients living with dementia.
- Where patients had additional needs such as a learning disability which impacted upon their ability to support themselves whilst in hospital; the hospital made special arrangements such as enabling carers to stay with the patient. Additional staff could be rostered on to support patients who required more regular routine care.
- The hospital offered four different holy books for patients to borrow during their stay. These encompassed the most popular religions practiced in the local area.
- Patients were given a choice of food and drink to meet their cultural and religious preferences.Family and friends could visit patients between 11am and 9pm; we saw staff were flexible with this in specific

circumstances. Visitors could order meals from the menu to eat with the patient they were visiting; or alternatively could access a canteen area and purchase food and drinks.

- Patients had access to free wi-fi, individual televisions and a bookshelf with a range of paperback books.

Access and flow

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

- Patients were able to book appointments via a range of methods. The service published available clinics and treatments on a centralised website so that NHS patients had flexibility of choice as to where they could undergo treatment. Private patients, including self-pay and private insured could book appointments through a centralised team or via the BMI website, which included a 'live chat' support function.
- Managers worked to keep the number of cancelled operations to a minimum. Data from the service showed that from January to June 2019, 56 procedures were cancelled. Of these, 48 were for clinical reasons and eight for non-clinical reasons. Data from the service told us that all NHS patients 38 in this time were offered a new surgical date within 28 days of their cancelled operation. Private patients were free to choose when they would like their procedure to be re-scheduled.
- Managers monitored waiting times and made sure most patients could access services when needed and received treatment within agreed timeframes and national targets.NHS patients referred for non-emergency consultant-led treatment were on 'referral to treatment' pathways. This is the length of time that a patient waited from referral to start of treatment, or if they have not yet started treatment, the length of time that a patient has waited so far. NHS patients should wait a maximum of 18 weeks for non-urgent surgery. Data from the service from January to June 2019 showed that patients undergoing surgery for gastroenterology, general surgery, trauma and orthopaedics and urology all received treatment in less than 18 weeks.
- Patients undergoing surgery for ear, nose and throat speciality did not always receive their treatment in 18 weeks. In January 2019 patients who had their operation had waited an average of 21 weeks, in February just over 19 weeks, in April just over 23 weeks, and in May just under 23 weeks. Patients waited less than 18 weeks who received their operations in March and June 2019.
- We saw for the gynaecology speciality; patients operated on in March 2019 waited just over 18 weeks. However, for all other months between January and June 2019, patients had waited less than 18 weeks.
- Managers and staff worked to make sure that they started discharge planning as early as possible. Expected length of stay was discussed with patients on their pre-operative appointment. Staff at the hospital followed pathways to encouraged enhanced recovery therefore reducing the patients' length of stay.

Learning from complaints and concerns

It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff. The service included patients in the investigation of their complaint.

- The service clearly displayed information about how to raise a concern in patient areas. Staff provided patients with leaflets and literature about how to give feedback and how to make a complaint. These were readily available in patient areas.
- We saw posters on display advertising changes made because of patient feedback. For example, one suggestion was "more and better communication between staff". As a result, the handover process was adapted to include the wider team such as the resident medical officer, physiotherapists and pharmacist.
- Patients, relatives and carers knew how to complain or raise concerns. Patients told us that where they had raised concerns the hospital had quickly resolved this. One patient told us about a complaint they made regarding communication about appointments. They reported that this was dealt with and no further problems had been noted.

Requires improvement

Surgery

- From July to December 2018; 18 complaints were submitted about the hospital. Of these, eight were submitted about the ward, and three about theatres. The remainder related to outpatients. The complaints data submitted by the service showed all complaints were 'resolved' expect for one where the outcome was 'unknown'. However, a meeting was set up with this patient to discuss their concerns. We saw that appropriate actions were set against complaint data to ensure learning.
- We requested more updated data from January to June 2019 which showed 16 complaints had been submitted. Of these, six were delayed in getting a final response to the patient as per the BMI complaints policy which stipulates a 20 day response turnaround. This was due to some investigations taking longer. Patients were kept informed of delays and a holding letter had been sent to each patient identifying the reason why their complaint investigation had not been completed.
- Managers shared feedback from complaints with staff and learning was used to improve the service. We saw minutes from team meetings whereby complaints were discussed; and areas for improvement identified.
- Staff used patient satisfaction results to improve the service. Information from January 2019 showed a patient satisfaction score of 98.5%. An action plan had also been developed following patient feedback which included managing pain levels better, promoting discharges before 11am and improving staff response to patient call bells.

Are surgery services well-led?

Inadequate

Our rating of well-led went down.We rated it as **inadequate.**

Leadership

Not all leaders at all levels had the skills or abilities to run the service. They did not always understand or manage priorities and issues the service faced.

However, local leaders were visible and approachable in the service for patients and staff. They supported staff to develop their skills and take on more senior roles.

- The local leadership structure at the hospital was clear. An executive director oversaw both BMI Edgbaston Hospital and BMI The Priory Hospital. Two directors of clinical services supported the executive director with the clinical management of the service across both sites. In addition; a quality and risk manager, an operations manager and a consultant relations manager worked at senior management level.
- Heads of department worked under the senior management team to lead their respective work areas such as theatres, the ward and pre-assessment. Senior staff nurses supported the heads of department.
- However, we found that not all leaders at all levels managed potential issues or concerns effectively or robustly. Please see the 'governance' and the 'managing risks, issues and performance' sections below for more detail.
- Staff told us they felt supported by local management who were visible and approachable.
- We reviewed a sample of minutes from various local departmental team meetings within 2019 and found that these included relevant information such as training, incident and complaint updates.

Vision and strategy

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

- As reported earlier; BMI The Edgbaston Hospital and BMI The Priory Hospital merged management structures in 2018 to become BMI Birmingham; although both still remain separately registered with CQC. This was to support staffing and sharing of resources and formed part of a strategy 'Stronger Together'. This strategy aimed to create a two-site single hospital which was able to deliver outstanding care in the right locations.

Underpinning this vision and strategy were values which supported the aim of "Prioritising our patients and staff ensuring a safe environment, whilst preserving an effective, responsive service being well-led by a professional, caring and trustworthy culture".

- Staff were familiar with the vision and values and knew where these were displayed. Staff told us the service promoted these values and felt this motivated them to work for the company.

Culture

Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service had an open culture where patients, their families and staff could raise concerns without fear.

- Staff told us they enjoyed working at the hospital and spoke of a 'family feel'. Patients we spoke with confirmed this and reported that the atmosphere of the hospital was friendly and warm; and that staff appeared genuinely happy to provide care and treatment. Staff spoke of working well as part of a team and providing support to each other.
- All staff we spoke with were familiar with the duty of candour, and when we asked, staff could provide examples of when they had seen this in practice. Staff reported on the importance of taking an open, honest and transparent approach with patients and their relatives/ carers when things went wrong.
- BMI Edgbaston Hospital had a local freedom to speak up guardian who was awaiting training at the time of inspection. This was due to take place in August 2019. We were told that some staff had approached the freedom to speak up guardian for advice and support.
- We were told that the freedom to speak up guardian at BMI The Priory Hospital had received information regarding patient recovery times post-surgery at BMI Edgbaston. As a result; this was explored and although a small number of cases were identified via the incident reporting process; no common themes were found with these.
- A BMI policy entitled 'raising concerns at work (whistleblowing)' outlined the different routes staff could take to raise concerns; and promoted that any staff member raising genuine concerns would not be penalised.
- Following our inspection, we reviewed samples of staff newsletters including one from across both hospital sites; and local departmental documents. These included positive messages for staff, personal celebrations such as weddings. The freedom to speak up service was advertised in these publications.
- During the financial year of 2018 to 2019; the hospital worked to improve staff wellbeing as part of a clinical quality indicator as agreed with the clinical commissioning groups. During our inspection this was not raised with the inspection team as having any impact upon staff wellbeing. However, evidence from the service shows that they had started some initiatives to support the process including 'walk to work' schemes and discussions around workplace wellbeing as part of the appraisal process.

Governance

Leaders did not always use or follow available governance processes effectively although these were in place. We raised concerns that had been undetected or unmonitored through provider and location wide processes. However, staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.

- A governance structure was in place. Locally; clinical governance meetings were held whereby senior managers across both BMI Edgbaston Hospital and BMI The Priory Hospital attended. Below this level, quality meetings were held; heads of department (local department managers) attended these. Heads of departments then cascaded any information down into local team meetings. Information from clinical governance meetings could be communicated to the provider wide senior and executive manager level.
- However, we found that when information of concern was raised this was not always effectively managed. Please see 'managing risks, issues and performance' below for more detail.
- Furthermore, we found that managers were not up-to-date with developments in practice. For example, safeguarding children training did not reflect the intercollegiate document; Safeguarding Children and Young People: Roles and Competencies for Healthcare

Staff (2019) which stated that all non-clinical and clinical staff who have contact with children, young people, parents/ carers or those who may pose a risk to children should have training in at least level two children's safeguarding. Data from the service in the above paragraph told us that all clinical and non-clinical staff who worked in pre-assessment, theatres and the ward area could potentially have contact with these groups. Therefore, all these staff should be trained to at least level two.

- We saw there were several committees whereby separate meetings were held. These included the infection prevention and control committee, the medicines management committee and the resuscitation committee. These fed back into the clinical governance meetings.
- We reviewed a sample of minutes from across the above mentioned meetings and found them to be detailed, meaningful and well attended.
- Managers at the service completed a weekly review of all incidents submitted (from both hospital sites) to monitor investigation processes. Through this; the quality and risk manager identified if incidents had been appropriately classified in terms of seriousness (level one, two and three) and ensured they were correctly allocated for investigation. Incidents identified as 'serious incidents' (level three) were investigated formally to identify a root cause.
- We saw an overview of incident analysis from March 2019. We saw across both BMI Edgbaston Hospital and BMI The Priory (figures were combined) 106 incidents were reported. Of these, 65 were reported as 'no harm', 42 as 'low harm', one as 'moderate harm' and none as either severe harm or death. We saw that clear descriptions and outcomes of the incidents were recorded and staff could access this information. Of these incidents; the majority related to delayed discharge and postponed operations. We saw that 48% of the incident reported came from the ward area, 17% came from pre-assessment and 8% came from theatres. This was further broken down into just BMI Edgbaston figures which showed that 27 incidents had been reported specifically from this location in that month.
- All incidents identified as level two or three were discussed within clinical governance meetings to ensure oversight and monitoring. Investigation reports were presented at this forum; attendees could question and challenge the investigation report to ensure it was robust. Attendees at these meetings included the local senior management team.
- In addition to clinical governance meetings; quality meetings were held whereby performance and adherence to clinical quality indicators were discussed. These were attended by heads of department (department managers) and the quality and risk manager.Incidents and complaints were also shared at these meetings; an overview of which was shared with all staff. Heads of departments could raise concerns at these meetings which would be escalated to clinical governance meetings where appropriate. The quality and risk manager attended both clinical governance meetings and quality meetings to ensure a flow of information in both directions.
- Incidents and learning were shared with the medical advisory committee (MAC) via the representatives for each medical speciality. Monthly MAC meetings covered both sites. However, we were not assured of the robustness of the MAC process as we found a number of examples of where good practice guidelines were not followed and areas of concern were not addressed in a timely way. We were not assured the MAC sufficiently challenged these practices to ensure risks to patient safety were fully mitigated.
- Staff attended monthly meetings held on the ward and in pre-assessment. We saw meeting minutes which reflected the topics discussed.
- Managers provided staff with clinical governance; quality and risk bulletins and asked staff to sign to confirm they had read the information. We reviewed these on inspection and saw they contained a range of information including national patient safety alerts, changes to medicines, and more local (BMI) incident and complaint overviews.

Managing risks, issues and performance

Leaders and teams did not always identify and escalate relevant risks and issues. Some individual audits were not well documented. However, leaders and teams used systems to manage performance effectively.

- At the time of our inspection, local managers told us of the documented top five risks to the service. One was a business-related risk regarding competitors. The others included staffing (nurses and allied health professionals), the General Data Protection Regulations (GDPR), failure of staff to report incidents and investment in critical building works. We were told of improvements and actions that had been taken to address these risks. For example, reporting of incidents had increased from an average of 18-24 per month in 2018 to 27-35 in 2019. Staffing was monitored daily to ensure patient safety was maintained. However, the risk register did not contain all risks. Issues of unsafe or inappropriate practices by specific individuals had not been fully identified or explored until after we alerted the registered manager. After the senior management team were made aware of significant risks to the service which had been in place in some cases for a number of years, action was taken. However, we were not assured this would have been undertaken unless we had raised these specific concerns with the leadership team.

  Departments within the hospital had local risk registers. Data sent before the inspection included risk registers for theatres and the ward as of February 2019. We noticed that the local risk registers did not reflect all of the relevant risks to the service and evidence that all potential risks were investigated or monitored robustly. Prior to our inspection we received information that one consultant was running two theatre lists consecutively. We explored this during our inspection and found that the senior management team were aware of this. Whilst this is not usual practice in the UK; it is acceptable to do so if a provider assures themselves this is being done in a safe way. We were told that checks had been undertaken to ensure this was safely managed; such as looking at any complications following these specific surgeries and ensuring both theatres were safely staffed to undertake this work. However, we were told that this was by a non-specialist member of the senior management team. However, post our inspection; the service told us that an observational audit was conducted by an independent BMI director of clinical services with a theatre background in April 2019. At this stage, no concerns with safety were raised or found, despite us identifying some unsafe practice. Therefore, we were not assured this practice was being undertaken safely or in line with best practice guidelines developed in other countries. As referenced in the sentences above, we found unsafe practice was occurring which had not been identified or addressed. This risk was some patients were experiencing prolonged anaesthesia prior to procedures being started. For example, we looked at two theatre lists on the 25th June 2019 were undertaken concurrently by the same surgeon. Each list had two patients. All four patients had been exposed to unnecessarily long times of being under anaesthetic; although no harm was caused.

- We asked for additional audit data on length of time patients spent under anaesthetic. We found the service had not identified this as an area of concern; and as a result, had not conducted any audits. Therefore, there was no oversight of this area of risk. We also found that despite there being a BMI policy in place; no audits were conducted regarding the temperature of patients who were under general anaesthetic; especially when this was for prolonged periods.

- We found that human tissue was being retained on BMI Edgbaston Hospital premises at the request of a consultant in 2018 and 2019 for research purposes. We found that the hospital did not, at this time, have authority to keep this on the premises. There was no documented evidence that patients had given their consent for their tissue to be stored for use in research. We found the service was aware of this; as per an audit by a manager within the BMI Healthcare Ltd group. The service had written to the consultant involved and asked them to remove the human tissue which was done. However; no further action was taken to ensure future planned patients provided consent for their tissue to be used for research. We have referred this to the appropriate regulator who are undertaking further investigations.

- We found other risks were not recognised; for example, during our inspection we found that not all medicines were stored in line with best practice guidelines from the Royal Pharmaceutical Society and the National Institute for Health and Care Excellence (NICE). We saw two different concentrations of intravenous potassium stored next to each other, out of any box or container which could lead to the wrong concentration being selected by a staff member in error. Despite this practice not being linked to any incidents occurring, best

practice guidance states that medicines that look alike should be segregated and stored separately to avoid this. This was escalated to the leadership team during the inspection period who rectified this immediately.

- During our inspection we observed two 'comms cells'. These were daily meetings held at midday at BMI Edgbaston, and earlier in the day at BMI Priory so information could be shared. These meetings included the director of clinical services, the duty manager, the quality and risk manager and representatives from all areas across the hospital including housekeeping and administration. In these meetings; each department gave a brief update regarding patient activity, capacity, staffing rates, incidents or complaints and any concerns or problems which was recorded on a whiteboard. This enabled daily oversight and quick management of any incidents or concerns. We did notice that there was no medical representation at these meetings such as the resident medical officer. We asked about this; and were told this idea would be taken forward and considered for the future.
- Local managers undertook a regular programme of audit to ensure day to day activity was in line with best practice guidelines and corporate policies. For example, audits included record audits, staff clinic observations for pre-assessment staff, Methicillin-resistant Staphylococcus aureus (MRSA) audits and hand hygiene audits. We sample checked a range of results. For May 2019, we found 91% compliance for the pre-assessment record keeping audits, and 100% compliance for clinic observation audits. During January 2019, 100% was achieved for compliance to MRSA protocols and pathways.
- Prior to our inspection; the service submitted data which included various audits. Whilst these audits demonstrated performance in specific areas such as infection prevention and control or the safer surgery checklist compliance; they were not always clear as to the nature of the audit or the outcomes. For example, we received a copy of an audit into safer surgery checklists as conducted in December 2019. We saw that this was entitled an 'observational audit' implying the auditor had actively viewed the process. However, the audit also reported that 10 records were sampled indicating this was a documentation audit. Therefore, we were not sure of this audit process. In addition; in the 'total' columns, instructions were given for the auditor to provide both a total 'score' and a compliance percentage. Only the score was given which may result in less meaningful results. Furthermore; there was no target specified so we were unsure of what compliance was considered adequate by the service. Another example was of a 'safe and secure medicine' audit. This had date of completion. No total score recorded or target to work against. No actions set nor any confirmation of the name of the person completing this documentation. Therefore, the audit as a performance measure was not useful, despite what appeared to be a high level of compliance against measures.
- Despite the above, we saw minutes from linked committee meetings where clear action plans were detailed, monitored and closed when appropriate. For example, minutes from an infection prevention and control meeting from October 2018 showed a good level of attendance from different areas of the hospital; and demonstrated a review of actions since January 2018. These minutes demonstrated clear oversight of this work stream.
- We requested data regarding audits post inspection and found that from January to June 2019, clear audit results with action plans were available to view. One recurring comment related to safeguarding training levels not being compliant. This was an area of concern we also identified as part of our inspection process. The audit document we reviewed reported this concern formed part of an action plan developed by the paediatric clinical services manager. We reviewed this action plan following the inspection which showed staff non-compliance of safeguarding training was being monitored . This was not on the risk register at the time of inspection.
- The service employed a quality and risk manager to oversee risk, issues and performance. We were told of changes to the audit programme process to ensure a more thorough oversight of performance. We saw that in the 12 months prior to the inspection trends had been identified through audits and incident monitoring; such as issues around pre-assessment and non-clinical cancellations for surgery. This identification enabled the service to monitor performance and identify if occurrences were linked or independent of each other. For example, in July 2019; two surgery cancellations had

occurred. The reasons for these were identified as un-linked; one was related to an unknown patient pregnancy and the other was relating to an incorrect MRSA screening result from a third-party provider.

- The service had set two care and quality indicators (CQUINs) in collaboration with local clinical commissioning groups. These were centred around reducing patient falls and supporting patients to reduce their intake of alcohol and tobacco. This was a new initiative at the time of the inspection and as such a new member of staff had been employed on a three-month contract to undertake the required audits to measure and monitor this.

Managing information

The service collected and analysed data. The information systems were integrated and secure. Data or notifications were consistently submitted to external organisations as required.

- During our inspection we saw that the service had a holistic view of performance which included information on quality, operations and finances. Information was shared through formal governance meetings and daily 'comms cell' meetings where representatives from each area of the hospital shared information.
- However, the service missed key opportunities to review practice to drive improvement and improve patient safety. For example, the service did not audit or monitor where surgeons used two theatres simultaneously. Some audits conducted by the service were not clear in terms of what was being audited or what the outcomes were. Some information sent post inspection was contradictory such as some mandatory training data. The service also did not submit a full range of outcome data when requested post inspection as Patient Reported Outcome Measures (PROMs) data was provided to BMI by an external provider who did not provide a full breakdown of the PROMs categories.
- We saw that where required, the service submitted formal notifications to CQC for example following a serious incident.
- Staff had access to accurate information to allow them to do their job.Staff had access to computers to access up to date policies and procedures.
- Management told us they had access to the right information to do their job well. Managers received local information on performance outcomes that enabled them to drive improvement in their specific areas; such as hand hygiene audit results.
- During our inspection, we did not identify any data security breaches. We saw that patient records were securely stored on site; and an electronic system was used to record the location of patient records for tracking. Staff asked information to enable patients to positively identify themselves before commenting with any care, assessment or treatment. This ensured that the patient being seen matched with the patient record.

Engagement

Leaders and staff actively and openly engaged with patients, and staff, to plan and manage services. They collaborated with partner organisations to help improve services for patients

- Patients could complete feedback and comments cards after their stay. These were included in the patient discharge pack and also within patient bedrooms. Staff told us that the response rate to patient feedback forms was not as good as it should be. Staff told us of plans to work towards increasing this by involving patients in providing feedback at the pre-assessment stage. We directly observed during a pre-operative assessment that staff did discuss providing feedback about their experience at the hospital.
- The service collaborated with the clinical commissioning groups to identify quality indicators to promote patients and staff health and wellbeing.
- Monthly newsletters were distributed to staff provided news and updates covering both BMI Edgbaston Hospital and BMI The Priory Hospital. In addition, local newsletters, for example ward based, were circulated with more specific information for the surgical ward staff.
- Monthly team meetings were held for both theatre and ward staff and were well attended. We reviewed minutes of team meetings and saw that they covered the most important issues to the areas at the time.

Learning, continuous improvement and innovation

Requires improvement

Surgery

Staff were committed to continually learning and improving services.

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

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

- The provider must ensure staff completion of mandatory training; including training in the Mental Capacity Act and Deprivation of Liberty Safeguards. This was a breach of the Health and Social Care Act, Regulation 18: Staffing.
- The service must ensure that staff are trained in line with the intercollegiate document; Safeguarding Children and Young People: Roles and Competencies for Healthcare Staff (2019). This was a breach of the Health and Social Care Act, Regulation 18: Staffing.
- The service must ensure all risks to the service are robustly investigated and monitored to ensure compliance to legislation. This was a breach of The Health and Social Care Act, Regulation 17: Good Governance.
- The service must ensure they undertake risk assessments for non-standard practice such as the use of two theatres consecutively by one consultant to undertake surgery. This was a breach of The Health and Social Care Act, Regulation 17: Good Governance.
- The service must ensure that patients are not unnecessarily exposed to prolonged periods of anaesthesia. This was a breach of the Health and Social Care Act, Regulation 12: Safe Care and Treatment.
- The service must ensure that all completed risk assessments in place also have recorded plans to manage any identified risk. This was a breach of the Health and Social Care Act, Regulation 12: Safe Care and Treatment.
- The service must ensure all medicines including intravenous fluids are stored as per best practice guidelines from the Royal Pharmaceutical Society and the National Institute for Health and Care Excellence (NICE). This was a breach of the Health and Social Care Act, Regulation 12: Safe Care and Treatment.

Action the provider SHOULD take to improve

- The service should continue to assure themselves that staff are documenting NEWS scores accurately and fully; and that escalation of deteriorating patients is completed in line with the provider policies.
- The service should ensure they comply with the Accessible Information Standard.
- The service should consider ensuring that individual audit documentation is completed to a high standard.

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
Surgical procedures Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing **Regulation 18 HSCA 2008 (Regulated Activities) Regulations 2014. Staffing.** **Persons employed by the service provider in the provision of a regulated activity must receive such appropriate support, training, professional development, supervision and appraisal as is necessary to enable them to carry out the duties they are employed to perform.** **Completion rates of some modules of mandatory training were low. This included care and communication of the deteriorating patient, basic and intermediate life support, information governance and chaperoning.** **Not all staff were compliant with safeguarding training as set out in the intercollegiate document; Safeguarding Children and Young People: Roles and Competencies for Healthcare Staff (2019).** **The service did not offer training to staff in the Mental Capacity Act or Deprivation of Liberty Safeguards.** **Regulation 18 (1)(a)**

Regulated activity	Regulation
Surgical procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance **Regulation 17 HSCA 2008 (Regulated Activities) Regulations 2014. Good Governance.**

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Requirement notices

Providers must operate effective systems and processes to make sure they assess and monitor their service against Regulations 4 to 20A of Part 3 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (as amended).

The provider must have a process in place to make sure this happens at all times and in response to the changing needs of people who use the service.

The provider must 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.

We found that managers at the service, including the registered manager, were aware of potential risks to patient safety and a lack of compliance to Human Tissue Authority Legislation; but did not robustly investigate or monitor this.

We found that not all patient risk assessments had a completed action plan within patient documentation.

Regulation 17 (1)

Regulated activity	Regulation
Surgical procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Regulation 12 HSCA 2008 (Regulated Activities) Regulations 2014. Safe Care and Treatment. Care and treatment must be provided in a safe way for service users. 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

This section is primarily information for the provider

Requirement notices

and safety of service users of receiving the care or treatment; (b) doing all that is reasonably practicable to mitigate any such risks; (g) the proper and safe management of medicines.

We found some patients had been exposed to unnecessarily long time of being under anaesthesia prior to procedures commencing. In addition, we found some patients were given anaesthetic via a route which was not recommended by current research; for example, a spinal block rather than general anaesthetic for hip or knee replacement surgery.

We found two different concentrations of intravenous potassium stored next to each other, out of any box or container.